# A Case of Insanity: Diagnostic Relevance in the Shadow of Columbine

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> What is naming? Is it an event which we can study as we study other events in natural history, such as solar eclipses, glandular secretions . . . ? In leaving it at that, we only succeed in concealing, rather than clarifying, a most mysterious happening.[1]—Walker Percy

As director of a forensic psychiatry fellowship program, I am sometimes asked how important psychiatric diagnoses are in sanity and competency opinions. Given that the legal, usually statutory, definition of mental disease or defect is the primary concern in criminal forensic opinions and that legal definitions do not reflect descriptive diagnoses, what difference does it make whether someone is given a descriptive diagnosis of schizoaffective disorder or schizophrenia? Since the psychotic symptoms and the impact of those symptoms on perception, thought, judgment, mood, behavior, and decision-making are most relevant in the criminal forensic setting, is descriptive accuracy that important? After all, in many jurisdictions, how symptoms of mental illness affect capacities is the relevant question asked of forensic psychiatrists and psychologists in the courtroom.

## A Case of Insanity

Bruco Strong Eagle Eastwood was 33 years old on February 23, 2010 when he drove his car from Hudson, Colorado to Deer Creek Middle School, approximately a one-hour drive, arriving around 2:50 p.m. Children were exiting classes and preparing to board buses in the parking lot. After entering the school building, signing a visitor's log, and briefly walking about the school, Mr. Eastwood returned to his car, pulled out a 30-06 rifle that belonged to his father, and shot twice, wounding two young students. Fortunately, two teachers on traffic duty in the parking area of the school tackled Mr. Eastwood to the ground, preventing him from reloading and further discharging his rifle and thus preventing injury or death of other students leaving school that day. (The chronology of events was made public in the court proceedings in September/October 2011.) Shortly after Mr. Eastwood's arrest, a defense forensic psychiatrist evaluated him and noted his history of severe mental illness and psychotic symptoms, including delusional parasitosis at the time of the shooting. The defense entered a plea of not guilty by reason of insanity. I was then assigned to complete a court-ordered sanity evaluation of Mr. Eastwood. As did the defense psychiatrist, I and another forensic psychiatrist who was subsequently ordered by the court to provide a third sanity evaluation, concluded that Mr. Eastwood was insane under Colorado law. (Colorado requires that forensic evaluators provide ultimate issue opinions.)

This incident occurred within a mile of the Columbine High School shooting in 1999 and in the same county as Columbine. The District Attorney's office was understandably reluctant to stipulate to the insanity findings, even if two of those opinions were from court-appointed evaluators. Eleven years after Eric Harris and Dylan Klebold walked into Columbine High School, killed 12 students and 1

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teacher and wounded more than 20 students, and then directed their weapons on themselves, Mr. Eastwood stirred fear, controversy, and even outrage in the Denver area. Parents were alarmed and angry that another school shooter could act in the shadow of the fourth most deadly school shooting in American history.

Relevant to the prosecution's case, Mr. Eastwood had a long history of marijuana use, dating to his adolescence. It was clear in the record that he had not been using substances in the weeks and months before the shooting, but the prosecution introduced the theory of voluntary intoxication based on the fact that Colorado does not recognize the settled insanity doctrine. Although the prosecution had other legitimate concerns, this was the first highly publicized case in Colorado in which the relationship of cannabis use to psychosis and culpability was raised vigorously in the subsequent criminal proceedings.

## Settled Insanity

### *The* Bieber *Case*

In *Bieber v. People*, the Colorado Supreme Court ruled that the settled insanity defense was precluded by statute.[2] Donald Bieber was convicted of felony murder, aggravated robbery, and second-degree aggravated motor vehicle theft. On appeal, he argued that the trial judge had erred in denying his request for jury instructions on the defense of settled insanity. The Colorado Court of Appeals issued three separate opinions on Mr. Bieber's appeal, and so the Colorado Supreme Court granted *certiorari* to resolve the matter.

