

Saint Louis University Public Law Review

Volume 25
Number 2 *Mental Capacity and the Death
Penalty (Volume XXV, No. 2)*

Article 7

2006

Mental Illness and the Death Penalty

Eileen P. Ryan

Sarah B. Berson

Follow this and additional works at: <https://scholarship.law.slu.edu/plr>



Part of the [Law Commons](#)

Recommended Citation

Ryan, Eileen P. and Berson, Sarah B. (2006) "Mental Illness and the Death Penalty," *Saint Louis University Public Law Review*: Vol. 25 : No. 2 , Article 7.

Available at: <https://scholarship.law.slu.edu/plr/vol25/iss2/7>

This Article is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in Saint Louis University Public Law Review by an authorized editor of Scholarship Commons. For more information, please contact erika.cohn@slu.edu, ingah.daviscrawford@slu.edu.

MENTAL ILLNESS AND THE DEATH PENALTY

EILEEN P. RYAN* AND SARAH B. BERSON**

This article explores the issue of mental illness and the death penalty, a timely topic given two recent Supreme Court death penalty decisions: *Atkins v. Virginia*¹ and *Roper v. Simmons*.² We discuss some of the pitfalls inherent in attempts to exempt the mentally ill from the death penalty, and explain why we think that narrowing any exemption to the *psychotic* mentally ill makes the most sense from a practical, as well as medical/psychiatric perspective.

Despite huge strides in our understanding of and ability to treat mental disorders in the past thirty years, the general public remains ambivalent and uninformed about many aspects of mental illness and the mentally ill.³ Perhaps nowhere is this more evident and worrisome than in society's beliefs and attitudes toward mentally ill criminals, particularly those who commit crimes of violence against others. The significance of this lack of understanding has increased in recent decades; the relationship between mental illness and capital punishment has become more intimate and complicated as the Supreme Court has woven the use of psychiatry and psychology into its death penalty jurisprudence.⁴

This relationship is complicated by the fact that psychiatry, like all medical specialties, changes as new theories are generated and older theories are refined or rejected in light of new information. National consensus and public opinion also change over time, of course. The Court acknowledges that national consensus is important, as are changes in it, by including it as a factor

* Associate Professor of Psychiatric Medicine, University of Virginia Health System, Charlottesville, Virginia. Medical Director, Institute of Law, Psychiatry & Public Policy. D.O. Chicago College of Osteopathic Medicine (1984), B.A. New York University (1975).

** J.D. expected June 2008, University of Virginia School of Law; B.A., 2003, Franklin & Marshall College.

1. *Atkins v. Virginia*, 536 U.S. 304 (2002).
2. *Roper v. Simmons*, 543 U.S. 551 (2005).
3. See Joanmarie Ilaria Davoli, *Still Stuck in the Cuckoo's Nest: Why do Courts Continue to Rely on Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987, 987-90 (2002).
4. See *Atkins*, 536 U.S. at 318-21 (holding that the application of the death penalty to the mentally retarded violates the Eighth Amendment); *Ford v. Wainwright*, 477 U.S. 399, 405 (1986) (The Court had to decide was "whether the Eighth Amendment prohibits the execution of the insane.").

in its decisions in several death penalty cases.⁵ Public opinion, however, is not a substitute for scientific knowledge. Scientific opinion changes, as does public opinion, and ought to be factored into decision making the way that public opinion is. However, scientific opinion is *not* public opinion, and we ought not to allow public opinion to be presented as medical knowledge.

Psychiatrists and psychologists have become increasingly involved in the capital sentencing process since the 1970s, when presenting mitigating information for juries' consideration became the right of capital defendants.⁶ In 1985, the Supreme Court expanded the role of psychiatric experts in death penalty cases⁷ by setting a minimum standard for capital defendants to have access to psychiatric consultation.⁸ As the role of psychiatry and psychology in death penalty law grows and changes, it is important that the science is used responsibly and consistently. This article explores several aspects of the relationship between psychiatry and the death penalty. The topic is particularly timely given two recent death penalty decisions from the Supreme Court, both of which have the potential to affect the relationship between psychiatry and capital punishment: *Atkins v. Virginia*,⁹ which dealt with the execution of mentally retarded criminals and *Roper v. Simmons*,¹⁰ which dealt with the execution of minors.

By discussing some of the pitfalls inherent in attempts to exempt the mentally ill from the death penalty and the bounds of psychiatric knowledge and how it ought to be applied, we will argue that any such exemption should be narrowed to the *psychotic* mentally ill.

5. See, e.g., *Roper*, 543 U.S. at 562-68; *Atkins*, 536 U.S. at 312-16.

6. Douglas Mossman, *Atkins v. Virginia: A Psychiatric Can of Worms*, 33 N.M. L. REV. 255, 255 (2003). Psychiatrists have also rebutted mitigating evidence and testified as to aggravating factors in capital sentencing hearings, most typically those involving the "future dangerousness" of capital defendants. The importance of psychiatrists and psychologists adhering to professional standards of medical and psychological evaluations and conclusions is well illustrated in the aggravating mental health testimony of Dr. James Grigson. Dr. Grigson, a Texas psychiatrist, has frequently testified for the prosecution and opined that defendants, some of whom he had never personally examined, were "100 percent" likely to kill again. These conclusions are not medically or scientifically grounded. Robert Weinstock & Liza H. Gold, *Ethics in Forensic Psychiatry*, in THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY 91, 110 (R.I. Simon & L.H. Gold eds., 2004); Laura Bell, *Groups Expel Texas Psychiatrist Known for Murder Cases*, DALLAS MORNING NEWS, July 26, 1995 (posted on the internet by Canadian Coalition Against the Death Penalty, <http://ccadp.org/DrDeath.htm>. (last visited Mar. 27, 2006)).

7. Howard Owens, *Criminal Law and Forensic Psychiatry*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 831, 841 (Richard Rosner ed., 2d ed. 2003) (discussing *Ake v. Oklahoma*, 470 U.S. 68 (1985)).

8. *Ake*, 470 U.S. at 74, 77-83.

9. *Atkins*, 536 U.S. at 312.

10. *Roper*, 543 U.S. at 555-56.

From Furman to Roper

In 1972, the Supreme Court, in *Furman v. Georgia*, held that the death penalty was being applied unconstitutionally and put a moratorium on executions.¹¹ Of the five-person majority, three argued that it was unconstitutional to apply the death penalty in a “capricious and arbitrary” manner¹² and that in order to comport with the Eighth Amendment, states must consider the proportionality of the punishment to the crime and use a consistent standard in their application of the death penalty.¹³ The other two justices found that the death penalty violated the Eighth Amendment’s ban on “cruel and unusual punishment” in all cases, not just those that were “arbitrary.”¹⁴ After *Furman*, several states revised their capital sentencing laws with an eye on the “arbitrary and capricious” hurdle, making the imposition of the death penalty more predictable by assigning a mandatory death penalty sentence to all homicides committed under certain specified conditions.¹⁵ In 1976, 1978, and again in 1982, however, the Court ruled that this approach was also unacceptable and that judges and juries tasked with the decision to impose the death penalty must consider “the character and individual circumstances of a defendant” in the case at issue and must receive enough information about both to do so.¹⁶

In 1976, the Supreme Court re-examined Georgia’s death penalty statute, revised post-*Furman*, in *Gregg v. Georgia*.¹⁷ The Supreme Court upheld Georgia’s statute, noting that while it did not “narrow the scope of its murder provisions,” it, among other things, sufficiently “narrow[ed] the class of murderers subject to capital punishment by specifying 10 statutory aggravating circumstances,”¹⁸ and adequately addressed the problem of arbitrariness noted in *Furman*.¹⁹ The Supreme Court also acknowledged that national consensus had shifted and there was greater support for the death penalty than in 1972, noting that a number of states had adopted new statutes post-*Furman* and this was used as evidence of change in national opinion toward the death penalty.²⁰

11. *Furman v. Georgia*, 408 U.S. 238, 239-40 (1972) (per curiam).

12. *Id.* at 240, 256-57 (Douglas, J., concurring); *id.* at 308-10 (Stewart, J., concurring); *id.* at 310-11, 313-14 (White, J., concurring).

13. *Id.* at 309 (Stewart, J., concurring); *id.* at 312-13 (White, J., concurring).

14. *Id.* at 305-06 (Brennan, J., concurring); *id.* at 358-60, 369-71 (Marshall, J., concurring).

15. *See, e.g.*, *Lockett v. Ohio*, 438 U.S. 586, 589, 593-94 (1978) (discussing OHIO REV. CODE §§ 2929.03-2929.04(B) (1975)); *Woodson v. North Carolina*, 428 U.S. 280, 285-86 (1976) (discussing N.C. GEN. STAT. § 14-17 (Cum. Supp. 1975)).

16. *Eddings v. Oklahoma*, 455 U.S. 104, 106, 113-17 (1982); *Lockett*, 438 U.S. at 604-09; *Woodson*, 428 U.S. at 303-05.

17. *Gregg v. Georgia*, 428 U.S. 153, 158, 196-207 (1976).

18. *Id.* at 196-97, 207.

19. *Id.* at 198, 206-07.

20. *Id.* at 179-81.

The properties of the Georgia statute itself that met the standard of non-arbitrariness were (a) changes in the scope of certain requirements which made the statute sufficiently narrow to ensure that it served the dual purposes of deterrence and retributivism by regarding the types and circumstances of crimes that led to consideration for the death penalty;²¹ and (b) required judges and juries to consider the nature of the defendant and the circumstances at issue when making sentencing decisions and provided them with the information to do so.²²

Six years later, in *Eddings v. Oklahoma*, the Supreme Court continued to gradually increase the constitutional protections for criminals, ruling that in the sentencing phase of a capital trial, judges and juries must have the opportunity to learn of the defendant's character and weigh mitigating factors when deciding whether or not to impose the death penalty.²³ Such potentially mitigating factors include a defendant's history of adverse circumstances during childhood, such as coming from a broken home and experiencing childhood abuse, as well as the defendant's history of mental illness.²⁴ Developing mitigation in capital cases typically requires expert witnesses (psychiatrists or psychologists) to assist in gathering and interpreting information regarding the defendant's mental health history, such as damaging psychological effects of abuse, and often testifying as to how such factors came to shape the defendant.²⁵

In 1986, the Supreme Court's ruling in *Ford v. Wainwright* prohibited the execution of the most gravely mentally ill criminals—those so severely mentally ill that they did not meet the very low bar of competence to death.²⁶ The *Ford* majority again considered the applicability of changes in the nation's opinion of the death penalty, noting that the “evolving standards of decency” ought to be considered.²⁷ While the majority opinion did not provide a definition of “competence,”²⁸ Justice Powell, in his concurring opinion, narrowed the category of the “gravely mentally ill” to “[only] those who are unaware of the punishment they are about to suffer and why they are to suffer

21. *Id.* at 196-98.

