Denouement of an Execution Competency Case: Is *Perry* Pyrrhic?

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In October 1992, the Louisiana Supreme Court ruled that that state could not forcibly medicate condemned, mentally ill prisoners to make them competent to be executed. *State v. Perry* has been seen as a victory for psychiatrists, but the decision contains bad news as well as good: although the Court extricated psychiatrists from having to medicate convicts involuntarily in preparation for their execution, the Court justified its decision by invoking a distortion-filled, highly critical interpretation of standard psychiatric treatment for psychoses. This article summarizes the *Perry* case and the Court's opinion, describes the perceptions of antipsychotic medication that animated the majority's legal conclusions, and reviews subsequent decisions in which *Perry* has been influential. The article suggests that *Perry*'s description of pharmacotherapy may not have been motivated by a reasoned view of neuroleptic therapy so much as the Court's desire to uphold the institution of capital punishment. By studying the *Perry* majority's opinion, psychiatrists can appreciate how certain characterizations or descriptions of psychotic symptoms and antipsychotic therapy lend themselves to distortion and misunderstanding by legal decisionmakers. Recently developed conceptions of schizophrenic symptoms and pharmacological therapy may provide psychiatrists with sophisticated modes of explanation that courts will find more difficult to misconstrue or misrepresent.

In October, 1992, a five-to-two majority of the Louisiana Supreme Court ruled that that state could not force a condemned, mentally ill prisoner to take antipsychotic medication that would render him competent to be executed. *State v. Perry*\(^1\) has become an AAPL "landmark case," and had been followed by forensic clinicians and their professional organizations for several years before its denouement. The final decision presents psychiatrists with good news and bad news. On one hand, many clinicians will agree with Paul Appelbaum,\(^2\) who felt "very pleased" that Louisiana now would not ask psychiatrists to medicate death row inmates involuntarily so that they are rational enough to be put to death, and who hoped that *Perry* would guide other courts (as it since has in South Carolina\(^3\)). On the

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other hand, the Perry majority opinion has added to case law another distortion-filled, highly critical interpretation of standard pharmacological treatment for psychoses.4

This article summarizes the Perry case, critically reviews the majority’s conception of neuroleptic therapy and its role in his psychiatric care, and discusses Perry’s impact on subsequent decisions through mid-1994. The article suggests that Perry’s description of pharmacotherapy may have been motivated not by a reasoned view of the risks and benefits of neuroleptics, but by the Court’s wish to uphold the morality of the death penalty despite its awkward consequences. Nonetheless, psychiatrists can learn from the Perry majority’s reasoning how certain characterizations or descriptions of psychotic symptoms and antipsychotic therapy lend themselves to distortion and misunderstanding. By emphasizing recently developed, conceptually sophisticated models of mental illness in forensic contexts, psychiatrists may make it more difficult for courts to misconstrue or misrepresent psychopharmacologic therapy.

Case Summary and Legal Holdings

Perry was arrested and charged with murdering his parents and three other relatives in the summer of 1983, when he was 28 years old. He had been diagnosed as having schizophrenia when he was 16 years old and had been committed to hospitals by his parents several times because of psychotic symptoms. Until 1983, he had no record of criminal conduct, but his family made him sleep in a shed behind his parents’ home because of his disruptive behavior.5

At the time of his arrest, Perry told police that his family had been harassing him and had stolen his property, and that the two-year-old nephew whom he killed “was evil, some sort of devil, witch of some sort.”6 On the recommendation of two psychiatrists who evaluated him several months after his arrest, Perry was sent to a state hospital for treatment.7 On admission, he reported a variety of paranoid and somatic delusions as well as auditory hallucinations.8 Perry was diagnosed as having paranoid schizophrenia, and was treated primarily with haloperidol. Eighteen months later, he was found competent to stand trial.9 Over objections of counsel, Perry withdrew his insanity plea and entered a plea of not guilty.10 His 1985 trial resulted in conviction on five counts of murder, for which Perry was sentenced to death.11 Perry’s treatment with haloperidol continued after his conviction, but he often had periods of psychosis even while receiving medication.12

