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Mental disorder and the criminal-justice system

On April 28, 2000, Richard Baumhammer, an immigrant lawyer, killed five people and severely injured one with his handgun as he drove his Jeep through suburban Pittsburgh, Pennsylvania. After getting arrested, Baumhammer was diagnosed as having several severe mental illnesses which made him incompetent to stand trial. Psychiatrists for the defense testified that, at the moment of killing, Baumhammer was suffering from delusional thinking including "that the FBI and CIA were following him, that the family house cleaner was a spy, and that his skin was peeling off".(Erickson, 2) He also showed symptoms of antisocial and narcissistic personality disorder -- having no remorse for the victims and think highly of himself. At last, however, the jury still convicted him of first-degree murder and sentenced him to the death penalty.

Why the jury convicted Baumhammer even though there seems to be enough evidence supporting his insanity defense? What is a mental disorder, and what role does it play in the judicial decision-making process? Who has the right to decide whether it is the criminal's mental disorder or his/her free will that caused the offense? In this paper, I am going to discuss the ways that the American criminal-justice system responds to criminals who are mentally ill, and more broadly, how contemporary American society views mental disorders and the problems raised by

it. Some of the content will also briefly touch on deep philosophical issues around personal anatomy and responsibility.

What is a mental disorder and what is special about it?

It is important for us to be clear about what a mental disorder or mental illness is before jumping into other topics. In American society, the diagnosis of mental disorders mainly follows the definition given by *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (DSM-5, 20)

There are several clarifications regarding this definition that I need to make before we move on. Firstly, DSM-5 terms mental disorders as "syndromes" and "disturbances" rather than actual illnesses or diseases because they are fundamentally different from the definition of "diseases" in a general sense which usually refers to somatic diseases. George Graham, a past president of the Society for Philosophy and Psychology, compares mental disorders and somatic diseases in his book *The Disordered Mind, An Introduction to Philosophy of Mind and Mental Illness* in terms of their symptoms. Almost all known and well-studied human somatic diseases have distinctive symptoms or clusters of symptoms that are not continuous with "normal variations in human somatic health".(Graham, 55) For instance, a common symptom of infectious diseases such as malaria and influenza is fever, while changes in body temperature is

never a normal human body variation. However, the case of mental disorders is much more complicated, for there are no hard edges or boundaries between normal variations of human mental health and (abnormal) mental disorders. Take major depression as an example, the typical syndromes are loss of pleasure, changes in appetite, sleep deprivation, feeling agitated or down, etc., but one doesn't have to suffer from depression to show these symptoms: I could be not willing to eat anything, feeling down and not able to fall asleep because my girlfriend just broke up with me and I am feeling sad, but it doesn't mean that I am depressed. Therefore, mental disorders, despite having a destructive impact on a person's life, seem to exist "on continua with normal behaviors and experiences".(Bentall, 115)

But aren't mental disorders essentially some chemical imbalance in human bodies? Can't we just make a diagnosis by running some body tests? The truth is, perhaps surprisingly, that there have been no scientific findings that are strong and significant enough to prove a causal relationship between any kind of chemical imbalance and mental disorders; therefore no psychiatrist would even know for certain which tests to run. On the other hand, the fact that there are drugs that successfully treat or control mental disorders by altering certain chemical levels does not prove that there is a chemical imbalance in a mentally ill person to begin with. For instance, alcohol helps alleviate social anxiety, but it does not mean that people with social anxiety have alcohol deficiency. (Tekin, 63) The reason of why it is so hard to study the chemical or biological cause of mental disorder is that the chemicals that we measure, neurotransmitters, are very indirect measurements of what is happening in the brain, not to mention that the brain has different parts and some parts sometimes perform the same activities, for example: the parietal lobe and the temporal lobe are both in charge of interpreting language.

Furthermore, all the methods we use to directly observe brain activities are more or less flawed. The newest method, functional magnetic resonance imaging (fMRI), working by detecting blood-oxygen level, cannot measure the whole brain simultaneously and is particularly bad at capturing fast thoughts.