22. *Id.* at 197-98.

23. *Eddings v. Oklahoma*, 455 U.S. 104, 113-17 (1982).

24. *Id.* at 107-08.

25. Gregory B. Leong et al., *The Death Penalty*, in *PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY* 81 (Richard Rosner ed., 2d ed. 2003).

26. *Ford v. Wainwright*, 477 U.S. 104, 401, 417-18 (1986).

27. *Id.* at 406 (noting that the “evolving standards of decency that mark the progress of a maturing society” should be included in Eighth Amendment considerations (*quoting* *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion)). “Moreover, the Eighth Amendment's proscriptions are not limited to those practices condemned by the common law in 1789.” *Id.* (referring to *Gregg*, 428 U.S. at 171 (opinion of Stewart, Powell, and Stevens, JJ.)).

28. *See id.* at 401-18.

it.”²⁹ This recommendation would essentially limit the prohibition to those prisoners who are psychotic.

In addition to not defining “competent,” the Supreme Court did not specify standards or procedures for evaluations and determinations of mental illness, an omission that has contributed to the diversity of death penalty statutes and the disparate degrees of protection they afford the mentally ill.³⁰

Atkins and Roper

In 1989, the Supreme Court held that mild mental retardation did not provide an exemption from the death penalty.³¹ At the time of that ruling, only two death penalty states banned the execution of the mentally retarded, and the Court did not consider this “sufficient evidence . . . of a national consensus” that executing the mentally retarded would constitute “cruel and unusual punishment” under the Eighth Amendment.³² By 2002, however, when the Supreme Court issued the *Atkins* decision, eighteen of the thirty-eight states that allowed capital punishment had banned the execution of the mentally retarded.³³ The Court interpreted this as evidence that national consensus had evolved to the point where imposing the death penalty on mentally retarded defendants did constitute “cruel and unusual punishment,” thus violating the Eighth Amendment.³⁴

Also in 1989, the Court addressed juvenile eligibility for execution. In the Court’s five-to-four decision in *Stanford v. Kentucky*, it noted contemporary standards of decency, but opined that the execution of a juvenile over the age of fifteen, but under age the age of eighteen, did not violate the Eighth and Fourteenth Amendments.³⁵ At the time, twenty-two of the thirty-seven death penalty states allowed the execution of 16-year-olds, and twenty-five states permitted it for 17-year-olds.³⁶ In 2005, the Supreme Court held by a five-to-four vote that the execution of juveniles was excessive and that juveniles were exempt from the death penalty.³⁷ The majority again took note of the changes in national standards since it issued its ruling in *Stanford*, by referring to

29. *Id.* at 422 (Powell, J, concurring).

30. Amnesty International, *United States of America: The Execution of Mentally Ill Offenders*, AI Index: AMR 51/003/2006 (Jan. 31, 2006), available at <http://web.amnesty.org/library/Index/ENGRAMR510032006>.

31. *Penry v. Lynaugh*, 492 U.S. 302, 307-08, 340 (1989).

32. *Id.* at 334-35; see also *Atkins v. Virginia*, 536 U.S. 304, 314 (2002) (citing *Penry*, 492 U.S. at 334).

33. *Atkins*, 536 U.S. at 342 (Scalia, J., dissenting); see also *id.* at 314-15 (opinion of the Court).

34. *Id.* at 316, 321.

35. *Stanford v. Kentucky*, 492 U.S. 361, 369-77 (1989) (opinion of the Court, Scalia, J.); *id.* at 380-81 (O’Connor, J., concurring).

36. *Id.* at 370.

37. *Roper v. Simmons*, 543 U.S. 551, 578-79 (2005).

Atkins, on which Simmons based his petition, and revisiting the concept of “evolving standards of decency.”³⁸

The decisions in *Atkins* and *Roper* raised hopes in some circles that the same principles (evolving standards of decency and national consensus) cited by the Supreme Court could be equally persuasive in arguing for exempting the severely mentally ill from the death penalty. However, psychiatry and psychology must be wary of an already fickle legal system that often distorts the use of psychiatric disorders and diagnosis and psychiatric and psychological testimony. One example of how courts and legislators can distort the use of psychiatric diagnosis and its meaning are sexually violent predator (SVP) laws.³⁹ In upholding the State of Washington’s Community Protection Act, the Supreme Court essentially allowed states to define mental illness however they wanted.⁴⁰ Although *Atkins* dealt with the execution of the mentally retarded, not the mentally ill, the majority opinion illustrates some of the hazards of using psychology and psychiatric “diagnosis” to justify an opinion that has some clear medical and scientific lacunae regardless of any moral justification.

The Trouble With Atkins

Daryl Atkins “was convicted of abduction, armed robbery, and capital murder [of an airman committed when he was age 18,] and [he was] sentenced to death.”⁴¹ Both Atkins and his accomplice claimed that the other had actually killed the victim, but apparently his accomplice presented a more “coherent” version of events and he was offered a plea bargain (to first degree murder, rather than capital murder) in exchange for his testimony against Atkins.⁴² Atkin’s history was littered with academic failure dating back to elementary school and concluding with his failure to finish high school.⁴³ The defense psychologist administered intelligence tests, in which Atkins obtained a Full Scale IQ of fifty-nine (well into the mildly mentally retarded range) and also, as is the standard in forensic evaluations, sought additional information

38. *Id.* at 560-68.

39. *See Seling v. Young*, 531 U.S. 250, 253-56 (2001) (discussing Washington’s Community Protection Act of 1990 and an instance in which the act was used against someone). *See Davoli, supra* note 3, at 989.

40. Washington State’s Community Protection Act of 1990 defines a sexually violent predator as one “who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.” WASH. REV. CODE ANN. § 71.09.020 (West 2002).

41. *Atkins v. Virginia*, 536 U.S. 304, 307 (2002); Donna St. George, *A Question of Culpability*, WASH. POST, July 23, 2005, at A01, available at http://www.washingtonpost.com/wpdyn/content/article/2005/07/22/AR2005072202101_pf.html.

42. *Atkins*, 536 U.S. at 307 n.1.

43. St. George, *supra* note 41, at A01.

regarding the defendant from others who knew him over the years.⁴⁴ Another psychologist, retained by the prosecution, did not perform intelligence testing and did not obtain collateral information;⁴⁵ however, he testified that Atkins was of “at least average intelligence.”⁴⁶

Atkins also had a prior criminal history, which included convictions for assault, a fact that was not lost on the two juries that voted for the death penalty.⁴⁷ In *Atkins* the Court held by a six-to-three majority that the execution of mentally retarded individuals violated the Eighth Amendment’s ban on cruel and unusual punishment.⁴⁸ The decision was based on two major factors:

1. the Court’s determination that a “national consensus” had developed that the mentally retarded should not be executed,⁴⁹ and

44. *Atkins*, 536 U.S. at 308–09.

45. An often overlooked complication in our adversarial system, which often relies on expert witnesses to help inform the courts, is that some experts approach their forensic evaluations with clear biases that they do little to control, and some just perform substandard evaluations for a host of other reasons (incompetence, inadequate time or compensation, a desire to “please” the retaining attorney, etc.). Hon. Earl J. Waits, *Evaluating Psychiatric Disorders: A View From the Bench*, 2 Ann.2003 ATLA-CLE 2583 (2003) (“Both the clinical and forensic fields produce occupational bias, though of a different nature.”).

46. *Atkins*, 536 U.S. at 309 n.6. Virginia Supreme Court Justices Hassell and Koontz dissented from the affirmation of imposition of the death penalty for Atkins in 2000, rejecting the prosecution’s opinion that Atkins was of at least average intelligence as “incredulous as a matter of law.” *Atkins v. Commonwealth*, 534 S.E. 2d 312, 323 (Va. 2000) (Hassell & Koontz, JJ., concurring in part and dissenting in part), *rev’d*, 536 U.S. 304 (2002).

47. *Atkins*, 536 U.S. at 308-09; St. George, *supra* note 41. In the months leading up to murder of the airman, Atkins, who also used marijuana and crack cocaine, had been involved in a string of robberies, and had shot one female victim in the abdomen. The first jury voted for a death sentence on Feb. 14, 1998, but the sentence was overturned on appeal when the Virginia Supreme Court ruled that the jurors had been given an improper verdict form. The second jury also voted for death on Aug. 19, 1999. St. George, *supra* note 41.

On August 5, 2005 after deliberating for thirteen hours a jury in York, Virginia determined that Daryl Atkins was not mentally retarded. The Supreme Court never ruled on whether Atkins was mentally retarded, so the issue of whether or not Atkins is retarded was revisited in 2005. The prosecution psychologist testified that Atkins showed no signs of intellectual disability when interviewed, providing as examples the fact that Atkins told him he was good at algebra (even though he had failed math at school), and correctly answered “Michelangelo” and “Einstein” when asked who painted the Sistine Chapel and who is associated with the theory of relativity. Atkins had previously received IQ scores ranging from fifty-nine to seventy-six, but had never been tested prior to age eighteen. Dave Reynolds, *Jury Says Atkins Does Not Have Mental Retardation; Judge Sets Execution Date*, Inclusion Daily Express, Aug. 5, 2005, available at <http://www.inclusiondaily.com/archives/05/08/05/080504vaatkins.htm>.

48. *Atkins*, 536 U.S. at 321.

49. *Id.* at 313-16.

2. that mentally retarded individuals who kill are less culpable and less likely to be deterred by the death penalty than the “average murderer.”⁵⁰

The question must be asked: What or who is the “average murderer?”⁵¹ There is no data or research to guide one in this area. Is the “average murderer” the individual who kills impulsively with minimal forethought in the commission of another crime, or is it the murderer who kills in the context of some interpersonal conflict? The “average murderer” even without the complication of mental illness would not meet the accepted threshold for meriting the death penalty, which has been reserved for the “worst” killers.⁵² In the majority opinion, Justice Stevens stated that “pursuant to our narrowing jurisprudence, which seeks to ensure that only the most deserving of execution are put to death, an exclusion for the mentally retarded is appropriate.”⁵³ This raises the question as to what is and/or should be the critical factor(s) contributing to “narrowing jurisprudence?” In his dissenting opinion, Justice Rehnquist dismissed the Court’s reliance on “international opinion, the views of professional and religious organizations, and opinion polls”⁵⁴ Justice Scalia, in his dissenting opinion, observed that “[s]eldom has an opinion of this Court rested so obviously upon nothing but the personal views of its Members.”⁵⁵ Death penalty opponents and scholars frequently point to public opinion polls that indicate that the public is opposed to executing the mentally ill.⁵⁶ However, the public’s idea of what constitutes “mentally-ill-enough” to avoid execution is no clearer than what “mentally-retarded-enough” meant in public opinion polls that were quoted in the *Atkins* decision.⁵⁷ Whether or not *Atkins* is acceptable from a legal perspective, its reasoning is deeply flawed from a medical and scientific perspective. Specifically, the way the decision used psychiatric diagnosis, has opened the door to considering whether other groups, including the mentally ill, are worthy of such categorical exemption from the death penalty.⁵⁸ Co-opting psychiatry to provide assistance and

50. *Id.* at 318-21.