In 1987, the Louisiana Supreme Court affirmed the conviction and sentence, but suggested that a determination of Perry’s competency to be executed “might be in order.”13 On January 21, 1988, the trial court appointed a panel to evaluate Perry’s competency. The trial court later authorized defense counsel to represent Perry in the competency “proceedings and to make decisions on Perry’s behalf.”14 On March 14, 1988, Perry’s counsel told prison authorities to stop all of Perry’s psychotropic medication.15 The trial court held its first hearing on April 20, 1988, and heard somewhat contradic-
tory testimony from panel members. On April 29 Perry’s counsel authorized re-
sumption of Perry’s medication, but had the medication stopped again when prison
authorities were asked to give the court periodic updates on Perry’s mental condi-
tion.16

The trial court eventually overruled counsel’s objection concerning status re-
ports and vacated its earlier order authorizing counsel to make decisions for
Perry. Based on the status reports it received, the court decided that a new com-
petency hearing was warranted. The trial court also ordered that Perry be treated
with medication pending this hearing, but the Louisiana Supreme Court stayed the
medication order.17

At Perry’s October 21, 1988 competency hearing, two physicians testified
that Perry suffered from schizoaffective disorder and that medication would pre-
serve his competency for execution. The court concluded that Perry was competent
to be executed, and that his competency was achieved through the use of medica-
tion. The court ordered the Louisiana Department of Public Safety and Corrections
to continue to treat Perry with psychotropics, if necessary, over Perry’s ob-
jection.18

Perry filed an application for supervi-
sory writs to the Louisiana Supreme
Court, which was denied,19 but Perry’s
petition for a writ of certiorari to the U.S.
Supreme Court was granted.20 However, the U.S. Supreme Court ultimately re-
manded the case to the trial court “for fur-
ther consideration in light of Washington
v. Harper.”21 (In Harper, the U.S.
Supreme Court upheld the constitutional-

ity of involuntary pharmacotherapy for
mentally ill prisoners who pose a danger
to themselves or others when such treat-
ment is in their medical interest.22)

The trial court reinstated its original de-
cision and involuntary medication order. It distinguished Perry’s situation from
Harper on the grounds that Perry’s case involved treatment to render him compe-
tent for execution, whereas Harper concerned prison regulations concerning
treatment of inmates to preserve prison security and safety. The trial “court held
that the state’s interest in obtaining and satisfying the jury verdict [the death
penalty] in this case outweighs Perry’s right to refuse medication.”23 At the re-
quest of Perry’s counsel, the Louisiana Supreme Court stayed the trial court’s
medication order and agreed to review the trial court’s decision.24

In its October 19, 1992 ruling, the
Louisiana Supreme Court majority re-
versed the trial court’s medication order
and stayed execution of the death sen-
tence, finding that treating Perry antipsyc-
chotic medication would “circumvent the
centuries old prohibition against execu-
tion of the insane,”25 violate Perry’s “right
to privacy or personhood,”26 and “would
constitute cruel, excessive and unusual
punishment. . . . Carrying out this punitive
scheme would add severity and indignity
to the prisoner’s punishment beyond that
required for the mere extinguishment of
life.”27 The Court also felt that the state’s
attempt to medicate Perry “in order to
chemically alter his mental condition for
execution is in itself inhumane treatment
violating his [state constitutional] right of
personhood and privacy.”28 as well as the
prohibition against executing the incompetent enshrined in Louisiana state law.29

The Louisiana Supreme Court found that Harper was “inherently inapposite and should not be applied to [Perry’s] case,”30 because Harper dealt with the state’s requiring a prisoner to accept treatment that addresses his medical needs (and maintains prison security and safety), whereas Perry addressed forcible administration of medication to implement execution.31 Because it based its findings on state constitutional considerations, the Louisiana Supreme Court’s decision terminated litigation without federal review.32 The state may apply for reinstatement of the death sentence if Perry regains competence without medication.33

**Perry’s View of Psychiatric Treatment**

The Perry decision has spared the inmate’s life so long as he remains incompetent, and relieved Louisiana prison physicians of having to administer treatment that could enable the state to execute him—a task that clinicians in Florida found to be emotionally and ethically intolerable.34 The decision also accords partially with the recommendations of the American Psychiatric Association (APA) and the American Medical Association (AMA): when Perry was under consideration by the U.S. Supreme Court, the APA and AMA joined in an amicus curiae brief that opposed the trial court’s order for competency-restoring medication, arguing that asking physicians to treat Perry would subject them to “an excruciating ethical dilemma.”35

The APA/AMA brief also recommended that inmates who are judged execution-incompetent should have their sentences commuted to life in prison so that they could receive treatment that might alleviate their incompetence-producing illness without making them eligible for execution.36 The Perry majority, however, apparently believed that allowing an incompetent and psychotic prisoner to remain on death row indefinitely while awaiting spontaneous recovery from his psychosis was preferable to finding a way for him to get treatment and less offensive than letting him receive competence-preserving pharmacotherapy. These judgments were based on three major lines of argument.