Mr. Bieber, on September 25, 1986, walked up to a truck in which William Ellis was sitting. He shot Mr. Ellis in the back of the head, opened the door of the truck allowing Mr. Ellis's body to fall to the ground, and then drove off in the truck. Witnesses testified that Mr. Bieber exhibited symptoms of paranoia and psychosis. Toxicology tests revealed long-term marijuana use, but the screening was negative for methamphetamines or other substances. Mr. Bieber had a long history of methamphetamine use and had a history of psychotic symptoms diagnosed as secondary to drug use. However, Mr. Bieber argued that he was not intoxicated at the time of the shooting of Mr. Ellis, but was legally insane under the Colorado statute,[3] as written at that time. He argued that he had an "amphetamine delusional disorder," a condition that does not require acute ingestion of amphetamine but is believed to be secondary to chronic use. He argued that because of his symptoms of delusions and paranoia, he was not able to distinguish right from wrong and thus was insane when he shot Mr. Ellis. He posited that the jury should be instructed that insanity produced by prolonged use of amphetamines affects responsibility in the same way as insanity produced by any other cause, if the mental disease or defect causing the insanity is settled. Furthermore, his attorneys proffered that jury instructions should explain that settled does not necessarily mean permanent or incurable, but that the mental disease or defect resulting in insanity is independent of the contemporaneous use of the drug. The trial court rejected the request and chose to instruct the jury in accordance with the statutory definition of insanity, including the qualification in the statute that "intoxication does not, in itself, constitute a mental disease or defect within the meaning of a plea of not guilty by reason of insanity."[4] The jury found Mr. Bieber sane and subsequently, in the guilt phase of the proceedings (at that time, Colorado had a bifurcated procedure for insanity claims), found him guilty of the charges, including felony murder.

The Colorado Supreme Court reviewed the doctrine of settled insanity in other jurisdictions and acknowledged that, in most other jurisdictions, the doctrine is accepted and recognized as a legitimate justification for finding a defendant not culpable. Other courts have made the distinction between acute intoxication and settled insanity, stating that justice requires that persons be responsible for acts committed in a state of voluntary intoxication. In *People v. Dong*, the court argued that every person "owes to his fellow men, and to society, to say nothing of more solemn obligations, to preserve so far as lies in his power, the inestimable gift of reason."[5] In other words, one is responsible for acts committed after the foolish decision to become inebriated. However, the court referenced previous California cases and continued:

> If it [reason] is perverted or destroyed by fixed disease, though brought on by his own vices, the law holds him not accountable, but if, by a voluntary act, he temporarily casts off the restraints of reason and conscience, no wrong is done him if he is considered answerable for any injury which, in that state, he may do to others or to society. . . . It must be "settled insanity," and not merely a temporary mental condition . . . which will relieve one of the responsibility of his criminal act [Ref. 2, p 1028].

The court then analyzed the Colorado statutory scheme, including the General Assembly's position on intoxication. In short, the court found that Mr. Bieber had a mental condition due to voluntary ingestion of a substance resulting in "intoxication," that his intoxication was "self-induced," and that he "ought to [have known]" of the effects that amphetamine would have and was having on his body and mind. The court argued that there is no distinction between a person who drinks or takes drugs and is aware of the momentary changes in mental state and a person who drinks or takes drugs knowing that he may have mental impairments as an eventual, long-term result of using substances.

With *Bieber*, Colorado established itself as one of the few states to reject the settled insanity doctrine, and in doing so raised complicated questions about the relationship of substance use to psychosis, insanity, and moral blameworthiness. While Colorado is in an extreme minority in its rejection of the settled insanity doctrine, forensic experts in criminal proceedings are often confronted with the question of whether the relationship between both current and remote substance use in the context of psychosis may or may not excuse the defendant. To examine the connection between these elements, one must consider the purposes, accuracy, and goals of diagnosis in insanity claims.

### *The* Eastwood *Case*

In the fall of 2011, Bruco Eastwood went to trial. Three forensic psychiatrists (two court-appointed and one defense-hired expert) opined that Mr. Eastwood was insane. The prosecution's forensic expert, who reviewed discovery, a videotaped interrogation of Mr. Eastwood, and hospital records, although unable to state an opinion on his sanity in the absence of an interview with Mr. Eastwood, provided observations that raised doubts about Mr. Eastwood's incapacity to distinguish right from wrong under Colorado law. The prosecution appropriately challenged several aspects of the defense's case, including the relationship between Mr. Eastwood's substance use history, especially his marijuana use, and his subsequent psychotic symptoms. The question of accuracy in the diagnostic process became a relevant and important consideration in the trial. The prosecution, given the unique situation in Colorado where the settled insanity doctrine is precluded, challenged the forensic experts' diagnostic conclusions and the relationship between cannabis use and psychosis. If it could be established that cannabis use causes psychosis, or at least, is linked to an earlier onset of symptoms of schizophrenia, then perhaps Mr. Eastwood should be held accountable for his actions because of the rejection of the settled insanity doctrine in Colorado. After a three-week trial that included testimony from the two young victims of Mr. Eastwood's actions, emotional testimony from family members and witnesses, and testimony of four psychiatric experts, the jury returned a verdict of not guilty by reason of insanity. Mr. Eastwood was ordered into the Colorado Mental Health Institute at Pueblo (CMHI-P) for treatment.