51. *Id.* at 319.

52. Charles Lane, *Changing Attitudes About the Death Penalty*, WASHINGTON POST, Jan. 2, 2006, at A11; see also *Roper v. Simmons*, 543 U.S. 551, 569 (2005) (“cannot with reliability be classified among the worst offenders”); *Atkins*, 536 U.S. at 319 (“If the culpability of the average murderer is insufficient to justify the most extreme sanction . . . the lesser culpability of the mentally retarded offender surely does not merit that form of retribution. . . . [O]ur narrowing jurisprudence . . . seeks to ensure that only the most deserving of execution are put to death . . .”).

53. *Atkins*, 536 U.S. at 319.

54. *Id.* at 328 (Rehnquist, C.J., dissenting).

55. *Id.* at 338 (Scalia, J., dissenting).

56. *Id.* at 328-37 (Rehnquist, C.J., dissenting).

57. *See id.* at 325-37.

58. Mossman, *supra* note 6, at 278.

testimony that is not medically or scientifically supported is dangerous for both the legal and medical professions. Regardless of one's personal beliefs about the death penalty, an examination of the reasoning and use of psychological research and findings in *Atkins* highlights potential pitfalls in crafting an overly broad exemption from execution for mental illness.⁵⁹

Legal Arguments Against Imposing the Death Penalty on the Mentally Ill

Christopher Slobogin has articulated several legal arguments against the imposition of the death penalty on the mentally ill. The "Equal Protection Argument"⁶⁰ states that given current prohibitions against executing juveniles and the mentally retarded, there is no rational basis for treating the mentally ill differently, and this differential treatment violates the Fourteenth Amendment requirement of equal protection under the law. The "Due Process Argument"⁶¹ states that consideration of mental illness as an aggravating factor in the sentencing phase is a due process violation, as it is contrary to law in every death penalty state, where it is stated that mental illness should be considered as a mitigating factor.⁶² Slobogin's third argument against the death penalty is the "Eighth Amendment Argument."⁶³ Here, he contends that the major functions of the death penalty, retribution and deterrence, are not carried out, because many severely mentally ill offenders are so impaired that they are unable to fully appreciate the significance of their sentence.⁶⁴ However, this lack of appreciation for the significance of their sentences would apply only to the most floridly psychotic of death row prisoners unless the words "fully" and "significance" were defined more stringently.⁶⁵

"Death Is Different" and The Problem of Using Mental Illness in the Incremental Abolition of the Death Penalty

Because the death penalty is "qualitatively different" from all other punishments, it requires special procedural protection against error.⁶⁶ The

59. *Id.*

60. Christopher Slobogin, *Mental Illness and the Death Penalty*, 1 CALIF. CRIM. L. REV. 3, ¶¶ 6-15 (2000), available at <http://www.boalt.org/bjcl/v1/vlslobogin.htm>.

61. *Id.* at ¶¶ 16-28

62. See *Lockett v. Ohio*, 438 U.S. 586, 604 (1978).

63. Slobogin, *supra* note 60, at ¶¶ 29-38.

64. *Id.* at ¶¶ 29-36.

65. *Id.* at ¶¶ 32-33.

66. *Ring v. Arizona*, 536 U.S. 584, 614 (2002) (Breyer, J., concurring in the judgment) ("[T]he Eighth Amendment requires States to apply special procedural safeguards when they seek the death penalty." (citing *Gregg v. Georgia*, 428 U.S. 153 (1976)); *Atkins v. Virginia*, 536 U.S. 304, 337 (2002) (Scalia, J., dissenting) (stating the majority's holding that it is cruel and unusual punishment to execute the mental retarded is the "pinnacle of . . . death-is-different jurisprudence"); *Wainwright v. Witt*, 469 U.S. 412, 463 (1985) (Brennan, J., dissenting) (citing "the previously unquestioned principle" that unique safeguards are necessary because death is

Supreme Court has consistently described two features of the death penalty that justify extraordinary procedural safeguards.⁶⁷ One is the irreversibility and irrevocability of death.⁶⁸ The other feature is the “enormity” or “severity” of this “ultimate” punishment.⁶⁹ However, there is not unanimity on the constitutional basis for the “death-is-different” jurisprudence on the current Supreme Court.⁷⁰ In his dissent in *Atkins*, Justice Scalia states “[t]here is something to be said for popular abolition of the death penalty; there is nothing to be said for its incremental abolition by this Court.”⁷¹ It is precisely this “incremental abolition” that creates dilemmas with respect to the concept of mental illness and the death penalty.⁷² The arguments made in *Atkins* were made again in *Roper* and similar arguments can be expected in the case that ultimately challenges the execution of a mentally ill petitioner, as we will discuss in the following sections.⁷³

Reaction from Professional Organizations to Atkins

The responses from a variety of professional organizations, including the American Psychiatric Association, to *Atkins* was contradictory to their usual stances regarding the use of diagnoses for non-clinical purposes.⁷⁴ After *Atkins*

“qualitatively different”); *Furman v. Georgia*, 408 U.S. 238, 286, 289 (1972) (Brennan J., concurring) (stating “[d]eath is a unique punishment . . .” and that “[d]eath . . . is in a class by itself.”); *id.* at 306 (Stewart, J., concurring) (stating that “[t]he penalty of death differs from all other forms of criminal punishment, not in degree but in kind”).

67. See, e.g., *Gregg*, 428 U.S. at 187.

68. *Ring*, 536 U.S. at 616 (Breyer, J., concurring) (“death is not reversible”); *Wainwright*, 469 U.S. at 463 (Brennan, J., dissenting) (“irrevocability”); *Gregg*, 428 U.S. at 187 (“There is no question that death as a punishment is unique in its . . . irrevocability.”); *Furman*, 408 U.S. at 290 (Brennan, J., concurring) (“[F]inality of death precludes relief.”); *id.* at 306 (Stewart, J., concurring) (Death is “unique in its total irrevocability.”).

69. *Gregg*, 428 U.S. at 187 (Stewart, Powell, and Stevens, JJ., joint opinion) (death is “unique in its severity”); *Furman*, 408 U.S. at 286, 287, 290 (Brennan, J., concurring) (death is the “ultimate sanction[;]” “uniqueness of death is its extreme severity[;]” and “[d]eath is truly an awesome punishment”).

70. *Atkins v. Virginia*, 536 U.S. 304, 337-38 (2002) (Scalia, J., dissenting) (“[D]eath-is-different jurisprudence. . . . [F]ind[s] no support in the text or history of the Eighth Amendment . . . Seldom has an opinion of this Court rested so obviously upon nothing but the personal views of its Members.”).

71. *Id.* at 353.

72. *Id.*

73. *Roper v. Simmons*, 543 U.S. 551, 567 (2005) (“As in *Atkins*, the objective indicia of consensus in this case—the rejection of the juvenile death penalty in the majority of States; the infrequency of its use even where it remains on the books; and the consistency in the trend toward abolition of the practice—provide sufficient evidence that today our society views juveniles, in the words *Atkins* used respecting the mentally retarded, as ‘categorically less culpable than the average criminal.’” (quoting *Atkins*, 536 U.S. at 316)).

74. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Text Revision) xxxvii (4th ed., 2000) [hereinafter DSM-IV-TR] (“The

was announced, Renée Binder, M.D., then Chair of the American Psychiatric Association's Committee on Judicial Action commended the Court's decision, noting that the Court had recognized that "there are objective and reliable determinations of whether an individual has mental retardation when the assessment is done by qualified professionals with substantial experience."⁷⁵

The amicus brief submitted by the American Psychological Association, American Psychiatric Association, and American Academy of Psychiatry and the Law, boldly states that "mental retardation can be identified using time-tested instruments and protocols with proven validity and reliability."⁷⁶ Furthermore, the brief states that psychologists and psychiatrists can make an "objective determination" regarding whether a defendant is or is not mentally retarded by using established tests of intelligence and adaptive functioning, and that examiners "undertaking separate assessments should reach the same conclusions."⁷⁷ However, there is a significant body of evidence and experience that contradicts these assertions.⁷⁸

The statement by Marilyn Benoit, M.D., then president of the American Academy of Child and Adolescent Psychiatry (AACAP), also issued after the

purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. . . . The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.").

75. Ken Hausman, *Court Bars Execution of Mentally Retarded Criminals*, PSYCHIATRIC NEWS, July 19, 2002, at 1, available at <http://pn.psychiatryonline.org>.

76. Brief of American Psychological Association, American Psychiatric Association, and the American Academy of Psychiatry and Law as *Amici Curiae* in Support of Petitioner at 3, *McCarver v. North Carolina*, No. 00-8727 (2001), available at <http://www.apa.org/psyclaw/alpha.html> [hereinafter Brief of APA]. The Supreme Court was slated to hear the case of a mentally retarded inmate. *McCarver v. North Carolina*, 532 U.S. 941 (2001). The Court dismissed this case when the North Carolina legislature passed a statute barring the execution of the mentally retarded. PsycLAW: *Atkins v. Virginia*, available at <http://www.apa.org/psyclaw/atkins-v-va.html> (last visited Mar. 28, 2006) [hereinafter PsycLAW]; See also *McCarver v. North Carolina*, 533 U.S. 975 (2001). The Court then allowed briefs that had already been prepared in support of *McCarver* to be presented in the *Atkins* appeal. PsycLAW, *supra*.

77. Brief of APA, *supra* note 76, at 3.

78. See generally Tomoe Kanaya et al., *The Flynn Effect and U.S. Policies*, 58 AMERICAN PSYCHOLOGIST 778 (2003), available at www.apa.org/journals/releases/amp5810778.pdf. "Thus, the 'official' definitions [of mental retardation] vary slightly, although all of them stipulate an IQ of 70 or below as being an important criterion for classification as MR. However, whether a child who meets the IQ score criteria for MR is actually labeled MR can vary substantially between school districts and agencies and even between psychologists within an agency or a school district. Part of this variability is due to the ambiguity in the definition of *limited adaptive skills* Moreover . . . it is possible to be subaverage during one epoch of life but not during another." *Id.* at 779 (citations omitted) (emphasis in original).