First, the majority took a highly critical view of standard care for psychotic disorders such as schizophrenia (i.e., neuroleptic therapy37), particularly as it might apply to the incompetent Perry. Neuroleptics, the Perry majority noted, do not cure mental illness but “merely calm and mask the psychotic symptoms which usually return when medication is discontinued.”38 The Court found that competency-restoring medication would put the inmate “under the influence of the drugs” to make him “able to understand the link between his crime and punishment.”39 It described Perry’s involuntary treatment with medication as an “invasion of his brain and body, ... the seizure of control of [Perry’s] mind and thoughts, and the usurpation of his right to make decisions,”40 the “chemical ... alteration of his mind and will,”41 and as compelling Perry “to yield control of his thoughts and will to the state ...”42 The Court also
thought involuntary psychotropic treatment was, for purposes of legal analysis, tantamount to the sort of governmental “thought control” prohibited by a U.S. Supreme Court decision that struck down a Georgia law restricting citizens from having pornography in their homes, and argued that “[g]overnment does not have ‘the power to control men’s minds’ or ‘the right to control the moral content of a person’s thought.”

Second, the Perry majority described standard neuroleptic treatment in general as being rather horrible. Reflecting anti-medication biases found in many earlier right-to-refuse treatment opinions, the Perry majority used 28 words to describe the purpose and benefits of neuroleptics, and devoted nearly 30 times as much space to quotations and citations from law review articles and medical texts that list neuroleptic side effects. (By contrast, a recent clinical psychopharmacology text—one that emphasizes neuroleptics’ toxicity and the use of alternatives in the treatment of psychoses—devotes six pages to indications, eight pages to therapeutic use, and eight pages to neuroleptics’ side effects.) The Perry majority concluded that neuroleptics are “powerful, dangerous and unpredictable drugs” and “powerful toxic chemicals” that incur risk of several “potential harms.” The Court imagined Perry’s treatment with neuroleptics in these terms:

he will be forced to linger for a protracted period, stripped of the vestiges of humanity and dignity usually reserved to death row inmates, with the growing awareness that the state is converting his own mind and body into a vehicle for his execution . . .

Rather than calling upon Perry to suffer only the extinguishment of his life in a humane manner, the state would have him undergo a course of maltreatment that is inherently loathsome and degrading to his dignity as a human being. Unlike sane death row prisoners who retain dignity until the end, Perry would be forced to endure the usurpation of control of his body and mind by the state and the deprivation of medical treatment in his best interests before he is dispatched by the lethal injection. He must experience an indefinite period of indignity, anxiety and fear, assimilating unwanted antipsychotic drugs into his brain and body against his will at the risk of harmful and fatal side effects . . . These circumstances amount to more than the mere extinguishment of life; they degrade human dignity and reach a sum in which there is something inhuman, barbarous, and analogous to torture.

The Court concluded that it was less “degrading to his dignity as a human being” to leave Perry psychotic than to restore his sanity. It thought that involuntary “treatment with antipsychotic drugs is even more severe and dangerous when done for purposes of capital punishment” and “that physicians who choose to forcibly administer drugs may pursue the clear goal of execution more vigorously than the vaguer duty of protecting the inmate from side effects.”

Third, the Perry majority viewed neuroleptic treatment as having been “ordered as an integral and essential part of Perry’s punishment,” and because the medication had been ordered “for the purpose of punishment” and “to facilitate his execution,” it did “not constitute medical treatment.” The majority recognized that psychiatrists take on other roles in death penalty cases that courts and psychiatrists find acceptable (e.g., helping to assess and restore competence to stand
trial), but thought that Perry’s pharmacotherapy would be “more closely tied to the execution itself,” and would “come . . . closer to being the cause of death.”

