Personality Disorders and 'Restoration to Sanity'

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Historically, the use of the insanity defense has been limited although not exclusively to those with a psychotic mental disorder at the time of the crime. Occasionally, an insanity acquittee may primarily suffer from a personality disorder at the time of commitment to the psychiatric hospital. Such examples can include someone with a personality disorder who malingers psychosis and legal insanity or who at the time of the crime may have been suffering from a drug-induced or brief reactive psychosis. One such case will be presented as well as dilemmas created for the clinician and forensic evaluator. In addition, pertinent medical and psychological literature and legal case precedents will be discussed. Finally, a proposed guideline for the treatment and evaluation of the personality-disordered insanity acquittee will be offered, focusing specifically on the aspects of the personality disorder that contribute to the individual's dangerousness.

There are numerous individuals in this country who have been found "not guilty by reason of insanity" (NGRI) and are undergoing psychiatric treatment in state hospitals or as outpatients. The goal of such treatment is to treat the individuals' mental illness in order for them to be safely returned to society. By law, this occurs when the individual is no longer mentally ill or dangerous and therefore has been "restored to sanity." For numerous reasons that will be discussed later, the majority of NGRI acquittees suffer from major mental disorders such as psychotic or mood disorders or mental retardation. There are, however, individuals who are diagnosed as suffering solely from a personality disorder (maladaptive, enduring personality traits) and found "not guilty by reason of insanity." These individuals, as well as those whose major mental illness goes into remission at the postacquittal treatment phase but whose personality disorder remains a source of impairment or distress, pose unique treatment and legal dilemmas. Such dilemmas occur because (1) state hospitals are better equipped to treat those with major mental disorders; and (2) the insanity laws were based on the premise that only those with severe mental impairment would be acquitted and treated as NGRIs.

This paper discusses the relationship between personality disorders and the

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insanity defense, especially with regard to the criteria for being found "not guilty by reason of insanity" and "restored to sanity." Furthermore, we present many of the treatment and legal dilemmas faced by those who treat and evaluate personality-disordered individuals once they have been acquitted as NGRI. Pertinent case law is also reviewed. Finally, a case example is offered and used as a basis for providing guidelines for the clinical assessment, treatment, and forensic evaluation of these individuals.

The Insanity Defense

The insanity defense is based on the fundamental assumption of Anglo-American law that humans possess both a rational mind and free will. Thus, it is assumed that when the "average reasonable person" commits an illegal act, the individual does so knowingly and voluntarily, and therefore should be held criminally responsible and punished.[1] However, a civilized society recognizes that there are also certain people for whom blame and punishment would be unconscionable. These individuals include persons who are functioning under a kind and degree of mental disorder that renders them incapable of having a criminal intent or *mens rea* (a guilty mind).

Currently in the United States, most states employ forms of either the M'Naghten or the American Law Institute (ALI) insanity standard.[2] The M'Naghten standard states that for a person to be found "not guilty by reason of insanity," it must be proved that the defendant was "laboring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."[3,4] Under the ALI standard, a person would be acquitted by reason of insanity if "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." The terms "mental disease or defect" in the ALI standard "do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."[4,5] A similar exclusion has been statutorily included in many of the states in which the M'Naghten standard is used.[2]

After one has been acquitted by reason of insanity there is usually a postacquittal hearing to assess the individual's dangerousness and need for hospital commitment. Historically, those who were found to be a continued danger to themselves or society were committed to a mental hospital and often institutionalized for life. However, in the 1960s, many NGRI acquittees began to challenge their indeterminate hospital commitments resulting in shorter periods of confinement.[6] The shorter commitment terms were largely the result of improved treatment for mental illness secondary to the advent of antipsychotic medications, and the emphasis on due process rights. Currently, some states have provisions for maximum commitment terms for the NGRI acquittee, the period of commitment being equal to the maximum sentence the individual would

have served for the crime if found guilty. Other states provide for maximum commitment terms with the possibility of extension, if the acquittee remains a danger to himself or society. There are still other states that continue to commit NGRI acquittees for indeterminate periods.[2] This practice was upheld in the U.S. Supreme Court case of *Jones v U.S.*[7]