Supreme Court's decision was announced, is perhaps the most telling.⁷⁹ She stated that child psychiatrists (the organization's members) "know that mentally retarded adults often begin as mentally retarded children who don't receive the proper intervention to help them. The answer to helping these offenders is appropriate intervention, not execution."⁸⁰ Such a statement seems to indicate strong opposition to the death penalty generally.

With the *Atkins* decision, the Individual Rights and Responsibilities Section of the American Bar Association recognized the opportunity to consider the extent to which mental illness should or should not lead to an exemption from the death penalty.⁸¹ A Task Force consisting of attorneys, legal scholars, psychiatrists, and psychologists is in the process of developing a proposal to "protect persons with mental illness from the death penalty."⁸² If the proposals of the Task Force are adopted by the American Bar Association (ABA) as they have been articulated in Catholic University's Columbus School of Law's recent symposium on mental illness and the death penalty, they focus on three major resolutions.⁸³

First, defendants who at the time of their offenses had "significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury" should not be sentenced to death or executed.⁸⁴ Second, defendants who at the time of their offenses "had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences, or wrongfulness of their conduct; (b) to exercise rational judgment in relation to conduct; or (c) to conform their conduct to the requirements of the law" should not be sentenced to death or executed.⁸⁵ The recommendation further states that a "disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability."⁸⁶

The third recommendation focuses on severe mental disorders after sentencing and states that the death penalty should not be imposed "if the

79. Hausman, *supra* note 75, at 2.

80. *Id.*

81. Interview with Richard J. Bonnie, John S. Battle Professor of Law and Director of the Institute of Law, Psychiatry and Public Policy, University of Virginia (Oct. 13, 2005).

82. *Editor's Preface, Symposium: The Death Penalty and Mental Illness*, 54 CATH. U. L. REV. 1113, 1113 (2005); Ronald J. Tabak, *Overview of Task Force Proposal on Mental Disability and the Death Penalty*, 54 CATH. U. L. REV. 1123, 1123 (2005).

83. *Recommendations of the American Bar Association Section of Individual Rights and Responsibilities Task Force on Mental Disability and the Death Penalty*, 54 CATH. U. L. REV. 1115, 1115-16 (2005) [hereinafter *Recommendations*].

84. *Id.* at 1115.

85. *Id.*

86. *Id.*

prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to assist counsel . . . in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reasons for its imposition in the prisoner's own case."⁸⁷ The resolution goes on to state recommended procedures for cases involving prisoners with severe mental disorders who want to stop or forego post-conviction proceedings, are unable to assist counsel in post-conviction proceedings, or unable to understand the punishment or its purpose.⁸⁸

The ABA Task Force resolution notes that in adopting these resolutions, the ABA "takes no position on the death penalty" apart from those individuals who would be exempted from execution under the above recommendations and those related to "existing Association policies" related to mentally retarded offenders and those under age eighteen at the time of their offenses.⁸⁹

SEMANTICS AND PSYCHIATRY

The Court has a long-standing regard of psychiatry as an "inexact science."⁹⁰ The idea undergirding this conception is that the rest of medical science is an "exact science."⁹¹ The fact is, however, that much of medicine, including psychiatry, is an "inexact science."⁹² The idea that psychiatry is fundamentally different from the rest of medicine leads all too easily to the conclusion that there is little or no science in the field of psychiatry, rendering the presence or absence of mental illness nothing more than the matter of one's opinion. This is reflected in the statutory definition of insanity relied on by some states, where an individual may commit criminal acts under the press of documented psychosis consisting of hallucinations and/or delusions and fail to meet the threshold for "insanity."⁹³

87. *Id.*

88. *Id.* at 1115-16.

89. *Recommendations*, *supra* note 83, at 1116.

90. *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985); *see also Addington v. Texas*, 441 U.S. 418, 430 (1979) (The Supreme Court stated that "psychiatric diagnosis . . . [is] based on [subjective] medical impressions This process often makes it very difficult for the expert physician to offer definite conclusions about any particular patient.").

91. *See James M. Berger, False Memory Syndrome and Therapist Liability to Third Parties for Emotional Distress Injuries Arising from Recovered Memory Therapy: A General Prohibition on Liability and a Limited Liability Exception*, 73 TEMP. L. REV. 795, 813 (2000).

92. *Davoli*, *supra* note 3, at 993.

93. *Deborah Giorgi-Guarnieri et al., AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense*, 30 J. AM. ACAD. OF PSYCHIATRY & L. S3, S28-S29 (Supp. 2002).

Courts perpetuate this conception of psychiatry by relying on obsolete psychiatric and psychological theories⁹⁴ and by using current terminology imprecisely.⁹⁵ By failing to correctly apply current medical knowledge to the area of psychiatric disorders, definitions of mental illness in law can be so broad as to be meaningless. Justice Stewart, writing for a unanimous court in *O'Connor v. Donaldson*,⁹⁶ asked, “[m]ay the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different?”⁹⁷ He goes on to analogize “harmless mental illness” to being “physically unattractive or socially eccentric.”⁹⁸ In the same case, Justice Burger describes the field of psychiatry as “baffling.”⁹⁹ What is “baffling” is the continuing acceptance of mental illness as a nebulous, subjective construct, even while such ideas are being rendered increasingly obsolete as research is advanced concerning the biological bases of severe mental illnesses.

POTENTIAL PROBLEMS IN THE DEFINITION OF “SEVERE MENTAL DISORDER OR DISABILITY” OR WHY THE ENEMY OF THE GOOD IS THE PERFECT

There is very little research on the incidence of severe mental illness in death row inmates.¹⁰⁰ The American Civil Liberties Union estimates that five to ten percent of prisoners on death row have a serious mental illness;¹⁰¹ however, what meets the threshold for a serious mental illness is never defined.¹⁰²

94. Davoli, *supra* note 3, at 991.

95. *Id.* at 995.

96. *O'Connor v. Donaldson*, 422 U.S. 563, 564 (1975).

97. *Id.* at 575.

98. *Id.* What is “harmless mental illness?” For that matter, what is harmless cardiac disease, harmless diabetes, or a harmless seizure disorder? “Harmless” is not an adjective associated with other serious medical illnesses. See Robert Brown, *Physical Illness and Mental Health*, 7 PHIL. & PUB. AFF. 17, 25 (1977).

99. *O'Connor*, 422 U.S. at 578 n.2 (Burger, J., concurring). Further, Justice Burger states, “Indeed, there is considerable debate concerning the threshold questions of what constitutes ‘mental disease’ and ‘treatment.’” (quoting Thomas Szasz, *The Right to Health*, 57 GEO. L. J. 734 (1969)). *Id.* at 584 n.5 Professor Szasz has construed mental illness as a myth. Szasz, *supra*, at 740.

100. Dorothy Otnow Lewis et al., *Psychiatric, Neurological, and Psychoeducational Characteristics of 15 Death Row Inmates in the United States*, 143 AM. J. OF PSYCHIATRY 838, 839-44 (1986) [hereinafter *15 Death Row Inmates*]. The authors report that all subjects had a history of “severe” head injury, and five subjects had objective signs of neurological impairment. *Id.* at 840. Six subjects had psychotic symptoms predating incarceration, and two others were manic-depressive (bipolar). *Id.* While the results are interesting and provocative, the results have not been replicated by other investigators using reliable, validated assessment instruments.

101. American Civil Liberties Union, *Mental Illness and the Death Penalty in the United States*, Jan. 31, 2005, available at <http://www.aclu.org/capital.mentalillness/10617pub20050131.html>.

102. See *id.*

Any exemption from the death penalty on the basis of severe mental illness should adhere to the same principles; that is, meeting a threshold condition requiring both a severe mental illness and clear functional impairment.¹⁰³ Specifically, the adjective “severe” merits additional consideration and clarification.¹⁰⁴

This section examines various disorders and clinical entities that could potentially qualify for exemptions from the death penalty under the ABA Task Force Recommendations, and discuss the importance of keeping the exemption as narrow and focused as possible on the severely mentally ill—specifically individuals with psychosis.

The Axis I psychiatric disorders with psychosis (schizophrenia, schizoaffective disorder, bipolar disorder, and major depression with psychotic features for example) are more firmly grounded (as opposed to personality disorders, and dissociative disorders for example) in the traditional medical model of illness. Although the fundamental pathologic processes associated with schizophrenia, major depression, and bipolar disorder have not been fully delineated, these brain disorders are related to structural and function brain pathology, including imbalances in neurotransmitters in the case of mood disorders¹⁰⁵ and problems in brain circuitry and neurotransmitters in the case of schizophrenia.¹⁰⁶ They follow a predictable course and respond to organically based treatments such as antidepressant and antipsychotic medication and electroconvulsive therapy.¹⁰⁷

Personality disorders, in contrast, describe patterns of emotions, thoughts, attitudes, and behaviors that deviate markedly from what is defined as “normative.”¹⁰⁸ While it is possible or even likely that there are biological

103. See, e.g., Ellen Byers, *Mentally Ill Criminal Offenders and the Strict Liability Effect: Is There Hope for a Just Jurisprudence in an Era of Responsibility/Consequences Talk?*, 57 ARK. L. REV. 477, 528 (2004-2005).

104. Compare Christina E. Newhill and Wynne S. Korr, *Practice with People with Severe Mental Illness: Rewards, Challenges, Burdens*, 29 HEALTH & SOC. WORK 297, 299 (2004) (“[W]e defined *severe mental illness* as “schizophrenia, major mood disorders, obsessive-compulsive disorder, and severe personality disorders.”) with Robert E. Drake, M.D. et al., *The History of Community Mental Health Treatment and Rehabilitation for Persons with Severe Mental Illness*, 39 COMMUNITY MENTAL HEALTH J. 427, 427 (2003) (“The conditions that we call severe mental illness – those mental disorders that interrupt, destabilize, and imperil lives for years – continue to challenge and preoccupy psychiatry and the other mental health professions.”).

105. Madhu Kalia, *Neurobiological Basis of Depression: An Update*, 54 METABOLISM CLINICAL & EXPERIMENTAL 24, 24-25 (Supp. 2005).

106. Leisa A. Glantz et al., *Apoptotic Mechanisms and the Synaptic Pathology of Schizophrenia*, 81 SCHIZOPHRENIA RES. 47, 47-48 (2006).

107. UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, *Overview of Treatment*, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, available at <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec6.html>.