Critique of the Majority Opinion

Misconceptions About Neuroleptics

Although our understanding of the causes of psychotic symptoms and the mode of action of antipsychotic drugs is imperfect, it is clear that the Perry majority misconceptualized the effects of antipsychotic medication and the nature of the symptoms it addresses. The majority opinion analyzes “positive symptoms” such as hallucinations and delusions as though they were unpopular moral viewpoints or expressions of individual privacy that neuroleptics “suppress.” When neuroleptics alleviate schizophrenic hallucinations and delusions, however, the drugs do not act on the basis of the peculiar moral or intellectual content of psychotic thoughts. Thus, when antipsychotic medications restore patients’ ability to think logically, entertain doubts about or evidence that conflicts with delusional beliefs, consider alternatives, formulate coherent sets of wishes, and make those wishes known, the action of antipsychotic drugs should not be construed as performing the intrapsychic equivalent of “banning books” or abolishing specific thoughts because their content is objectionable.

In altering neuronal transmission, antipsychotic medications do not “censor” particular thoughts, “seize control” of patients’ minds, nor “alter” patients’ will. Medications also do not let the state “usurp” one’s right to make decisions. This is especially true if, as Justice Cole pointed out in his dissenting opinion, one “is so incompetent as to be unable to appreciate his surroundings, circumstances, or the nature of and reasons for” a death sentence. When an individual’s very ability to make (legally cognizable) decisions does not exist without medication, it makes little sense to suggest that medication could usurp his “ability to control his own mind and thoughts.” Neuroleptics are to psychosis what eye glasses are to myopia: both interventions remove impediments to perception; neither proscribes particular thoughts or actions, though both may enhance decisionmaking and the ability to respond.

“Parade of Horribles”

Although neuroleptics can have disastrous side-effects, so can most medicines. As Justice Cole’s dissent noted, “One could, with little difficulty, peruse the PDR in search of a similar parade of horribles and find virtually all prescription medications may produce adverse, unintended consequences . . . . That does not, however, render them instruments of torture . . . .” Although the majority opinion lists all of haloperidol’s potential side effects, it does not mention how potential side effects can be avoided or successfully managed. The majority opinion does not mention whether Perry—who had received neuroleptic treatment for years before and after his trial—actually suffered from any drug side effects, or whether Perry or his counsel had asked for consideration of potentially more effective, nonneuroleptic treatments (e.g., mood stabilizers or electroconvulsive therapy) after Perry’s diagnosis was revised from schizophrenia.
to schizoaffective disorder. The majority opinion also does not mention that Perry’s attorney prevented careful consideration of alternative therapies by blocking treatment, or that the Court itself could have monitored Perry’s treatment and condition with the help of consultations from independent psychiatric experts.

**Medication as Punishment** The majority’s contention that administering competency-preserving medication would be done as part of, and for the purpose of, punishing Perry is disturbing for two reasons.

First, the trial court found in October, 1988 that Perry’s execution competence was “achieved through the use of . . . antipsychotic drugs including Haldol” and therefore ordered Louisiana corrections personnel “to maintain defendant on the above medication . . . and if necessary to administer said medication forcibly to defendant and over his objection.” This order merely required Perry to resume the same treatment he had received for years before and after his trial, in effect telling the prisoner that he could not discontinue his medication to render himself exempt from execution. Antipsychotic treatment had been interrupted at the request of Perry’s attorney in March, 1988 in anticipation of a review of Perry’s execution competency, resumed (with counsel’s authorization) after Perry’s first execution competency hearing in April, 1988, and then discontinued again by Perry’s attorney “as a result of the trial court’s request for . . . reports” about Perry’s mental status. The majority opinion does not suggest that Perry or counsel had ever objected to his treatment before the question of his execution competency was raised. As described in Justice Marcus’s dissent, the sequence of events instead suggests that counsel’s treatment decisions were calculated to allow Perry to become execution incompetent.

Had the trial court found Perry marginally competent, but ordered that he have additional treatment (e.g., electroconvulsive therapy) with the hope that a clearer mind would increase his mental anguish and suffering as he awaited execution, it might make sense to construe this new treatment as ordered for purposes of punishment. But it is hard to see why resumption of treatment that was accepted as appropriate prior to trial, that Perry needed to remain rational, and that he presumably would have continued to receive if he had been sentenced to life in prison, can be construed as being a part of Perry’s punishment.