In 1983, *Jones v U.S.* held that when a criminal defendant is found not guilty by reason of insanity, the government can "confine him to a mental institution until such time as he has regained his sanity or is no longer a danger to himself or society" (p.354). In some states, continued hospitalization of NGRI acquittees (i.e., not being declared "restored to sanity") requires that the acquittee must be both dangerous and mentally ill. Therefore, if the acquittee no longer meets one of the two criteria, i.e., the person is no longer mentally ill or no longer dangerous, he/she should be released. The remaining states are divided as to their criteria for continued commitment. For continued confinement, some rely solely on the determination that the acquittee is mentally ill; others require a finding that the acquittee is either dangerous or mentally ill; and finally, some need only show that the acquittee is dangerous. However, a recent U.S. Supreme Court decision, *Foucha v Louisiana*,[8] will likely modify the requirements in some states for continued confinement. The Court held that it was unconstitutional because of a violation of the due process clause to confine Foucha (a NGRI acquittee) in a mental hospital on the basis of dangerousness alone, when the state admitted that he was no longer mentally ill at the time of the court hearing. Thus, the Court ruled that a NGRI acquittee who is a continued danger cannot be confined absent a finding of current mental illness.

Psychiatric Diagnoses and the Insanity Defense

To qualify for the insanity defense, the defendant must have a mental illness or defect which produces enough impairment to meet the insanity standard. That is, for a defendant to qualify as legally insane under the M'Naghten test, the defendant must have a mental illness or defect that renders the individual so impaired at the time of the crime as to not understand the "nature and quality of his act," or its "wrongfulness." The type of mental illness that causes such a level of impairment is usually severe, viz psychosis.[9]

Whereas the M'Naghten and ALI rules are both nonspecific as to which mental disorder or defect may be the cause of the defendant's impairment, there is one diagnosis that is generally excluded. As mentioned earlier, many states have specifically barred individuals from using repeated antisocial or criminal conduct as the basis for their insanity plea, when this behavior is the only manifestation of mental illness.[2] Therefore, although not distinctly named, antisocial personality disorder is rarely successfully used as a mental disorder for legal insanity because of its heavy reliance on a history of antisocial

conduct as a diagnostic requirement. Another form of mental disorder that would not appear to meet the necessary threshold level of mental impairment for the insanity standards is a personality disorder. A "personality disorder" is defined in the *Diagnostic and Statistical Manual of Mental Disorders Third Edition Revised* (DSM-III-R)[10] as "behaviors or traits that are characteristic of the person's recent (past year) and long-term functioning since early childhood. The constellation of behaviors or traits causes either significant impairment in social or occupational functioning or subjective distress" (p. 335).

Some believe that the definition of "mental disorder" for legal insanity should be more restrictive. For example, Bonnie[11] stated that a mental disease or defect should refer to "only those severely abnormal mental conditions that grossly and demonstratively impair a person's perception or understanding of reality and that are not attributable primarily to the voluntary ingestion of alcohol or intoxication substances." The American Psychiatric Association advocates a similar belief and qualifies that the mental disorders must be "serious," usually psychotic or of similar severity.[12] Indeed, most persons found insane are suffering from a psychotic disorder at the time of the court evaluation.[4, 13–16] More recently, some states have begun to limit the use of certain diagnostic entities for the insanity defense. For example, in 1983, Oregon altered its insanity statutes to eliminate those defendants suffering "solely from a personality disorder"[17]; in 1994, Arizona revised its statute to exclude specifically "character defects" as a mental disease or defect for the purpose of qualifying for an insanity defense.[18]

Psychiatric Diagnoses for Committed Insanity Acquittees

Despite the previously outlined limitations and suggested restrictions in diagnostic categories suitable for the insanity defense, two studies have suggested that a noteworthy number of insanity acquittees have a primary diagnosis of a personality disorder at the time of their hospital commitment, although not necessarily at the time of the crime or the court evaluation. By "primary diagnosis" we mean a psychiatric diagnosis that is the current focus of assessment and treatment. Of the 275 insanity acquittees in New York between 1971 and 1976, 68.9 percent had a primary diagnosis of a psychotic disorder during their hospital commitment.[19] This finding is what one would expect. However, 10.7 percent of the acquittees had a primary diagnosis of a personality disorder; of these, approximately half had the diagnosis of antisocial personality disorder. In Connecticut, there were 25 insanity acquittees between 1970 and 1972, 48 percent of whom were thought to have a personality disorder.[20] Again, most of these were diagnosed as having an antisocial personality disorder. More recently, it was discovered that after Oregon specifically barred the use of personality disorders for the insanity defense (in 1983), that state did not experience a significant decrease between 1984 and 1986 in the number of NGRI acquittees

whose primary diagnosis was a personality disorder at the time they went under the jurisdiction of the Psychiatric Security Review Board. Once found NGRI and committed, there were 14 individuals who were identified as having a personality disorder. Of these 14, eight had been diagnosed pretrial as suffering from a major mental disorder, e.g., mental retardation, organicity, psychosis, and affective disorder. The remaining six had other preacquittal diagnoses, such as pedophilia, posttraumatic stress disorder, personality disorders, or no diagnosis; two of these individuals were found NGRI solely on the basis of personality disorders.[21] These studies suggest that despite the safeguards built into the insanity standards (social policy and operational criteria) and legislative exclusion, a meaningful number of insanity acquittees suffer primarily from a personality disorder at the time of the crime, during the preacquittal court evaluation, or after an NGRI commitment.