108. DSM-IV-TR, *supra* note 74, at 686.

underpinnings to some severe personality disorders, the internal variability of symptom patterns as well as their inconsistent response to treatment suggest that they are normatively defined and should not be characterized as illnesses.¹⁰⁹

In *Atkins*, the Court emphasized that execution of the mentally retarded is inconsistent with both the retributive and deterrent functions of the death penalty.¹¹⁰ The Court noted that individuals with mental retardation have “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.”¹¹¹ Moral culpability, however, is not completely related to IQ. The impulsive and panicked shooting/murder of a gas station attendant in a botched robbery attempt by a mentally retarded individual without a history of repeated or predatory violence seems very different from the murder of a victim who begged for his life or where torture was involved. There is really no scientific justification to broadly characterize the mildly mentally retarded as being less capable of empathy with their fellow human beings. There is no justification for believing that a mildly mentally retarded individual would or should be more callous than non-retarded individuals.

Actively psychotic individuals are typically far more impaired than individuals with mild mental retardation in the areas of understanding and processing information, logical and rational communication, abstraction, logical reasoning, and impulse control. Delusions and hallucinations typically severely compromise the psychotic individual’s ability to appreciate the meaning of one’s environment, including the motives and meanings of others’ behavior. Psychosis might cause an individual to believe that her child was possessed by the devil and needed to be killed in order to secure his place in heaven. Severe perceptual distortion is not uncommon in schizophrenia, whereas it is not an associated feature of mental retardation.¹¹²

Severe Mental Illness with a Psychotic Component

Whereas psychotic phenomena can be experienced in a variety of psychiatric disorders, mental illnesses in which there is persistent hallucinations and/or delusions fall into roughly two major categories in the DSM-IV-TR—“Schizophrenia and the Other Psychotic Disorders” and “Mood Disorders.”¹¹³ A discussion of each of these major categories should help

109. Bruce J. Winick, *Ambiguities in the Legal Meaning and Significance of Mental Illness*, 1 PSYCHOL. PUB. POL’Y & L. 534, 608 (1995).

110. *Atkins v. Virginia*, 536 U.S. 304, 319-20 (2002).

111. *Id.* at 318.

112. DSM-IV-TR, *supra* note 74, at 41-42, 49, 297, 312.

113. *Id.* at 297-98, 410, 413, 415, 416.

clarify what it is that renders psychotic individuals (regardless of whether they meet the legal threshold for insanity) less culpable for their acts than individuals suffering from personality disorders, even if those personality disorders are severe.¹¹⁴

Schizophrenia and the Other Psychotic Disorders

The DSM-IV-TR includes a number of psychotic disorders grouped together in order to facilitate the differential diagnosis of disorders that have psychotic symptoms as the predominant or primary aspect of their presentation.¹¹⁵ The term “psychotic” in the DSM refers to the presence of certain symptoms (hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior).¹¹⁶ Schizophrenia is the most dominant clinical entity among the psychotic disorders and the disorder most easily

114. In the most recent version available of the ABA-IRR Task Force Recommendations on Mental Disability and the Death Penalty, it is recommended that “defendants . . . [who] at the time of the[ir] offense . . . had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences, or wrongfulness of their conduct; (b) to exercise rational judgment in relation to conduct; or (c) to conform their conduct to the requirements of the laws . . . [should not be executed or sentenced to death].” Slobogin notes that some conditions that are not Axis I disorders “might also, on rare occasions, become ‘severe’ as that word is used in [the ABA] recommendation,” specifically noting borderline personality disorder. See Christopher Slobogin, *Mental Disorder as an Exemption from the Death Penalty: The ABA-IRR Task Force Recommendations*, 54 CATH. U. L. REV. 1133, 1139, 1141 (2005) [hereinafter *Mental Disorder*].

115. DSM-IV-TR, *supra* note 74, at 297. “The disorders [included] in this section [Schizophrenia and the Psychotic Disorders] include Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder due to a General Medical Condition, Substance-Abuse Induced Psychotic Disorder, and Psychotic Disorder, Not Otherwise Specified.” *Id.*

116. *Id.* at 297-98. *Hallucinations* are sensory perceptions that are unrelated to outside events—in other words, seeing or hearing things that aren’t there. A *delusion* is a false belief and the persistent, unshakeable acceptance of the false belief. The distinction between hallucinations and delusions involves content. In hallucinations, sensory input is improperly processed, whereas delusions are ideas or beliefs (complex thoughts) that are abnormal. *Thought disorganization* refers to compromised ability to engage in goal-directed thinking. Schizophrenia for example often affects a person’s ability to “think straight.” The person may be unable to connect thoughts into logical sequences, and may be unable to sort out what is relevant to the situation. Their thoughts can be disorganized and fragmented and may come and go rapidly, with the person being unable to concentrate on one thought for very long and unable to focus. Thought disorganization is typically reflected in *disorganized speech and behavior*. *Catatonia* is characterized by stupor associated with either marked rigidity or flexibility of the musculature and is associated with a variety of neurological and psychiatric conditions. *Id.* at 299-300 (emphasis added).

recognized by lay persons as representing psychosis.¹¹⁷ It is important to keep in mind however that not all psychosis is schizophrenia.¹¹⁸ “Schizophrenia is a [severe mental] illness that can involve [a] massive disruption of thinking, perception, emotions and behavior.”¹¹⁹ It has a worldwide lifetime prevalence rate of one percent and is a major cause of long-term psychiatric disability.¹²⁰

A variety of neuropsychological deficits have been noted in schizophrenia.¹²¹ The most consistently replicated deficits are in the areas of attention and concentration, information processing, learning and memory, and executive functions.¹²² One of the most consistent findings on neuroimaging (CT and MRI) has been that of enlarged brain ventricles, although the relationship of this finding to the pathophysiology of schizophrenia is uncertain.¹²³ MRI studies have also repeatedly shown reduced medial temporal and prefrontal lobe¹²⁴ volumes and progressive structural brain changes occurring from the earliest phases of the illness.¹²⁵

Schizophrenia is a well recognized severe mental disorder, with a similar prevalence in every population in which it has been studied—developed and undeveloped nations, in rural and urban area.¹²⁶

The symptoms of schizophrenia can be categorized into three broad groups: positive, negative, and disorganized.¹²⁷ It is well known that acutely

117. EARLY IDENTIFICATION OF PSYCHOSIS: A PRIMER 4 (Mental Health Evaluation & Community Consultation Unit), available at <http://www.mheccu.ubc.ca/documents/publications/GPprimer.pdf>.

118. *Science Inches Towards an Understanding of the Causes of—and Cures for—Mental Illness*, 43 INST. OF GOV'T STUDIES PUB. AFF. REP. 12 (2002).

119. D. Frank Benson et al., *Psychosis*, in SYNOPSIS OF NEUROPSYCHIATRY 321 (Barry S. Fogel et al., eds., 2000).

120. *Id.*

121. Christos Pantelis et al., *Structural Brain Imaging Evidence for Multiple Pathological Processes at Different Stages of Brain Development in Schizophrenia*, 31 SCHIZOPHRENIA BULLETIN 672, 672 (2005).

122. Benson, *supra* note 119, at 322-23. *Executive functions* refer to functions of the frontal lobe of the brain that are “important for adapting to [one’s] environment, such as preparation, initiation, and modulation of action; . . . abstract reasoning; hypothesis testing, and monitoring of ongoing purposeful behavior.” *Id.* at 323 (emphasis added).

123. *Id.*; see MARVIN I. HERZ & STEPHEN R. MARDER, SCHIZOPHRENIA: COMPREHENSIVE TREATMENT AND MANAGEMENT 6 (2002).

124. HERZ & MARDER, *supra* note 123, at 9. The medial temporal lobe of the brain is important in the process of sensory information, which may explain some of the highly distorted interpretations of the environment (hallucinations and delusions) that individuals with schizophrenia experience. *Id.* The prefrontal cortex is that area of the brain responsible for some of the most complex and highly evolved thought processes in humans, including the regulation of working memory and attention (which necessitates the filtering out of extraneous information from consciousness). *Id.* “The inferior parts of the prefrontal cortex are involved in emotional expression.” *Id.*

125. Pantelis et al., *supra* note 121, at 672.

126. HERZ & MARDER, *supra* note 123, at 3.

ill patients with schizophrenia have floridly psychotic symptoms such as hallucinations and/or delusions and are severely disorganized in their thinking.¹²⁸ Their functioning is so impaired that they are unable to adequately care for themselves.¹²⁹

Persistent psychotic symptomatology (hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior) may be part of a variety of other primary psychotic disorders, termed in DSM-IV as Psychotic Disorder, Not Otherwise Specified.¹³⁰ This diagnosis would include persistent psychotic symptomatology about which there is inadequate information to make a diagnosis or disorders with psychotic symptoms that do not meet the criteria for any other specific psychotic disorder.¹³¹

127. *Id.* at 23. Positive symptoms include hallucinations and delusions. *Id.* Negative symptoms include emotional dulling or flattening, decreased thought and speech production, loss of the ability to experience pleasure, and decreased ability to initiate goal-directed behavior. *Id.* at 23, 25. “Disorganized symptoms include disorganized speech ([reflecting disorganized thinking and]thought disorder) . . . and disorganized behavior and attention . . .” *Id.* at 23.

128. DCFS Web Resource – Schizophrenia, <http://dcfswebresource.prairienet.org/resources/schizophrenia.php> (last visited Mar. 27, 2006) [hereinafter DCFS Web Resource]. The course of the disorder can be divided roughly into three phases. *Id.*; see also AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINE FOR THE TREATMENT OF SCHIZOPHRENIA 3 (2d ed. 2004) [hereinafter PRACTICE GUIDELINE]. The *acute phase*, as mentioned above, is the phase with floridly psychotic symptoms such as hallucinations, delusions, disorganized thinking and behavior, and severely impaired functioning. DCFS Web Resource, *supra* (emphasis added). The *stabilization phase* is characterized by a gradual decrease in the intensity of psychotic symptoms. *Id.* This phase may last an average of about 6 months after the onset of an acute episode, and it is during this time that the individual is the most prone to relapse. *Id.* (emphasis added); see also PRACTICE GUIDELINE, *supra*. In the *stable phase* symptoms are relatively stable and almost always less intense than the acute phase. DCFS Web Resource, *supra* (emphasis added); see also, PRACTICE GUIDELINE, *supra*. Some individuals may have persistent positive or negative symptoms. See HERZ & MARDER, *supra* note 123, at 25.