Second, it is simply wrong to regard psychiatric treatment of an incompetent, psychotic condemned inmate as either a cause of his death or as a part of his punishment. Unless death results from side effects of the medication (e.g., neuroleptic malignant syndrome), injecting neuroleptics is unlike injecting lethal doses of a barbiturate, an action that physically causes death. Labeling customary psychiatric treatment as the cause of, or a part of, a prisoner’s execution simply misassigns responsibility, because it takes a subsequent series of well-planned actions to effect a death penalty. Accurate assignment of responsibility would have us say, “but for his having committed a crime (or but for the jury’s having condemned him,
or but for the legislature’s having legalized executions), psychiatric treatment would have allowed the prisoner to resume a more normal life.” These last statements correctly focus on the condemned criminal’s (or the jury’s or society’s) responsibility for what are, in this particular case, the temporal sequelae of treatment.68

The following thought experiment emphasizes the above point. Suppose that Jones, an otherwise quite psychotic man, receives a wonderful new medication, “Sane-plant,” which is implanted under the skin, releases medication slowly, requires replacement every 10 years, is well tolerated, and alleviates his symptoms. Suppose that one year after implantation, Jones commits a capital offense with a clear mind, and is later found guilty and sent to prison to await execution. Six years later, most of the available appeals have been exhausted, and execution appears likely in the next several months. Sane-plant is still working. Jones, who knows that removal of the implanted drug soon would result in his becoming psychotic and execution incompetent, asks doctors to perform the minor surgery needed to rid him of Sane-plant’s now-unwanted effects. Should physicians who failed to do this be criticized for withholding life-saving treatment and for causing Jones’s death? If Sane-plant were not removed, would it be a part of Jones’s punishment?

The only difference between Jones’s and Perry’s treatment is that current haloperidol therapy requires oral ingestion or at least monthly injections, rather than once-a-decade implantation. Termination of haloperidol treatment involves discontinuation of previous behavior (or, alternatively, omission of the act of administering medication), whereas termination of “Sane-plant” would require commission of a new and specific course of action—surgical removal. It seems highly counter-intuitive to say that “Sane-plant,” or the failure to remove it from the subcutaneous tissue, is the potential cause of Jones’s death. The author believes that the commission/omission distinction will not support a different view of haloperidol’s role in a condemned inmate’s death, and that this conclusion should inform our views about any putative causation by actually available antipsychotics.

Perry’s Subsequent Impact

As of mid-1994, Perry’s primary role in subsequent legal decisions was as an authority for Louisiana cases involving state constitutional issues. However, in at least four cases, Perry has either influenced the outcome of other law-psychiatry opinions, or has been cited in ways that illuminate the motivations for its holdings.

Two 1993 Louisiana appellate cases raised issues closely related to those in Perry. State v. Bibb69 reviewed several claims of trial error brought by counsel for a man convicted of killing his children. The appeals court found no error in the trial judge’s continuing Bibb’s trial and ordering “medical aid or assistance” for him at a time when his attorney stated he “was unable to respond to any of my questions,” couldn’t “stop crying,” and was “incoherent.”70 Bibb was later treated with hydroxyzine (Vistaril, Pfizer Labs,
Is Perry Pyrrhic?

New York, NY) and at one point “was carried from the courtroom by the Deputy Sheriffs, sobbing and moaning.” Claiming that the medication rendered the defendant “unable to assist Counsel,” Bibb’s attorney motioned for a mistrial, which the trial judge denied.71 At appeal, Bibb claimed that Perry required declaration of a mistrial because Bibb had received forced medication that affected his thinking. The appeals court disagreed, arguing that Bibb had not received antipsychotic medication (as did Perry), and that because hydroxyzine was “administered by defendant’s treating physician, [it] was not forcibly administered.” Although a psychiatrist testified at Bibb’s second competency hearing that he had considered changing Bibb’s medication, the doctor “did not say that Vistaril was medically inappropriate” or that it diminished Bibb’s competence.72

State v. Fisher73 addressed the conviction of a man sentenced to 15 years at hard labor for possessing cocaine in an amount that implied intent to distribute. After police officers entered his motel room with a search warrant, Fisher swallowed a plastic bag believed to contain about 20 “rocks” of crack cocaine. Officers took Fisher to an emergency room where a physician, concerned about the potential danger to Fisher’s life, pumped his stomach even though Fisher, who “was coherent and spoke clearly and plainly about his wishes,” wanted no medical treatment and asked to leave the hospital.74 The gastric contents ultimately tested positive for cocaine.75 The appellate court modified the conviction (finding sufficient evidence of possession but not of intent to distribute), but rejected Fisher’s claim that evidence was illegally obtained and that pumping his stomach violated his right to refuse treatment under Perry. Unlike Perry’s case, said the appeals court, the physician had acted in Fisher’s medical interests and not to secure evidence or punish Fisher. Her decision, said the Court, “was purely a medical decision and was not the result of governmental action.”76

