Death Row Syndrome and Demoralization: Psychiatric Means to Social Policy Ends

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J Am Acad Psychiatry Law 33:153–5, 2005

Choosing death, whether as a terminally ill patient refusing further treatment or as a death row inmate refusing further appeals of a death sentence, invariably raises questions of mental state. In answering them, we strive to assess diagnoses objectively and employ competency criteria that balance preservation of autonomous decision-making with more paternalistic goals. Two recent developments suggest the risk that novel psychiatric diagnoses may be employed to support findings of incompetence, diminishing the freedom to relinquish medical and legal interventions at these critical junctures, thereby achieving social policy goals that might otherwise be stymied.[1]

In the first case, Michael Ross, a sexually sadistic serial killer and rapist on Connecticut's death row for many years, decided to forgo further appeals and proceed to execution. Through numerous interviews and legal proceedings, Ross stated his position that, while he would accept a sentence of life in prison without parole, he did not wish to put the families of his victims through the further torment of additional hearings on appeals or another penalty phase. He had been represented by an attorney of his own choosing who agreed to support him in his quest to achieve his own execution. He was examined for four hours by Dr. Michael Norko, an experienced forensic psychiatrist, who had examined him in the past. Dr. Norko found no active major psychiatric illness (other than sexual sadism) and suggested that Mr. Ross was competent to decide to forgo appeals. Mr. Ross was found competent by the Connecticut Supreme Court and a date was set for execution.

Mr. Ross's former public defenders intervened with a series of challenges that reached the U.S. Supreme Court, to no avail. But with only 75 minutes remaining until Ross was to be executed, his attorney, T. R. Paulding, after months of representation of Mr. Ross's wishes based on his belief that Ross was competent, called the execution to a halt, citing his own conflict of interest in representing Mr. Ross's desire to proceed with execution.[2] Mr. Paulding's turn-around followed a telephone conversation with Chief U.S. District Judge Robert N. Chatigny, in which the judge berated him (and threatened his law license) for his failure to meet his obligation adequately to ensure Mr. Ross's competence.[3] In court the following Monday, Mr. Paulding moved for a stay of execution, citing evidence of "death row syndrome" and concerns brought to his attention over the weekend about two letters that Mr. Ross had written. In one, written six years earlier, Mr. Ross stated that, while he cared for the welfare of his victims' families, he was driven primarily by a desire to end his own life. In the second, written in 2003, he noted, "I honestly don't think that I can do much more of this," and explained that he could understand why some death row inmates volunteer for execution. In addition, Dr. Norko provided an affidavit stating that he would have questioned Mr. Ross about this new evidence had it been available to him, and that it was possible that Mr. Ross's answers to those questions would have influenced his assessment.

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The concept of death row syndrome can be traced to a 1986 article by Dr. Stuart Grassian,[4] in which he described 14 inmates in solitary confinement. The living conditions of the inmates examined by Dr. Grassian were extreme: a 6 × 9-foot cell with no window to the outside world, furnished only with a steel bed, steel table and stool, and a steel open toilet, all lighted by a single 60-watt bulb. There was no television or radio and no reading materials other than a Bible. A solid steel door with only a small plexiglas window to an inner corridor was shut throughout the day. Solitary confinement was unbroken for 23 hours a day.

Dr. Grassian[4] described a number of severe psychiatric reactions to these conditions, which together have come to be referred to in legal venues as death row syndrome. A small body of literature[5] has emerged since then that supports the finding that severe conditions of confinement can and often do produce severe psychopathologic reactions. But the devil is in the details, and as Haney[5] suggests, a disproportionately large percentage of prisoners confined in "supermax" or solitary conditions are individuals with serious mental disorders to begin with, and the degree of psychiatric symptomatology produced varies in relation to the severity of the conditions of confinement. (The conditions of Mr. Ross's confinement have been nowhere near as severe as those described in Dr. Grassian's article.) The symptoms described both by Dr. Grassian[4] and in the review by Haney[5] include the fullest panoply of severe symptoms, from extreme anxiety, to dissociation, to full-blown psychosis. The problems with lumping these symptoms into a new syndromic diagnostic category go beyond the obvious observations that the diagnosis is diffuse, overly inclusive, and inadequately researched and cannot possibly at this time be thought to have face validity or reliability. The problem extends to the new use, or more specifically, the misuse of psychiatric diagnosis to achieve a social goal—in this case, *de facto* abolition of the death penalty.