There are some plausible explanations as to why NGRI acquittees may have a primary diagnosis of a personality disorder at the time of their hospital commitment. These could include defendants malingering a major mental disorder that would render them insane or psychiatric evaluators misapplying the insanity standard. In addition, the insanity acquittee may have a personality disorder and coexisting severe mental illness. There is usually a significant time interval between the crime and commitment to a psychiatric hospital. Thus, when the major mental illness is in remission, the personality disorder may become the prominent clinical feature. Transient mental disorders are clear illustrations of mental illnesses that may have manifested during the period surrounding the crime, but resolve in the course of hospital commitment. Examples of such diagnoses include brief reactive psychosis; drug-induced psychosis; posttraumatic stress disorder; and postpartum psychosis.

Dilemmas Regarding Personality-Disordered Insanity Acquittees and "Restoration To Sanity"

As noted earlier, most defendants can be found insane if they suffer from a mental disease or defect that renders them so impaired as to meet forms of either the M'Naghten or ALI standard. The focus of a restoration hearing tends to be on acquittees' mental illness and/or its relationship to their dangerousness. The entry criteria for finding a defendant "not guilty by reason of insanity" are legally different from the exit criteria in "restoration to sanity." Consequently, the type of mental illness or disorder qualifying for the two standards may vary. Thus, an acquittee who is suffering from a personality disorder either solely or with a mental illness in remission poses several dilemmas for the clinician and forensic mental health evaluator.

From a clinical perspective, personality disorders are chronic, enduring, and usually difficult to treat. Unlike major mental disorders such as schizophrenia, there are few effective somatic or psychopharmacologic treatments for the

personality-disordered patient. Change tends to be difficult and occurs only after a lengthy period of intense psychotherapy. Moreover, these patients often tend to evoke significant negative staff countertransference (negative feelings staff have toward the patients, generally for unconscious reasons) that can further impede effective treatment for these individuals.

In addition to the above treatment dilemmas, a legal conflict may arise as to whether a personality disorder qualifies as a mental disease or defect for the purposes of continued NGRI hospital commitments. In *Foucha v Louisiana*,[8] a state psychiatrist testified that the defendant was in "good shape" mentally and had recovered from his original condition (a drug-induced psychosis which was now in remission). The psychiatrist also stated that Foucha had an antisocial personality, "a condition that is not a mental disease and that is untreatable" (p. 6855). The U.S. Supreme Court, however, did not address the issue of whether antisocial personality is a mental disorder, and stipulated to the State's finding of no mental illness. However, in a recent 1991 California Appellate Court decision, the Court did address this issue and held in *People v. Williams*[22] that antisocial personality disorder is a mental disorder for the purpose of extending the maximum commitment term of a NGRI acquittee. The Court reasoned that antisocial personality disorder is a disorder which includes symptoms other than just repeated criminal conduct (e.g., impulsivity and lack of empathy), and thus should qualify as a mental disease or defect for extension purposes. Although *Williams* refers to an extension proceeding, one could infer that other states that require a finding that the acquittee is no longer mentally ill as the grounds for "restoration to sanity" could offer a similar argument in allowing an antisocial personality disorder to be used as a mental disorder for the purpose of continued hospital commitment. (It should be noted that we are not aware of the psychiatric diagnosis that served as the basis for Williams' NGRI acquittal. That is, in addition to a personality disorder, he may have had a mental illness in remission at the time of his extension hearing, as Foucha did at his restoration hearing.)