Opinions from two other state supreme courts have viewed Perry favorably. In a short opinion, the Supreme Court of Nevada ordered that David Riggins, whose previous conviction and death sentence had been reversed by the U.S. Supreme Court,77 be retried without involuntary antipsychotics unless the district court could show that such medications were “medically appropriate” and needed for safety reasons or to maintain the defendant’s trial competence.78 In a dissenting opinion that railed at “the ignominy of forcing mind-altering drugs down the throats of persons who are presumed to be innocent,”79 Justice Springer approved of Perry’s position that inducing “synthetic sanity” to carry out executions was “loathsome.”80 Using language that echoes Justice Kennedy’s concurrence in the U.S. Supreme Court’s reversal of Riggins’s earlier conviction,81 Springer’s dissent questions whether courts should be allowed, “for any reason, to conjure a chemically-induced form of synthetic sanity in an incompetent accused by forcing the accused to put unwanted, mind-altering drugs in her or his own brain.”82 Springer doubted whether one could ever “show that forced mind-drugging is nec-
Mossman

“necessary” to sustain trial competence, and argued that “a physician certainly does not have the expertise to testify that the drug is necessary” for competence because this is not a medical but an ethical judgment. Springer did not suggest that psychotic defendants not be brought to trial, however, but argued that physical restraints would be a preferable method for “dealing with . . . insane [sic] defendants,” and suggested that prefrontal lobotomy might be less intrusive than antipsychotic medication.

Finally, in Singleton v. the South Carolina Supreme Court held that its state constitution prohibited the involuntary medication of a condemned inmate who had become incompetent to be executed, and that a postconviction relief (PCR) court had erred in vacating his death sentence and a new sentence of life imprisonment. Noting similarities between its state constitution and that of Louisiana, the South Carolina Supreme Court found that Singleton’s privacy rights “would be violated if the State were to sanction forced medication solely to facilitate execution,” and that medication could be forced only when an inmate met the Harper criteria (i.e., dangerousness plus medical interest). Unlike Perry, the Singleton opinion does not criticize antipsychotic medication per se, but holds simply “that justice can never be served by forcing medication on an incompetent inmate for the sole purpose of getting him well enough to execute.” In addition to finding that the PCR court’s substitution of a life sentence simply was invalid under South Carolina law, the Supreme Court made this curious objection to the PCR judge’s reasoning: by basing “his order on the assumption that Singleton was hopelessly insane,” the judge ignored the possibility that “the ebb and flow of medical science” might make such a ruling “difficult to live with in years to come.”

The Supreme Court apparently wanted South Carolina to retain the option of executing Singleton if the doctors were wrong about his prognosis and he recovered spontaneously, or if he received psychiatric treatment that met Harper criteria and that incidentally restored his execution competence.

Discussion

If the Louisiana Supreme Court has given standard antipsychotic therapy another legal black eye, how should psychiatrists react? Two lines of response seem appropriate.

The “Teleology” of the Courts  Perry reminds psychiatrists that courts discount medical descriptions of drugs and illness and rely on legal formulations of treatment as “synthetic sanity” and “mind control” because medical and social science findings are often vehicles for fulfilling legal ends, rather than data that receive careful, dispassionate assessment. As Perlin observes, “Several scholars have argued that individual [U.S. Supreme Court] justices employ an outcome-determinative approach, uncritically accepting social science data bolstering opinions when they are in the majority, but debunking it when they are in the minority” (pp 60–61, footnote omitted). In his review of 1975 to 1983 cases, Appelbaum characterizes as “teleological” the justices’ approach to psychi-
Is *Perry* Pyrrhic?