Michael Ross may indeed have been too demoralized to fight for his life against a death sentence. But did his condition qualify for this diagnosis? Judge Chatigny, in his telephone conversation with Mr. Paulding, seemed to suggest that it did when, referring to Mr. Ross's mental state, the judge said: "He looks rational, he sounds rational, but in fact he's at the end of his rope."[3] The suggestion is that severe demoralization is a mental illness. If that turns out to be the case, Connecticut may be setting a standard for competence that no one on death row would be likely to meet.

The criteria for competence to refuse further appeals of a death sentence are not highly refined. Judge Chatigny lent some degree of definition when he challenged Mr. Paulding to be sure that Mr. Ross's refusal was "knowing, intelligent and voluntary,"[3] a fairly ambiguous standard. The problem of an ambiguous legal standard for competence is compounded by an equally ambiguous, poorly researched, and unvalidated psychiatric diagnosis. The concept of death row syndrome, as described to date, lumps every conceivable psychiatric reaction to severe confinement. But if one becomes psychotic or suicidally depressed in reaction to these conditions, certainly other well-established diagnoses may support a finding of incompetence. It is the other inmates, of course, who create the conundrum. They are the ones who are seriously demoralized, distressed, and anxious, though not otherwise diagnosably mentally ill, who may knowingly choose death, perhaps coerced by their situation. They are the ones who are making a desperate choice in a desperate situation. Will demoralization, even desperation, qualify as death row syndrome?

If we label these inmates' condition a mental illness and use that to reach a finding of incompetence, what we are really doing is implementing a social policy (abolition of the death penalty) on the back of psychiatry. This is a misuse of psychiatry and an end run around the law. If, as a society, we wish to abolish the death penalty—as I believe we should—we should legislate that change and not pin it on the inappropriate use of a speculative psychiatric diagnosis.

Concerns that severe demoralization might qualify as death row syndrome and support a finding of incompetence come on the heels of suggestions from another arena that demoralization should be considered a diagnosable cognitive disorder reflecting "morbid existential distress." David Kissane,[6] writing in the *Hastings Center Report*, suggests the diagnosis of "demoralization syndrome" for terminally ill individuals who, in the absence of diagnosable depression, express the wish to forgo further treatment to facilitate their deaths. The risk, of course, is that this diagnosis may be used as the foundation of a finding that the terminally ill individual lacks com-

petence to refuse further treatment. As Ganzini and Prigerson[7] suggest in an editorial accompanying Dr. Kissane's article, there is almost no evidence yet that demoralization is a distinct psychiatric diagnosis. They reflect on ". . .the long history of misusing psychiatric diagnosis to meet moral and political ends and deprive individuals of choice" and warn that ". . .the politically motivated use of psychiatric labels to prevent euthanasia may become a slippery slope to unwarranted paternalism."

Perhaps future research will point the way to a valid and reliable diagnosis of demoralization, and we may apply this diagnosis to individuals facing end-of-life decisions in a hospital or on death row (and in many less critical situations). If that is ever to happen, we must surmount the formidable challenge of drawing a line between existential and moral distress and psychopathology. This effort will call for input from nosologists; descriptive, dynamic, and forensic psychiatrists; neuroscientists; ethicists; and philosophers. It should be quite a discussion. In the meantime, psychiatry must take care that legal and clinical paternalists do not co-opt the authority of psychiatry through unvalidated diagnoses and ambiguous competency criteria to reach social and policy goals they cannot otherwise achieve.

References

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