Lastly, personality-disordered patients pose a unique assessment dilemma for the mental health professional evaluating them for legal purposes including "restoration to sanity" hearings. For example, symptoms of a personality disorder tend to be more difficult to identify than those manifested in such serious mental disorders as schizophrenia. That is, the symptoms of schizophrenia such as hallucinations and delusions are usually quite apparent, often even to an untrained observer. However, the symptoms (personality traits and characteristics) seen in a personality disorder tend to be more subtle and vague. In addition, it is more difficult to assess when an individual with a personality disorder has been successfully treated as compared with the person suffering from a major mental illness. For example, in schizophrenia, remission of the major psychotic symptoms would indicate a

positive therapeutic response; however, change in personality characteristics are harder to evaluate. Furthermore, the symptoms of those acquittees suffering from a personality disorder may not be as obviously linked to their dangerousness as in cases of other mental disorders. That is, an acquittee with the diagnosis of schizophrenia may have committed the crime because of significant decompensation and responsivity to a paranoid delusion or command hallucinations to act out. Although there are numerous other factors that may contribute to this individual's dangerousness (intoxication, personality traits, social and environmental stressors), when these psychotic symptoms are in remission, the likelihood of the patient committing dangerous acts is significantly reduced. The strong relationship between psychiatric symptoms and dangerousness in an individual with a psychotic mental disorder is somewhat more obvious in comparison with the more subtle interaction between psychiatric symptoms and dangerousness in the patient with a personality disorder.

Complicating the clinician's assessment dilemma is the fact that there are few research studies on the assessment of dangerousness in NGRI hospitalized patients with personality disorders. Furthermore, much of the literature describing the relationship between personality traits and dangerousness is based largely on clinical observations. A review of this literature may be obtained from Mulvey and Lidz[23] and Krakowski, Volavka, and Brizer.[24]

A Proposed Guideline for Resolving the Dilemmas

Given the previously outlined dilemmas, a basic guideline in the treatment and assessment of insanity acquittees who have a primary diagnosis of a personality disorder is needed. In that personality disorders have been admitted as "mental illnesses" for "restoration to sanity" purposes, we believe that the treatment and assessment of these individuals should focus specifically on the symptoms of their personality disorder that directly relate to their dangerousness, i.e., risk of harm. When assessing for "restoration to sanity," if an individual has a major mental illness with an underlying personality disorder, the personality disorder should only be considered if it significantly contributes to dangerous behavior or to an exacerbation of the major mental illness. This is in contrast to an individual whose potential for danger is linked to a major mental illness but not related to his/her underlying personality. Such an example could be an individual suffering from bipolar disorder, who commits a dangerous criminal act in the midst of a manic frenzy. When this individual's bipolar condition is stabilized with the appropriate medication, and when he/she is compliant with treatment and has a good understanding of the need for continued psychiatric care, most clinicians would regard this person as "restored to sanity." They should not be concerned about the underlying personality in that it was unrelated to the potential risk of harm.

The identification of the specific personality traits attributable to an individ-

ual's dangerousness enables the treatment team to develop a more focused and cohesive treatment plan. Thus, clinicians can focus on certain personality characteristics for treatment and assessment, rather than focusing on the individual's entire personality disorder. Consequently, the staff would be able to address issues that expressly relate to the patient's threat of harm, and they could more easily assess the patient's progress. This approach would also provide a higher degree of fairness to NGRI acquittees. First, acquittees would be aware of the particular issues that need to be addressed with regard to their "restoration to sanity;" and second, their personality disorder would not have to be "completely cured" (i.e., they would have to be no longer mentally ill) as a contingency for release from the hospital. Without such an approach, the likelihood is greater that many of these personality-disordered individuals would not be "restored to sanity" and discharged prior to their maximum commitment term.

Case Example

The following case example illustrates the application of the proposed guideline. The patient is an NGRI acquittee who was committed to the state hospital. As consultants, we were asked to assess the issue of dangerousness in relation to whether she is "restored to sanity" and to offer treatment recommendations.

The patient is a 34-year-old white female who was acquitted by reason of insanity on the charge of assault with a deadly weapon. Since adolescence, she has had a history of substance abuse, including heroin and PCP use; unstable abusive relationships; intermittent suicidal ideation; mood swings; and poor self-identity. During the periods of substance abuse, she often had psychotic episodes in which she engaged in harmful behaviors. For example, on one occasion, she set a bush on fire outside of a bus station; on another, she poured boiling coffee on the head of a passenger waiting at the bus station. Her substance abuse and subsequent psychotic episodes precipitated several psychiatric hospitalizations.