...tric expertise: the Court, in an effort to limit judicial involvement in mental health facilities, was skeptical of psychiatry “when to do so provide[d] a justification for the court to restrict judicial activity . . . [but] when the purposes of judicial restraint ... are better served by extolling psychiatric abilities, the Court, and especially the Chief Justice, display[ed] few qualms about completely changing their tune” (p. 831).90

A similar process would explain why the *Perry* majority opinion, which cited Gutheil and Appelbaum’s article discussing courts’ misperceptions of antipsychotic medications, endorsed those very misperceptions itself and concluded that Perry’s psychiatric treatment would be “inhuman, barbarous, and analogous to torture.”93 The prohibition against executing the incompetent, combined with the likelihood that death rows will house increasing numbers of offenders with severe mental disturbances, entail that prison psychiatrists may face more situations that pose a choice between treating someone knowing that execution will follow, or allowing him to remain alive but interminably psychotic. The notion that a psychiatrist might have to choose between preserving a patient’s humanity or his life has been viewed by some commentators as posing a troublesome conflict of medical aims and as being a perversion of medical practice.95

Ward has suggested that if we shudder at the thought that modern psychiatric treatment can expedite a death sentence, “our uneasiness reflects a more basic abhorrence of the death penalty itself” (p. 99) and should cause us to question capital punishment’s place in modern systems of criminal justice rather than criticize psychiatric treatment *per se.* But the supreme court of a state that has executed many prisoners in recent years and that ardently supports the death penalty may have found it more palatable to make psychiatric treatment, rather than the capital punishment and its consequences, look ugly. If psychiatric treatment itself is horrible, it may not be objectionable to let a person stay untreated, psychotic, but eligible for execution should he regain competence spontaneously; if treatment is horrible, there is no reason to commute a death sentence (as would Maryland) so that treatment might be offered. If psychiatric treatment is horrible, then the conflict between the obligation to offer prisoners medical treatment and the prohibition against executing the incompetent can be transformed into a justification for withholding treatment and a means for preserving a death sentence. In a state where the legislature has approved the death penalty, commutation—which, from a political perspective, may be an unacceptable alternative—is also avoided.

Similar considerations make sense of subsequent decisions that have looked at *Perry.* Although *Singleton* did not adopt *Perry’s* views about psychiatric treatment, the South Carolina decision still entails leaving prisoners on death row indefinitely to await execution should their competence spontaneously return. Springer’s dissent in *Riggins* shows that misconceptions and skewed perspectives about psychopharmacology are convincing to those members of the judiciary who discount the intrinsic importance of ratio-
nality or who minimize the pain and indignity of psychosis. A disdain for standard psychiatric care (or simply ignorance about mental illness) may explain why Springer did not consider whether trying a shackled but psychotic defendant might violate those aspects of his constitutional rights—such as the Sixth Amendment right to confront accusers—that, to be meaningful, require a modicum of clear thinking.

Springer’s Riggins dissent, Perry, Bibb, and Fisher share an outlook in which the value of psychiatric health is minimized for the sake of preserving convictions and penalties. This outlook allowed the Bibb appellate court to ignore clear indications that the defendant may have been incompetent at trial, and to fail to recognize that Bibb’s treatment may have “chemically altered his mind and will” and “merely calmed and masked” the depressed defendant’s symptoms in exactly the way imagined and decried by the Perry majority. The same concern may have led the Fisher court to view potential resumption of Perry’s antipsychotic treatment as an unwarranted government intrusion, but the stomach pumping of a competent, but refusing “patient” brought for evaluation by police to be a “purely a medical decision and . . . not the result of governmental action.”

Refining Forensic Explanations

Even though psychiatric data often serve hidden agendas in legal decisions, forensic psychiatrists still should ask whether advances in our understanding of psychosis and pharmacotherapy offer us the potential for conceptualizing symptoms in ways that are both more accurate and harder to abuse. Some standard definitions of psychiatry’s “technical terms” illustrate the problem as it now exists:

Delusion—A false personal belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. (p 765)

Psychotic—Gross impairment in reality testing and the creation of a new reality. . . . When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality. (p 404)

These definitions are so familiar that most psychiatrists might wonder what could possibly be wrong with them. The flaws are hinted at by legal opinions claiming that involuntary neuroleptic therapy raised First Amendment issues, and by Perry’s comparison of medication effects to a state’s restricting the private use of pornography. The DSMs’ intentionally atheoretical definitions suggest that a psychotic person has certain beliefs or experiences that, although false or nonveridical, refer to the psychotic person’s reactions to and “perceptions” of “reality” as he understands it. These definitions implicitly accord those “beliefs” and “experiences” the same ontological and epistemological status as the inferences and perceptions ordinarily designated by the terms “beliefs” and “experiences.” A psychotic person who thinks that the FBI is monitoring him can thus be viewed as believing falsely in the same way that 20th century member of the Flat Earth Society believes falsely. It then follows logically that forcible use of neuroleptics potentially interfere with First Amendment freedoms (sometimes described, in
Is Perry Pyrrhic?

this context, as the “right to mentation”\textsuperscript{105}, because these treatments may be followed by changes in psychotic patients’ beliefs, ideas, perceptions, and thoughts that are (except for their falseness) equivalent to nonpsychotic citizens’ beliefs, ideas, perceptions, and thoughts.