## Cannabis and Psychosis

Estimates are that there are more than 17 million habitual users of cannabis in the United States. In 2010, the National Survey on Drug Use and Health reported that 2.4 million individuals over the age of 12 used marijuana for the first time within the preceding 12 months.[6] This was the largest number of new initiates for a specific illicit drug category, followed by nonmedical use of pain relievers and nonmedical use of tranquilizers. As of 2012, 17 states and the District of Columbia have endorsed medical marijuana laws. Eleven states rejected such laws in 2012. The controversies on the medical uses of cannabis are plentiful, but certain medical effects and potential adverse side effects are not in dispute. The potential benefits of cannabis in creating relaxation, calmness, and a sense of well-being in persons who are experiencing the side effects of certain medications and illness are well known. In contrast, unregulated cannabis is more potent than the marijuana smoked by individuals in the 1960s and 1970s, and that raises concern. That dysphoria, paranoia, and psychotic symptoms are associated with high doses of cannabis is well established.

There are many arguments for and against the legalization of cannabis for medical purposes; however, what may have relevance in criminal proceedings and should concern forensic experts, including members of the American Academy of Psychiatry and the Law (AAPL), is the relationship between cannabis use and psychosis and the attribution of psychotic conditions to chronic cannabis use. While the literature is far from agreement on various aspects of the relationship between cannabis use and psychosis, there appears to be some agreement in several

areas.[7–10] Frequent cannabis use may precipitate earlier onset of psychosis. Although this may be the case, it is unclear whether cannabis can precipitate a chronic psychotic disorder that would not have occurred without its use. That many cannabis users do not develop chronic psychotic illnesses suggests that there are many other variables and vulnerabilities at play in the relationship between cannabis use and psychosis. The question of a relationship between cannabis use and schizophrenia remains contentious in the literature. There is evidence that cannabis has a negative impact on the course and severity of symptoms in schizophrenia. Some studies have suggested that individuals who have schizophrenia and use cannabis have an increased severity of positive symptoms, may have earlier onset of psychotic illness if already vulnerable to the development of psychosis, may be more prone to relapses, may have greater rates of rehospitalization, and may be less responsive to antipsychotic medications. The relationship between cannabis use and adolescent development evokes particular concern when considering the evolution of social policy regarding legalization of medical cannabis.

## Relevance of Diagnosis

Does diagnosis matter? I believe the answer is: it depends on what you mean by diagnosis. Even though the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[11] is clear in its introduction that the manual may not be "wholly relevant" for forensic practice, it has become the standard for making psychiatric diagnoses in the courtroom. On the specific question of whether to assign a substance-induced psychotic disorder, it provides some guidance that is useful in the courtroom in cases such as Mr. Eastwood's. Psychotic symptoms of hallucinations and delusions must have "developed during, or within a month of, substance intoxication or withdrawal." Furthermore, the DSM-IV-TR is clear that the substance-induced psychotic disturbance must not be "better accounted for" by other psychotic disorders. It then spells out "evidence" that another psychotic disorder is a more appropriate diagnosis where substance use is implicated. In such diagnoses, the symptoms precede the onset of the substance use; the symptoms persist for a substantial period (e.g., about a month) after cessation of the acute withdrawal or severe intoxication; the symptoms are substantially in excess of what would be expected, given the type or amount of the substance used or the duration of use; or other symptoms are present that suggest an independent non-substance-induced psychotic disorder (e.g., a history of recurrent non-substance-related episodes).

Overall, these criteria are helpful to an expert when testifying and explaining to a jury why substance use may be relevant, but they are not necessarily a reason to ignore or deny underlying severe symptoms of mental illness that may justify an opinion of insanity or at least of diminished capacity.

What I find most troubling in insanity cases is the tendency for the adversarial process to subvert and for some forensic practitioners to neglect the purpose of an insanity defense by failing to appreciate and acknowledge that diagnoses can be both informative and obfuscating. The descriptive diagnosis can mislead and misdirect audiences from understanding the phenomenological aspect of psychiatric symptoms and how those symptoms influence perceptions, judgments, and decisions. Central to the question of culpability is an assessment of the symptoms of mental illness that may cause an individual to make irrational and involuntary decisions and that society may view as an excuse for certain actions, even horrendous actions. The insanity claim is part of a legal mechanism for staging responsibility and thus the appropriateness and degree of punishment within the judicial process. Central to judgments about culpability is the question of the voluntariness and rationality of a defendant's actions and decisions. Understanding how rationality and autonomy are affected by symptoms of mental illness leads to opinions on whether a defendant appreciated the wrongfulness of his actions or whether he was capable of forming a culpable mental state. While a show of remorse or limited rationality in the immediate aftermath of a horrendous act may raise questions about state of mind at the time of the act, it is the state of mind at the moment of the act that is the most important question to be answered in insanity claims. A descriptive diagnosis tells us little about that moment if we are unable to couple the descriptive diagnosis with an understanding and explanation of the associated irrationality and loss of autonomous choice that are often the consequences of severe psychotic symptoms.