I made the above clarifications not just to correct some common misconceptions, but they are also critical to my next discussions about mental disorder in context with the criminal-justice system. Even in such a serious topic, we should keep in mind that mental disorder is still an under-researched field in which the theories are still being perfected and research methods being improved. There should be no black-or-white answers or absolutely irrefutable statements, especially in topics like competence which require us to consider many other factors such as social, political, and philosophical issues regarding one's mental states.

Criminal laws v.s. behavioral science

In Baumhammer's case, the conflict between criminal laws and behavioral science is exposed: even though the psychiatrists had evidence of Baumhammer being severely mentally ill, the jury still convicted him and sentenced him to death. In today's American society, criminal laws are ambivalent about the role of behavioral science in the judicial justice system because they have fundamentally different ways to consider human behavior. Shaped by social and cultural tradition and built on the assumption that all people possess free will, criminal laws place great emphasis on "philosophical tradition of moral reasoning as well as on religious ideas concerning good and evil" when examining one's behavior. (Erikson, 10) A criminal's blameworthiness, according to criminal laws, comes from his *mens rea* (guilty mind) and *actus reus* (wrongful actions). (Erikson, 11) Therefore, if a person commits a crime (act wrongly),

he/she must have a guilty mind at that moment, which means being evil and immoral. This line of logic is outdated because it fails to recognize other factors that might have an impact on one's mental state and behavior, such as his/her social, psychological, and biological history. On the other hand, behavioral science treats every person as a unique case, examines them with empirical rules, and takes any possible factors into consideration. It does not consider the nature of blameworthiness because it regards criminal behavior as a result of a complicated compound of events or changes in one's life, rather than simply a moral failure.

Criminal laws and behavioral science also hold different standards over a defendant's competence to stand trial (adjudicative competence). The Sixth Amendment of the U.S. Constitution guarantees that "the defendants must receive a fair trial," meaning that the court has no right to bring a defendant to trial when he/she is not both physically and mentally competent; otherwise it would be as unfair as if the person were not there. (Erikson, 57) Therefore, the fundamental principle of adjudicative competence is to make sure that the defendant is able to understand the legal processing and the charges against him/her as well as help his/her lawyers. The conflict between criminal laws and behavioral science over this issue appears on how they determine if one is competent to stand trial. While behavioral science makes decisions on the presence or absence of psychosis, criminal laws hold that one may be psychotic but could still be able to stand trial if he/she possesses enough insight about the trial process.

Here is a real case that helps illustrate the complexity of the issue of competence. On December 14, 1994, Ralph Tortorici, armed with a rifle and a hunting knife, hostage the students in a lecture hall at the State University of New York and seriously injured one. After getting arrested, Tortorici was found incompetent to stand trial by psychiatric examiners who stated that

he was "unable to understand the charges against him and to assist in his own defense".(Erikson, 51) Tortorici was then sent to Mid-Hudson Psychiatric Center, a forensic hospital for observation and treatment. When hospitalized, he received counseling but refused all medications, and after ten weeks the psychiatrists judged that he was competent to stand trial. After being sent back to the Albany County Jail, however, Tortorici waited another eight months for the trail, receiving no medication or other psychological treatment. Finally, at the pretrial hearing, he claimed that he was not guilty by reason of insanity and did not desire to be present. The prosecution thus had him examined again by another psychiatrist, and the result came back stating that he was "incapable of rational participation in court proceedings" and "not fit to proceed to trial".(Siegel, 8) Nevertheless, though acknowledging that Tortorici was not competent to stand trial after reading the report, the defense counsel claimed that he was ready to proceed to trial. Hearing no objections, the judge, relying on the now eight-month-old report from Mid-Hudson Psychiatric Center rather than the one that just came out, confirmed to proceed to trial. Tortorici, getting convicted and sentenced at last, committed suicide by hanging himself in his prison cell.