129. DCFS Web Resource, *supra* note 128. The standard for and meaning of being unable to care for oneself is sometimes debated. *Id.* Many of the severely mentally ill homeless who live on the streets of cities would not be considered candidates to be hospitalized against their wills. See Michael Jonathan Grinfeld, *Dying for Treatment: Police Shootings Spur Calls for Change*, PSYCHIATRIC TIMES, Feb. 2000, at 3, available at <http://www.psychiatrictimes.com/p000283.html>. However, their ability to “choose” a life on the street is hampered by severe mental illness (and often intensified by substance abuse), and they often deteriorate until they present a clear danger to themselves or others (typically involving an overt act), at which point they are able to be hospitalized involuntarily. *Id.* One can easily see how a homeless and severely psychotic defendant could be portrayed by the prosecution as making a reasoned “choice” to live on the streets, and his or her ability to survive as demonstrating shrewd and rational behavior. *Id.*

130. DSM-IV-TR, *supra* note 74, at 343.

131. *Id.* Examples of psychotic disorders in this category that could be argued as qualifying for death penalty exemptions might include postpartum psychosis that does not meet criteria for major depression with psychotic features and substance-abuse-triggered psychosis that persists. *Id.* Here again, it is not difficult to see how postpartum psychosis would engender far less controversy than a psychotic disorder related to substance abuse even in the face of similar severe

Mood Disorders and Psychosis

In addition to schizophrenia and the other psychotic disorders, a number of severe mood disorders may have associated psychotic features.¹³² These include major depression with psychotic features and bipolar disorder (either manic or depressed) with psychotic features.¹³³ These disorders are distinguished from the primary psychotic disorders discussed above in that in these disorders psychotic symptoms are secondary to the primary mood disorder. Most commonly in mood disorders, the hallucinations and/or delusions are consistent with the depressive or manic themes.¹³⁴ Psychotic symptoms are more common in mania, appearing in over one-half of manic episodes.¹³⁵

Problems with Traumatic Brain Injuries and Personality Disorders

Broadening the definition of what constitutes severe mental illness beyond thought disorders and mood disorders with psychotic features opens the door to include a variety of disorders that few psychiatrists opine to be “equivalent” to schizophrenia, schizoaffective disorder, major depression with psychotic features, or bipolar disorder with psychosis with respect to the level of impairment in one’s ability to interpret one’s reality and make rational decisions.¹³⁶ There is far less debate among psychiatrists regarding the role that biologically based severe mental illnesses with psychotic features or symptoms plays in reducing an individual’s culpability than the role of personality and dissociative disorders in lessening culpability. The reason for

impairments in cognition, judgment, appreciation, and impulse control. *Id.* However it could also be anticipated that persistent psychosis induced by substance or alcohol abuse or dependence would constitute a very rare exemption, and would require the same forensic diagnostic skills as the evaluation of any other psychotic disorder. *See id.* at 342.

132. *Id.* at 699.

133. *Id.* at 349, 382, 412.

134. *Id.* at 412. For example, an individual suffering from a major depression with psychotic features may suffer from nihilistic delusions (e.g. of world or personal destruction), somatic delusions (e.g., that they are being consumed by cancer, or otherwise “rotting away”), delusions of deserved punishment (e.g., that they are being punished for some moral transgression or personal inadequacy), delusions of poverty (e.g., of being bankrupt), or delusions of guilt (e.g., being responsible for the death or illness of a loved one). *Id.* Manic delusions typically are also mood congruent, for example believing that one has special powers or is on a mission from God or is the President. *Id.* at 414. However, less commonly the psychotic features may have little to no relationship to the manic themes, and this presentation appears to be associated with a poorer prognosis. *Id.*

135. American Psychiatric Association, *Practice Guideline for the Treatment of Patients with Bipolar Disorders*, 159 AM. J. PSYCHIATRY 2, 11 (Apr. Supp. 2002), available at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

136. “Psychotic features” is diagnostic terminology that indicates psychosis. DSM–IV–TR, *supra* note 74, at 413, 415–16, 827.

this is that psychosis is characterized by major alterations in mental function and includes severe disturbances in cognitive (thought) and perceptual processes (hallucinations, delusions) and/or the inability to distinguish reality from fantasy or thoughts (impaired reality testing).¹³⁷

Traumatic Brain Injury

The ABA Task Force Recommendations include Traumatic Brain Injury (TBI) as an exemption from execution.¹³⁸ Unfortunately there is no uniform definition of what constitutes TBI. The Centers for Disease Control (CDC), however, estimates that approximately 1,500,000 people incur traumatic brain injuries in the United States each year and that about seventy-five percent of them experience long-term disability.¹³⁹ Definitions tend to have variations in inclusion criteria and to vary according to specialties. The problem goes beyond multiple definitions; the ground that these definitions attempt to cover is too large and in some areas too contentious to be a suitable category for exemption. Here are some examples of the disparate definitions. Often, the term “brain injury” is used synonymously with head injury, which may or may not be associated with neurological deficits.¹⁴⁰ Traumatic brain injury occurs as the result of an external mechanical force applied to the head and intracranial contents (most importantly the brain).¹⁴¹ The Centers for Disease Control defines¹⁴² traumatic brain injury as either:

- 1) an occurrence of injury to the head that is documented in a medical record with one or more of the following conditions attributed to head injury:
 - observed or self-reported decreased level of consciousness (may refer to partial or complete loss of consciousness)
 - amnesia (memory loss). There are different types of amnesia. Retrograde amnesia refers to memory loss for events immediately preceding the injury. There can be amnesia for the injury itself. Anterograde amnesia relates to memory loss for events that occur after a traumatic event

137. *Id.* at 827.

138. *Recommendations, supra* note 83, at 1115.

139. CENTERS FOR DISEASE CONTROL AND PREVENTION, TRAUMATIC BRAIN INJURY IN THE UNITED STATES: A REPORT TO CONGRESS 1 (2006), <http://www.cdc.gov/ncipc> (last visited Mar. 28, 2006).

140. *Id.* at app.

141. *Id.*

142. *Id.*

- skull fracture, objective neurological, or neuropsychological abnormality,¹⁴³ OR
- diagnosed intracranial lesion (such as a bleed or scar tissue visualized on CT or MRI scan)

The Individuals with Disabilities Education Act (IDEA) definition of TBI, however, is far more inclusive.¹⁴⁴ IDEA defines TBI as:

[A]n acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance.¹⁴⁵ The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psycho-social behavior; physical functions; information processing; and speech.¹⁴⁶ The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.¹⁴⁷

Despite varying criteria for severe versus mild TBI, it seems fairly consistent across a number of well designed research studies that after accounting for premorbid psychopathology, severe but not mild brain injury increases the risk for psychiatric pathology.¹⁴⁸ There are few studies that specifically address the prevalence or severity of clearly defined TBI among capital defendants or even inmates on death row. Many defendants who are diagnosed with TBI will have sustained the brain injury during childhood or

143. Neurological abnormalities are determined from neurological examination performed by a physician (not necessarily a neurologist) and documented on physical examination. *Id.* Some examples include abnormalities of motor or sensory function, or reflexes; speech abnormalities such as an inability or difficulty understanding written or spoken language despite normal hearing (receptive language), or difficulty initiating or maintaining speech (expressive language). *Id.* Neuropsychological tests (for example the Weschler Adult Intelligence Scale-Revised, Rey Auditory Verbal Learning Test, Luria-Nebraska Neuropsychological Battery, and Benton Visual Retention Test) are indicators of cerebral integrity that are more sensitive than neurological examination and EEG, and sometimes neuroimaging. *Id.* In the early stages of dementia, the sensitivity of neuropsychological tests is greater than neuroimaging and neurological examination. AMERICAN PSYCHIATRIC ASSOCIATION, GUIDELINE WATCH: PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ALZHEIMER'S DISEASE AND OTHER DEMENTIAS OF LATE LIFE 2 (2004).

144. 34 C.F.R. § 300.7 (c)(12) (2001).

145. *Id.*

146. *Id.*

147. *Id.*; see also NATIONAL ASSOCIATION OF STATE HEAD INJURY ADMINISTRATORS, TRAUMATIC BRAIN INJURY FACTS: CHILDREN AND YOUTH, available at <http://www.nashia.org/docfiles/children.pdf>.

148. Agnes H. Whitaker et al., *Traumatic and Infectious Brain Injury in Children: Psychiatric Sequelae*, in CHILD AND ADOLESCENT PSYCHIATRY: A COMPREHENSIVE TEXTBOOK 434 (Melvin Lewis ed., 2002).

adolescence. A hint of the scope of the problems that may surface with the inclusion of TBI as an exemption to the death penalty can be found in some research, which has not been replicated, looking at the prevalence of a history of severe head injury and “sequelae” (which would easily meet the definition TBI of unspecified severity) in several death row populations.¹⁴⁹ It is not difficult to foresee the inevitable widening of the door to allow petitions for death penalty exclusion based on claims of traumatic brain injury sustained during childhood or later.

Personality Disorders

The potential for severe personality disorders to be argued as exclusions for the death penalty is perhaps the most problematic of the diagnostic entities discussed in this section. Granted, the ABA Task Force recommends that “a disorder manifested *primarily* by repeated criminal conduct” does not alone qualify for exemption from the death penalty according to the proposed resolutions.¹⁵⁰ However, this stipulation does not narrow the field sufficiently when it comes to the area of severe personality disorders. Antisocial personality disorder is the only personality disorder in the DSM-IV-TR that would categorically disqualify a defendant or prisoner from the death penalty, as it is the only DSM-IV-TR personality disorder characterized by repeated criminal conduct.¹⁵¹

If the ultimate goal is to chip away at the death penalty itself, it makes sense to include severe personality disorders in the narrow definition of mental disorders for exemption. But this is not our goal, and we ought not to cloak death opposition in psychiatric medical opinions, which should be based on something more. Although no research on the prevalence of personality disorders in death row inmates exists, research on personality pathology among

149. Dorothy Otnow Lewis et al., *Neuropsychiatric, Psychoeducational, and Family Characteristics of 14 Juveniles Condemned to Death in the United State*, 145 AM. J. PSYCHIATRY 584, 584 (1988) [hereinafter *14 Juveniles*]; *15 Death Row Inmates*, *supra* note 100, at 838. In a study of adults, the authors report that all subjects had a history of “severe” head injury, although by descriptions only eleven subjects sustained any loss of consciousness, the significance of which was unclear. *15 Death Row Inmates*, *supra* note 100, at 838, 840-41 & tbl.1. In another study, out of all thirty-seven juveniles awaiting execution at the time of the study, the authors studied fourteen in four states. *14 Juveniles*, *supra*, at 584. Nine had “major neurological impairment,” seven had “significant organic dysfunction on neuropsychological testing,” and only two had Full Scale IQ test scores above ninety. *Id.* at 585. All fourteen subjects, despite wide variability in the severity of head trauma sustained as well as the subjective neurological symptomatology and objective evidence of neurological dysfunction, may have met the threshold for diagnosis of TBI given the authors’ descriptions. *Id.* at 586 tbls. 1, 2.