As our understanding of the biological basis of schizophrenia and other thought disorders deepens, psychiatrists may be able to describe or explain psychotic phenomena using findings that correlate pathology in anatomy and neuropsychological processes, and make content-independent contrasts between psychosis and normal mentation. For example, recent neuroimaging studies (the results of which can only be summarized here) have yielded increasingly convincing evidence that schizophrenic patients suffer disturbances in the anatomy, functioning, and interaction of the frontal lobes, temporolimbic system, and basal ganglia,\textsuperscript{106} and that the positive and negative symptoms of schizophrenia bear important relationships to what we know about the cognitive functions associated with those structures.\textsuperscript{107} In the future, psychiatrists may wish to explain that although people who hallucinate describe themselves as “hearing voices” and act as though they are “hearing voices,” they do not hear voices, but exhibit dysfunctions in a broad array of language processing tasks that arise from abnormalities in brain structures that handle these tasks.

Similarly, psychiatrists may be able to explain delusional thinking without reference to “false beliefs based on incorrect inferences,” describing such thinking instead in a content-free manner that reflects the difference between the processes of normal inference and delusional belief. The developing literature on neural network modeling of cognitive processes offers several rich, intriguing examples of these types of explanations. For example, noting that dopamine enhances neural transmission by increasing neuronal “gain” and reducing distortion by “noise,” Cohen and Servan-Schreiber summarize several of their computer studies showing how simulating a hypodopaminergic state in the components of neural network models that simulate the prefrontal cortex results in performance deteriorations homologous to the well-documented cognitive problems of schizophrenic subjects.\textsuperscript{108,109} Hoffman and McGlashan theorize that schizophrenic patients’ symptoms arise from impaired interactions between portions of the brain regions, and have modeled these impairments by removing connections between elements in previously well-functioning neural networks. Doing this generates bizarre outputs as well as network subpopulations that are functionally autonomous and that disregard input from other parts of the network. A subset of functionally autonomous circuits yields “parasitic foci” that slavishly reproduce the same cognitive output. Delusions of control, paranoid delusions of the \textit{idée fixe} type, thought broadcasting, ‘voices,’ and certain deficit symptoms are postulated outcomes of parasitic foci located at different levels of language processing” (p 119).\textsuperscript{110} Explanatory schemes that give content-free emphasis to neuronal dysfunction elucidate the striking character of delusional thinking—its disregard of
countervailing evidence, its inconsistencies with other beliefs, its blanket rejection of alternative points of view or the possibility of error, and its disproportionate strength and important relative to other beliefs—without suggesting that it is the content itself that makes delusional thinking pathological.\footnote{111}

In general, psychiatrists should aspire to providing courts with descriptions of psychotic states that specify pathological thought patterns and processes rather than certain kinds of contents (e.g., “creation of a new reality”). Attention to how we describe symptoms of psychosis might give courts less reason for thinking that psychotropics “restrict thought” in the same way that state censorship restricts commerce in moral or political ideas.

\textbf{Conclusion}

\textit{Perry} represents a Pyrrhic victory for the inmate and for psychiatry. The decision stays Perry’s execution, but leaves him suffering from psychosis on Louisiana’s death row. Even if one accepts the \textit{Perry} majority’s contention that “sane death row prisoners . . . retain dignity until the end,”\footnote{112} it is hard to see how an incompetent prisoner who is left untreated (but who still is eligible for execution if his mental state spontaneously improves) retains his dignity. This is especially the case when one recognizes that to be competent for execution prisoners need only be aware “of the punishment they are about to suffer and why they are to suffer it.”\footnote{113} \textit{Perry} extricates psychiatrists from having to use their craft in a morally dubious context, but does so by taking a very critical view of standard neuroleptic therapy. Psychiatrists should recognize that the \textit{Perry} decision reflects neither their ethical concerns about treatment that restores execution competency nor a reasoned view of neuroleptic treatment of death row prisoners, but the Louisiana Supreme Court’s desire to preserve the death penalty despite its often awkward consequences.

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Is Perry Pyrrhic?

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Mossman


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