The patient stated that prior to her arrest, she was homeless, hitchhiking, and smoking marijuana. One evening, she slept in a car along the roadside. The following morning the owners arrived and summoned the police. She refused to get out of the vehicle, leaving the police to forcibly remove her. At that time, she grabbed a knife and made stabbing motions at the police but was quickly disarmed without any injury to herself or others. She pled "not guilty by reason of insanity" and psychiatric experts diagnosed her as suffering from schizophrenia, substance abuse, and a personality disorder. She was eventually acquitted as legally insane and committed to the state hospital.

At the time of our consultation, the patient had been at the hospital for four years. During her commitment, there was no evidence of psychosis, nor was she taking any antipsychotic medications. Consequently, the staff diagnosed her as suffering only from a personality disorder. However, approximately three

months before we interviewed her, she had returned to her original jurisdiction for a "restoration hearing" and spent several weeks in jail. During that time, she had a brief psychotic episode, in which she believed that bugs were crawling into her head. On returning to the hospital, however, the psychosis quickly remitted.

The majority of her psychiatric symptoms occurring during her hospitalization appeared to be related to her personality disorder. The staff noted that she was unable to control her anger and had numerous fights with other patients. In addition, she still had an unstable mood and little insight into her illness and need for treatment, and she continued craving drugs despite a course of drug treatment in the hospital. Moreover, she engaged in a significant amount of "staff-splitting" and manipulation. Because of this, various staff members were disciplined by the hospital administration and team members were at odds with each other over the treatment of this patient.

As consultants, we diagnosed the patient as suffering from a history of either substance-induced psychosis—in remission or brief reactive psychosis—in remission, polysubstance dependence, and borderline personality disorder. When asked to comment on her dangerousness, we believed that she still presented a risk to society for the following reasons. She continued to display an inability to control her anger, such as when fighting with peers as well as engaging in other impulsive behaviors. In addition, her craving for drugs persisted during her hospitalization, despite a course of substance abuse treatment. Moreover, she had clearly demonstrated a proneness to psychosis under stress or from possible substance abuse while at the county jail. Given this clinical picture, we believed she was at high risk for continued drug abuse that would result in psychosis and impulsive and aggressive behavior in the community. Both her drug intoxication and psychosis would impair her perceptions, judgment, and insight, so that she would be more likely to display her anger in an impulsive, dangerous manner. The constellation of drug abuse, psychosis, and impulsivity had been linked to previous dangerous behavior, including the instant offense (a drug-induced psychosis resulting in an assault on a police officer) and her reported episodes at the bus station (setting a fire, assaulting a passenger with hot coffee). Therefore, it was our opinion, that she was not "restored to sanity" at the time of our consultation. The personality factors which directly contributed to her dangerousness included her anger, impulsivity, craving for drugs, and proneness to brief psychotic episodes.

Although she also had a history of unstable relationships, mood swings, and staff-splitting, these factors, although clinically significant, were not necessarily relevant to the assessment of dangerousness. That is, these behaviors were not closely linked to conduct that would place her at risk for engaging in harmful acts, and therefore, would not be considered when evaluating "restoration to sanity."

The second issue we were asked to consider was treatment recommendations. Although the patient demonstrated many problem areas that could be addressed through treatment, our recommendations focused primarily once again on the symptoms that contribute significantly to her dangerousness. Thus, we made treatment recommendations in regard to medication intervention for her proneness to psychosis; resumption of substance abuse treatment; and individual psychotherapy to address her impulsivity, anger, and aggressiveness. In addition, we offered recommendations for the staff with respect to dealing with her manipulation and staff-splitting. This was considered an important recommendation for assuring effective treatment, in that these behaviors on the part of patients frequently create negative staff countertransference. These negative unconscious emotions by the staff could cause anger and resentment toward the patient, hampering beneficial treatment. Furthermore, there is the risk that negative staff countertransference could detrimentally bias the patient's evaluations; e.g., she could be identified as posing more threat of harm than she actually does, which would thereby impede her discharge as "restored to sanity."

Conclusion

In conclusion, we believe that NGRI acquittees who suffer from personality disorders are not an uncommon phenomenon. Undoubtedly, state hospitals throughout the country are currently treating many NGRI acquittees whose primary psychiatric difficulty during their hospitalization is a personality disorder. Presently, there do not seem to be any legal restraints against continued commitment of the personality-disordered NGRI acquittee, as long as the courts are willing to accept a personality disorder as a "mental illness" for legal purposes. The treatment and assessment of these individuals should focus specifically on the aspects of the personality disorder that contribute to their dangerousness, i.e., potential to harm. Finally, one must be aware of the negative countertransference that these patients often evoke as it impacts on their treatment and forensic evaluations, such as the assessment of the patients' "restoration to sanity."

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