150. *Recommendations*, *supra* note 83, at 1115.

151. See DSM-IV-TR, *supra* note 74, at 701. Antisocial Personality Disorder is characterized by a “pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.” *Id.*

the general criminal population indicates a high prevalence of personality disorders, which potentially could qualify for exclusion.¹⁵² The specific feature of personality disorders that capital defendants' attorneys might apply to an argument for exemption is the presence of "psychotic-like symptoms . . . during times of stress" at the time of the offense.¹⁵³

The DSM-IV-TR indicates that borderline, paranoid, and schizotypal personality disorders are characterized by a vulnerability to experience transient psychotic symptoms under severe stress.¹⁵⁴ Others have noted that narcissistic and histrionic personality disorders¹⁵⁵ are also prone to these brief psychotic interludes, sometimes called "micropsychotic episodes."¹⁵⁶ In personality-disordered individuals, micropsychotic episodes may be precipitated by drugs or stress.¹⁵⁷ The psychotic symptomatology may include visual or auditory hallucinations, depersonalization, derealization, and paranoid thinking.¹⁵⁸ The psychotic symptoms associated with personality disorders, unlike the psychotic features associated with Axis I major mental disorders, are transient, lasting minutes to hours.¹⁵⁹ The associated symptoms in borderline personality disorders may include a pattern of unstable and intense interpersonal relationships; a markedly and persistently unstable sense of self; recurrent suicidal threats or behavior or self injury (such as cutting or burning); impulsivity in at least two areas that are potentially self-destructive (spending, sex, substance abuse, reckless driving); affective (emotional) instability due to markedly reactive mood; and inappropriate and intense anger

152. Merrill Rotter et al., *Personality Disorders in Prison: Aren't They All Antisocial*, 73 PSYCHIATRIC QUARTERLY 337, 342-43 & tbl.2, 346-47 (2002). In this study, authors found a prevalence of ten percent for personality disorders other than antisocial among prisoners in the New York State prison system. *Id.* at 343, 346. It is hard to imagine how a personality disorder could qualify as grounds for precluding execution after sentencing, given the fact that even a severe personality disorder, such as borderline personality disorder, would not qualify as being so incapacitating as to preclude a prisoner's ability to: 1) make a rational decision to forgo or terminate post-conviction proceedings, 2) assist counsel, or 3) understand the nature and purpose of the death penalty and the reason for its imposition in his or her own case. *See Recommendations*, *supra* note 83, at 1115. However, interpersonal volatility including extremes of idealization and devaluation of significant others (one's attorney in this situation would certainly qualify) could significantly interfere with the attorney-client relationship and be construed as an obstacle to assisting counsel. *See id.* (stating that "[a] sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity . . . to understand or communicate information, or otherwise assist counsel . . .").

153. *Mental Disorder*, *supra* note 114, at 1141.

154. DSM-IV-TR, *supra* note 74, at 692, 698, 708.

155. SHAWN CHRISTOPHER SHEA, PSYCHIATRIC INTERVIEWING: THE ART OF UNDERSTANDING 333 (2d ed., 1998).

156. *Id.*

157. *Id.* at 332.

158. *Id.* at 333; *see also* DSM-IV-TR, *supra* note 74, at 698.

159. DSM-IV-TR, *supra* note 74, at 698-99.

or trouble controlling anger (which may include frequent anger outbursts or rages, constant anger, and physical fights).¹⁶⁰ Borderline personality disorder is often associated with a history of childhood abuse and/or neglect beginning in early childhood.¹⁶¹

Psychiatric Diagnosis and Its Relevance

Courts reinforce their reluctance to appropriately weigh and consider relevant psychiatric medical and scientific evidence when they misuse or misconstrue psychiatric diagnoses. The problem stems from an attempt to compare apples and oranges – applying diagnosis developed in a clinical or treatment setting and then applying it in a forensic setting. The often baffling reluctance of courts to appropriately weigh and consider medical and scientific evidence in their opinions regarding issues that bear on the medical specialty of psychiatry is only reinforced and abetted by the mixing of apples and oranges in the area of psychiatric diagnosis and its relevance to the legal issue at hand. While psychiatric diagnosis is immensely useful in clinical settings, where the primary purpose is to determine appropriate treatment, its utility is less clear in forensic settings. When do psychiatric diagnoses clarify and when do they obscure the legal issue? A discussion of an exemption from the death penalty for severe mental illness provides a useful backdrop for revisiting this issue.

As previously noted, the DSM-IV-TR provides a caution against the forensic use of diagnostic categories found in the DSM.¹⁶² This caution is sometimes erroneously interpreted to mean that psychiatric diagnoses can never be applied to defendants or litigants. In reality, the caution means that clinical diagnoses were not developed for legal purposes and are not the equivalent of legal definitions. For example, schizophrenia is not the medical equivalent of legal insanity and PTSD does not translate into either causation or compensation.¹⁶³ A person with pedophilia is not the medical equivalent of

160. *Id.* at 710.

161. Rebehah Bradley et al., *Etiology of Borderline Personality Disorder: Disentangling the Contributions of Intercorrelated Antecedents*, 193 J. NERVOUS & MENTAL DISEASE 24 (2005).

162. DSM-IV-TR, *supra* note 74, at xxxvii.

163. *Compare id.* at 312 (providing the following with respect to the characteristic symptoms of schizophrenia: “Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): (1) delusions; (2) hallucinations; (3) disorganized speech (e.g., frequent derailment or incoherence); (4) grossly disorganized or catatonic behavior; [and] (5) negative symptoms, i.e., affective flattening, alogia, or avolition”) with RICHARD J. BONNIE ET AL., CRIMINAL LAW app. at A-36 (2d ed., 1997) (reproducing MODEL PENAL CODE § 4.01) (“A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.”). *Compare* DSM-IV-TR, *supra* note 74, at 467-68 (providing the

the legal definition of a sexually violent predator.¹⁶⁴ When diagnosis becomes a legal determinant for exemption, culpability, or competence, the result may confound rather than clarify.

In the insanity defense, where most codifications make the presence of a mental disease or defect an essential element, psychiatric diagnosis is a crucial legal element of the defense if a proper foundation exists for the diagnosis. However, there are also functional criteria that must be met in the legal defense. Even in situations where psychiatric diagnosis is an essential element of a claim or defense (competence to stand trial or insanity), the diagnosis of a mental illness in and of itself is insufficient. For example, one could suffer from Schizophrenia, Paranoid Type, Episodic with Interepisode Residual Symptoms (the DSM-IV-TR diagnosis) and not meet the legal standard of insanity.¹⁶⁵ An insanity defense requires that a nexus be established between the mental illness and insanity (however insanity is codified within a particular jurisdiction).

PUBLIC KNOWLEDGE AND POTENTIAL PITFALLS

Mitigation

Despite the fact that evidence of mental illness should be mitigating against the imposition of the death penalty,¹⁶⁶ the reality is that it is often aggravating.¹⁶⁷ For example, a man in Florida was convicted of capital murder for killing a cab driver whom he raped while she was dead or dying.¹⁶⁸ At the sentencing phase, the defendant's attorney introduced extensive evidence that the defendant suffered from schizophrenia and experienced hallucinations and

diagnostic criteria for post-traumatic stress disorder) with BLACK'S LAW DICTIONARY 212, 277 (7th ed. 1999) (providing definitions for both "causation" and "compensation").

164. Compare DSM-IV-TR, *supra* note 74, at 572 (providing the following diagnostic criteria for pedophilia: "(A) Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger); (B) The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty; [and] (C) The person is at least 16 years and at least 5 years older than the child or children in Criterion A.") with WASH. REV. CODE ANN. § 71.09.020 (West 2002) (defining sexually violent predator as "any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.").

165. The Art of Forensic Psychology: Insanity, http://www.crimelibrary.com/criminal_mind/forensics/forensic_psychology/6.html (last visited Mar. 31, 2006).

166. See *Eddings v. Oklahoma*, 455 U.S. 104, 116 (1982).

167. Ella Fells Berkman, Note, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 291 (1989); J.L. Judson et al., *A Study of the California Penalty Jury in First Degree Murder Cases*, 21 STAN L. REV. 1297, 1339-40 (1969).

168. *Miller v. State*, 373 So. 2d 882, 883 n.1 (Fla. 1979).

delusions that other women were his hated mother.¹⁶⁹ Although the Supreme Court has held that mental illness should be considered a mitigating factor in the decision to impose the death penalty,¹⁷⁰ the jury recommended the death penalty and the judge imposed it based on the defendant's propensity to commit violent acts.¹⁷¹ The Florida Supreme Court ultimately vacated the defendant's death sentence on the basis that the aggravating circumstances stemmed from his mental illness.¹⁷² However, it is hard to ignore the reality that if juror behavior is considered a proxy measure of public opinion, the public is inclined to perceive the vileness of an individual crime and the defendant's future dangerousness as outweighing the mental illness of a defendant, regardless of how severe it may be.

Not Guilty By Reason Of Insanity

Those few studies that have examined the issue of severely mentally ill defendants and the death penalty indicate that defendants who unsuccessfully raise an insanity defense are significantly more likely to receive a death sentence than defendants who do not plead Not Guilty By Reason Of Insanity (NGRI).¹⁷³ There has been the general assumption in the scant literature addressing the issue of mental illness and the death penalty that public ignorance and fear accounts for this seemingly illogical association between mental illness and harsher punishment.¹⁷⁴ There is no research to substantiate this hypothesis. A more provocative, and as of yet also unresearched question is whether ignorance and ambivalence about genuine mental illness on the part of defense attorneys compromises their defense strategies.

The adversarial system in which the opinion of one expert witness is pitted against another undoubtedly contributes to jurors' perception that the presence or absence of mental illness in an individual is debatable.¹⁷⁵ It appears that the

169. *Id.* at 885 n.4.

170. *Eddings*, 455 U.S. at 116.

171. *Miller*, 373 So. 2d. at 885-86.

172. *Id.*

173. Berkman, *supra* note 167; Judson et al., *supra* note 167.

174. TEXAS APPLESEED & TEXAS TECH UNIVERSITY SCHOOL OF LAW, MENTAL ILLNESS, YOUR CLIENT AND THE CRIMINAL LAW 1 (2d ed. 2004), available at http://www.hogg.utexas.edu/PDF/mental_illness.pdf.