The judicial process usually takes a long time to complete, and a defendant's competence could wax and wane when waiting for trial at prison where no medication or other psychiatric treatment is provided -- in Tortorici's case, it was eight months. Moreover, not only the things that are "missing" (e.g. medications), but any change in life during the judicial process can also worsen the defendant's mental state. For instance, the person's health condition may deteriorate, taking that mentally ill people are more likely to have a history of substance abuse; he/she may lose a family member, getting abused in prison, etc.. Conducting another psychiatric examination before trial is therefore necessary. Nevertheless, in Tortorici's case, even though he was

examined again before the pretrial hearing and was considered not competent to stand trial by the psychiatrist, his defense counsel and the judge didn't take it seriously. This demonstrates the fact that criminal laws do not place great emphasis on the role of behavioral science in the judicial-justice system: the judge did not realize that a mentally ill person's mental state is highly unstable and can be easily changed with other changes in his/her life. To make the judicial process fairer, criminal laws and behavioral science should thus be better integrated through ways such as systematically educate people in the judicial system with knowledge and facts about mentally ill offenders.

Responsibility and personal autonomy

The issues of blameworthiness and competence do not just reveal the tension between criminal laws and behavioral science; they also trigger some philosophical thinking over the topics of responsibility and personal anatomy. When trying to figure out whether an offender is "blameworthy", we first decide whether he/she is responsible for his/her behavior. There are two influential theories about responsibility and mentally ill offenders that avoid "distorting and homogenizing claims about mental illness".(Tekin, 329) The first one is the Character Theory which holds that people are responsible for actions and omissions that comes from their character. In psychology, a person's character is a set of interconnected webs of neurophysiological states that enable relative patterns of thoughts and actions; that is, one's character should be predictive about one's general responses to a stimulus and should not be affected by the context too much as the character is built internally and is not subject to change unless something unusually drastic happens. Therefore, under this construction, only people with personality disorders -- an "enduring [dysfunctional] pattern of inner experience and behavior

that ... is pervasive and inflexible ... and is stable over time" -- are responsible for their choices, while other mental disorders should be seen as episodic and situation-particular in this context because even though they also last for a period of time, personality disorder is characterized by its stability that is beyond the level of the other disorders. (APA, 645) Another theory is called the Control Theory which states that people are responsible for actions that are under our control at the time of the action, or we are amenable to control prior to the action. For example, someone is responsible for committing gaffe when he/she is drunk while he/she could have avoided getting drunk. Even though this theory appears solid as it is situationally specific, it has a drawback of being too "historical" -- it only considers whether the person is in control at the time or shortly prior to the action, but many non-personality disorders are "highly variable across time and context", for example: bipolar disorder features stages of manic, hypermanic, and depression; major depression sometimes develops in specific seasons and after pregnancy. (Tekin, 331) From the offender's perspective, even though he, rather than his mental disorder, was in control of his body and mind at the time of the offense, it is still not fair to be attributed responsibility for it when the disorder is currently in remission (the conditions are being well-managed). Therefore, it is worthwhile to explore a new theory that does a better job at the issue of attributing responsibilities to mentally ill offenders.

What's more, the debate over responsibility also promotes some further concerns on personal autonomy, for it is another way to say "being in control of one's own actions". Nevertheless, the notion of "free" and "unfree" actions is blurred -- the dynamics of degrees of freedom looks more like a slope rather than a two-stage setting cutting clearly between free and unfree actions. We can be "more or less free" depends on the situation, but it seems like there

aren't many cases where one is completely out of control. One example of "having very little freedom but still not being unfree" is tax payment: we pay taxes because the law tells us to -- not by "forcing" us but rather impose a severe repercussions if we don't do so, but we can still accept the repercussions and not pay the tax. In this case, we still have *choices*, so it is not an "unfree" situation. One way to completely take away one's freedom on a certain thing is by directly manipulating the brain: brainwashing, brain implant, lobotomy, etc.. To decide whether mental disorders or what kind of mental disorders eliminate one's freedom of action (or his autonomy), at least at the time period when they are active in the cases like seasonal depression, further studies, and perhaps more advanced technologies are needed.