I have reviewed many forensic reports in which the narrow focus on diagnoses and narrow application of diagnostic conclusions to the legal standard results in distraction and obfuscation from the deeper moral drama involved in insanity claims. Too often, foren-

sic reports focus attention solely on the descriptive diagnostic question, without describing or educating the audience on how symptoms, assuming that those symptoms are authentic, impair rationality, decision-making, and ultimately, actions. As forensic psychiatrists and psychologists, we are the experts called first to evaluate and then educate others on our findings. Juries, attorneys, judges, and, in some cases, the public are our audience, and it is our experience and knowledge as mental health professionals that allow us to describe the destructive and disabling nature of psychotic symptoms that can and do deprive individuals of rationality, impair decision-making, and lead to horrendous behavior. It is the phenomenon of psychosis that may be more important than the descriptive diagnoses itself and that therefore must be given attention and weight in our reports and in the courtroom. To provide one without the other is a failure of professional obligation, a failure to use and share our knowledge and understanding of the devastating impact of chronic mental illness.

In the *Eastwood* case, the question of a causal link between cannabis use and psychosis was relevant and important. In raising these questions, the district attorney was fulfilling an appropriate and important professional service for the community and the victims of this tragic shooting. Responding to this question was important in the trial. In the end, however, it was a detailed elucidation of how delusions of reference, delusions of parasitosis, the experience of thought insertion and thought broadcasting, auditory hallucinations, and the delirium-like nature of some psychotic states that was necessary to explain why Mr. Eastwood was unable to distinguish right from wrong. Over the years, psychotic symptoms transformed Mr. Eastwood, leaving him a fractured, fragmented, disorganized, and alienated human being, unable to act rationally or autonomously at the time of the shooting. These severe symptoms of mental illness as phenomena were not only appropriate considerations, they were essential in assisting the jury in the difficult task of determining the proper measure of Mr. Eastwood's culpability in the shadow of Columbine.

## The Phenomenological Approach

When I am invited to perform forensic assessments, civil and criminal, I am mindful of how important it is to approach each situation, some of which are tragic, with a fresh and curious sense, and to be interested in the phenomena of what I am trying to understand as if experiencing it for the first time. I am reminded again of the novelist Walker Percy. Percy was a physician who began writing after contracting tuberculosis in the 1940s while an intern in pathology at Bellevue Hospital in New York City. While resting in a sanatorium in upstate New York, his attention turned to philosophy, religion, and art. By his own admission, he viewed the novel as a tool to explore, an art form that could be used to "diagnose the malaise" of the times (Ref. 12, p 204).

Percy developed an interest in semiotics. He wrote numerous papers probing the process by which language signifies and denotes phenomena and thus understanding. He became a critic of the way in which labels distance us from experience and compromise understanding of the events that define and shape us. In his essay, "The Loss of the Creature," Percy probed the process by which familiarity and labels prevent us from using our senses to explore and discover.[13] He coined the term "preformed complex" to characterize how our experiences and the objects of the world are settled in the imagination by cultural expectation and comparison to the "preformulated" label of an experience or object (Ref. 13, p 47). Percy argued that the preformulated label prevents the observer from making a "sovereign discovery of the thing before him."

To illustrate his position, he compared the experience of a Boston tourist who visits the Grand Canyon with his family for the first time with that of the early Spanish explorers who stumbled on the great canyon for the first time. For the tourist on the tour bus, after reading about the canyon, viewing numerous photographs of it, and exchanging stories with friends and family who have visited it, his subsequent trip to the canyon was shaped by comparison to these preformulated expectations. In contrast, it is Percy's view that the early Spaniards were free of these preformulations and therefore could discover the canyon by a "penetration of the thing itself, from a progressive discovery of depths, patterns, colors, shadows, etc." (Ref. 13, p 47). The Spaniard, according to Percy, was able to "gaze directly at the Grand Canyon under these circumstances and see it for what it is—as one picks up a strange object from one's backyard and gazes directly at it" (Ref. 13, p 47). He describes Robinson Crusoe landing on his island and experiencing the objects of his new world

through fresh senses, free of the labels that detract from seeing and knowing.

As educators, we should consider the problem of descriptive diagnoses and how these labels may detract from the more complicated moral reflection on culpability and responsibility in the context of symptoms of mental illness, a phenomenological diagnosis. One cannot approach the evaluation of mental states relevant to the insanity claim without a historical and philosophical appreciation of why this defense has remained embedded in our social and legal history. If the insanity defense is to have value, forensic practitioners must see their responsibility broadly: to educate and explain the devastation and destructiveness of psychotic symptoms and the impact of them on rationality and autonomous choice. We have obligations to the law and legal standards as well. To fulfill these broad obligations, we must first understand and then provide a voice for those who cannot explain their misery and alienation, whose symptoms of mental illness have separated them from the qualities of reason and autonomy that define human beings.

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