175. See Jonas Robitscher & Andrew Ky Haynes, *In Defense of the Insanity Defense*, 31 EMORY L.J. 9, 43 (1982) (citing *Should We Abolish the Insanity Defense?* 6 MIND & MED. 1, 1 (1979-1980)). Most forensic evaluators agree on both diagnoses and legal opinions. Kenneth K. Funkunaga et al., *Insanity Plea: Interexaminer Agreement and Concordance of Psychiatric Opinion and Court Verdict*, 5 L. & HUM. BEHAV. 325, 326 (1981); J. Robert Russell, *Criminal Discovery and Psychological Defenses in West Virginia: "Squeezing a Lemon" or "Kicking a Dog,"* 99 W. VA. L. REV. 207, 216 (1996) (citing Jeffrey Janofsky et al., *Defendants Pleading Insanity: An Analysis of Outcome*, 17 BULL. AM. ACAD. PSYCHIATRY L. 203, 210 (1989)). The perception of battling experts on the issue of mental illness and insanity appears to be an artifact

process of “death qualification” for sitting on a capital jury may significantly lessen a defendant’s chance to be found Not Guilty By Reason Of Insanity.¹⁷⁶

Guilty But Mentally Ill

The Guilty But Mentally Ill (GBMI) verdict is worthy of mention because defendants found GBMI may still be put to death.¹⁷⁷ GBMI statutes provide a good example of how bad law affecting the mentally ill is created in response to public outcry with little or no regard to existing scientific research.¹⁷⁸ The first GBMI statute was enacted in Michigan in response to the Michigan Supreme Court’s ruling in *People v. McQuillan*.¹⁷⁹ Prior to *McQuillan*, insanity acquitees were automatically committed to the Michigan Department of Mental Health for an indefinite period of time.¹⁸⁰ In the *McQuillen* decision, the Michigan Supreme Court declared this practice unconstitutional because it violated due process and did not afford insanity acquitees equal protection, as insanity acquitees were not afforded the same procedures for obtaining release as patients civilly committed.¹⁸¹ As part of *McQuillan*, 270 insanity acquitees were evaluated, and 214 were released, with 2 of the released acquitees committing highly publicized, heinous crimes within a year of their release.¹⁸² The Michigan GBMI statute was enacted a year later, and stated that a defendant could be found GBMI if the judge or jury found that the defendant was guilty of the offense, was mentally ill at the time of the offense, and lacked sufficient capacity either to appreciate the nature, quality, or wrongfulness of his conduct, or to conform his conduct to the requirements of

based on the fact that the vast majority of insanity pleas are settled out of court and agreed to by both the defense and prosecution. Funkungaga et al., *supra*, at 326; Russell, *supra*, at 216 (citing Janofsky et al., *supra*, at 210).

176. Phoebe C. Ellsworth et al., *The Death-Qualified Jury and the Defense of Insanity*, 8 LAW & HUM. BEHAV. 81, 91-92 (1984).

177. See Lisa M. Sloat & Richard L. Frierson, *Juror Knowledge and Attitudes Regarding Mental Illness Verdicts*, 33 J. AM. ACAD. PSYCHIATRY & L. 208, 212 (2005).

178. See Michelle R. Prejean, Comment, *Texas Law Made This Mad Woman Sane*, 42 HOUS. L. REV. 1487, 1493-95 (2006).

179. *People v. McQuillan*, 221 N.W.2d 569 (Mich. 1974); see also Andrew J. Black, *People v. Lloyd: Michigan’s Guilty But Mentally Ill Verdict Created with Intention to Help is Not Really a Benefit at All*, 79 U. DET. MERCY L. REV. 75, 79 (2001).

180. *McQuillan*, 221 N.W.2d at 572.

181. *Id.* at 586.

182. Sloat & Frierson, *supra* note 177, at 208 (citing L. W. Blunt & H. V. Stock, *Guilty But Mentally Ill: An Alternative Verdict*, 3 BEHAV. SCI. & L. 49 (1985)); Lynn W. Blunt & Harley V. Stock, *Guilty but Mentally Ill: An Alternative Verdict*, 3 BEHAV. SCI. & L. 49, 51-52 (1985).

the law.¹⁸³ Interestingly this is essentially the same criteria as the American Law Institute definition of legal insanity.¹⁸⁴

After John Hinkley, Jr. was found NGRI in the assassination attempt on President Reagan, there was a significant groundswell of public opinion against the insanity defense¹⁸⁵ (despite its rarity both in terms of being raised as well as its success).¹⁸⁶ Juries can find a defendant GBMI if they believe that a mental illness was present at the time of the offense, but was not of such an extent as to warrant an NGRI verdict. GBMI verdicts became more popular after the *Hinkley* trial, as it was represented as a way to acknowledge the defendant's mental illness, without finding him or her NGRI (which by definition exonerates the defendant from moral responsibility for his or her act(s)).¹⁸⁷

Guilty But Mental Ill verdicts appear to have roughly two meanings among the different states that have enacted it.¹⁸⁸ The first meaning denotes an inability to control one's actions.¹⁸⁹ By definition, the GBMI verdict in South Carolina indicates that the defendant was acting under an irresistible impulse, and unable to conform his behavior to the law.¹⁹⁰ However, despite the fact

183. MICH. COMP. LAWS ANN. §468.36 (West, Westlaw through P.A. 2006, No 1-59).

184. PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 277-79 (1991). See also BONNIE ET AL., *supra* note 163.

(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect, he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law. (2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.

Id.

In the post-Hinkley era, the Model Penal Code does not represent the prevailing approach to insanity in the United States. About twenty states use a variation of the Model Penal definition and a few states use a variation of "irresistible impulse." Three states have eliminated the insanity defense. Insanity Defense FAQs, <http://www.pbs.org/wgbh/pages/frontline/shows/crime/trial/faqs/html> (last visited Mar. 31, 2006). Only one state uses the "product" test. Mark Moran, *Insanity Standards May Vary, but Plea Rarely Succeeds*, *PSYCHIATRIC NEWS*, Apr. 19, 2002, at 24, available at <http://pn.psychiatryonline.org/cgi/content/full/37/8/24>; Aaron Malo et al., *The Temporary Insanity Defense in California*, <http://w3.uchastings.edu/plri/spring95/tmpinsan/html> (last visited Mar. 31, 2006).

185. BONNIE ET AL., *supra* note 163, at 454.

186. Christopher Slobogin, *The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*. 53 *GEO. WASH. L. REV.* 494, 494, 498-500 (1985).

187. Prejean, *supra* note 178, at 1493-95.

188. Van W. Ellis, *Guilty But Mentally Ill and the Death Penalty: Punishment Full of Sound and Fury, Signifying Nothing*, 43 *DUKE L.J.* 87, 106-07 (1993).

189. *Id.* (citing and quoting S.C. CODE ANN. §17-24-20(A) (1992)). South Carolina's statute states: "A defendant is guilty but mentally ill if, at the time of the commission of the act constituting the offense . . . because of mental disease or defect he lacked sufficient capacity to conform his conduct to the requirements of the law." S.C. CODE ANN. §17-24-20(A).

190. S.C. CODE ANN. § 17-24-20(A).

that an individual unable to control his behavior is suffering from volitional impairment, a lack of voluntariness, the South Carolina Supreme Court does not acknowledge that the verdict of GBMI has any bearing on the defendant's blameworthiness or culpability. Defendants found GBMI in South Carolina can be put to death.¹⁹¹

It is probable that the majority of jurors sitting in judgment of defendants for whom a verdict of GBMI is presented as a possible outcome do not fully understand its ramifications, including the fact that the death penalty is a potential dispositional outcome.¹⁹² GBMI verdicts may be incorrectly perceived as a compromise position between finding a defendant NGRI and a guilty verdict.¹⁹³ GBMI verdicts do not guarantee prisoners adequate mental health treatment. Georgia's statute specifically states that prisoners who have been found GBMI receive treatment only as financial resources permit.¹⁹⁴ In *People v. Marshall*, the Illinois Supreme Court ruled that failing to provide psychiatric treatment for prisoners found GBMI did not render the statute unconstitutional.¹⁹⁵

Some states have attached a different meaning to GBMI—that is mental illness where the impulse is less controlling.¹⁹⁶ Once again, archaic terminology and language that has not kept pace with scientific advances in the understanding of mental illness shape legal arguments and rationales. For example, proponents of preserving the possibility of the death penalty for defendants found GBMI note that such defendants have not been deprived of all their volitional capacity (again, a legal term and concept without a medical/psychiatric counterpart harkening back to at least the 18th century),¹⁹⁷

191. *State v. Wilson*, 413 S.E.2d 19, 23, 25-28 (S.C. 1992), *cert. denied*, 506 U.S. 846 (1992).

192. Sloat & Frierson, *supra* note 177, at 211-12. In this study of ninety-six qualified and "highly educated" (eighty-five percent of high school graduates with a median income of \$40,000 a year) jurors in South Carolina, only 4.2 percent of jurors were able to correctly identify both the definitions and dispositions of defendants found Not Guilty By Reason Of Insanity (NGRI) and GBMI. *Id.* at 210-11. Eighty-four percent of responders thought that juries should be informed of dispositional outcomes before deciding a verdict, and 68.4 percent of jurors mistakenly believed that a defendant found GBMI could not receive the death penalty. *Id.* at 212.

193. *See id.* at 209.

194. GA. CODE ANN. §17-7-131(g)(2) (2004).

195. *People v. Marshall*, 448 N.E.2d 969, 980 (Ill. App. Ct. 1983).

196. Ellis, *supra* note 188, at 109.

197. BONNIE ET AL., *supra* note 163, at 448-49 (discussing Arnold's Case, How. St.Tr. 695, 764 (1724)). Judge Tracey's charge to the jury in the Arnold's Case was that in order to be "exempted from punishment" (i.e. found insane) "it must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast." *Id.*

and that their culpability is not unlike defendants from poverty stricken and abusive backgrounds.¹⁹⁸

CONCLUSIONS

We should clarify that our position is *not* that the severely mentally ill should be eligible for the death penalty. We believe, however, that death penalty opposition in general exerts a strong pull to “make the shoe fit,” that is it attempts to broaden the net that could potentially exempt individuals facing potential execution with reasoning that is not medically and scientifically justified. The exemption for mental illness should apply to Axis I disorders in which there is psychosis.¹⁹⁹ To narrow the requisite mental illness in this manner would preserve this exemption for the sickest of the sick—for those defendants and prisoners about whom there would be minimal debate regarding the presence of a severe mental illness or its severe functional impairment.

198. *See Sanders v. State*, 585 A.2d 117, 134 (Del. 1990) (“The fact that Standers might, in theory, have resisted his pathological impulses provides a justification for punishment.”).

199. DSM-IV-TR, *supra* note 74, at 27-28. The DSM is a multiaxial system of assessment. *Id.* at 27. Axis I is for reporting all mental disorders except for personality disorders and mental retardation which are recorded on Axis II. *Id.* at 28-29.