Ethical issue of medication and incarceration of mentally ill

In the discussion of competence, I mentioned that when a defendant is considered mentally incompetent to stand trial or be executed, he/she will be sent to a forensic hospital for treatment. Among all the established therapeutic methods of mental disorder, medication -- using drugs that directly alter the person's neurotransmitter level that is related to the disorder -- is the quickest way to change a patient's mental state. However, many psychotropic drugs have severe side effects including but not limited to: drowsiness, restlessness, vomiting, fatigue, loss of sexual interest, stroke, and even death. Even though it is not clearly stated, in most cases a person has the right to refuse his medication, except in the situation where he becomes dangerous to himself or to people around him (doctors, nurses, policies, etc.) due to his mental condition. Even if the defendant agrees to take the medication, nevertheless, there are still two ethical issues. Firstly, it is unknown whether psychotropic drugs could change individuals' way to interpret and express themselves. Secondly, the drug may also change the individual's "outward

effect", which could result in the jury's prejudice against the defendant at trial. (Erikson, 72) For example, a severely sedated defendant may give the appearance to the jury that he/she does not care about the trial. What's more, even if the psychotropic drug successfully restores the defendant's competence at the time of the trial, it may only temporarily "mute" the symptoms and leave him untreated. If the government stops the medication after the trial and the symptoms of the defendant's mental disorder reemerges, not only his competence on trial would become a false competence, but the case also becomes that the government provide medication solely to restore the defendant's competence, rather than trying to treat him and save him from long-term suffering.

After being convicted on trial, the mentally ill offender is sent to prison. According to the Eighth Amendment of the U.S. Constitution, "cruel and unusual punishment" if banned from the prison.(U.S. Congress) There are also other non-constitutional approaches to protect the incarcerated mentally ill prisoners such as the Civil Rights of Institutionalized Persons Act (CRIPA) which works on securing agreements at federal and state levels for improvements in the confinement of mentally ill prisoners. Nevertheless, it seems like none of these efforts has successfully changed the horribly harsh situations of mentally ill inmates in prison. Firstly, there is considerably excessive use of force by correctional officers because they "don't know how to react to the often irrational and sometimes violent behavior of mentally ill prisoners".(Erikson, 42) The ways that correctional officers use to restrict the prisoners often cause injury or even death: placing a prisoner into a prone position with his arms behind his back makes his respiratory muscle impossible to function. In addition, other correctional methods such as strapping nude and placing on a restraining chair, snapping head, choking are also reported for

being used and causing death. Secondly, since the 1980s, there is a growing "trend" of segregating mentally ill prisoners into solitary confinement cells -- a very small, sometimes windowless cell with cement walls and floor -- for hours, sometimes days. Mental health experts believe that staying at a solitary cell, being placed in the condition of isolation and reduced mental stimulation is "psychologically destructive" to mentally ill prisoners. (Erikson, 43) Lastly, mentally ill prisoners are also under high risk of committing self-mutilation and suicide. Reported self-mutilation include but are not limited to: cutting one's own body, headbanging, overdosing on medication, swallowing inedible objects such as needles, pins, pens, nails, lightbulbs, pieces of walls, etc.. In the U.S. prison population, a high percentage of suicide population are also ones with mental disorders. A study conducted by New York's Office of Mental Health on prisons in the state of New York found that 70 percent of prisoners who committed suicide had a history of mental illness, and 40 percent has stayed in some psychiatric hospitals. Therefore, it is urgent for prisons to improve the confinement condition for mentally ill inmates such as by educating and training the prison staff the right way to deal with people with abnormal mental state. What mentally ill prisoners need are special care and understanding, not extra punishment.

Conclusion & looking forward

Mental illness has always been a tough issue in the judicial-justice system due to the conflict view between behavioral science and criminal laws. The deep psychological and ethical issues behind this topic also add complexity to the puzzle. Maybe we won't be able to find the answer until the day we finally cracked every mystery of human psychology and mental illness, for if we still don't know what it is, how are we supposed to talk about it? (Plato, Meno)

In the 20 years since the Baumhammer's case, lots of new research on mental disorders has been conducted; many new psychotropic drugs has been created with the help of technology; the judicial-justice system has been modified; and more and more minor social groups, including mentally ill, has gained their rights and understanding by the society. However, the more we find, create, and discuss, the more we will get confused, because just as the relationship between behavioral science and criminal law, it takes much more time for two or more interrelated fields as well as new findings and theories to reconcile with each other. What will happen if artificial intelligence participates in jury decision-making? Would the decision be fairer? What if someday science finds a human gene that links with one's ability of empathy. Would that eliminate antisocial personality disorder? In this journey of answering old questions and getting new ones, what we should do is to learn lessons from the past mistakes we make, and never stop exploring.

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