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Schizotypal Personality Disorder and the Insanity Defense

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ABSTRACT: What constitutes a "mental disorder" for purposes of the insanity defense? Does mental disorder denote any diagnosable condition listed in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders?* Is a mental disorder a disturbance wherein the functional criteria of the appropriate insanity law appear to be met? Or does insanity law define mental disorder apart from functional criteria of insanity? The answer to the last question is that some insanity laws attempt to define or qualify mental disorder, but many do not. Unclarities in the law leave room for unnecessary disagreements between expert witnesses even before the functional criteria for insanity are to be addressed. The potential for confusion is compounded when the defendant's disturbance is ambiguous, amphibious, or both. Schizotypal personality disorder is offered as an example of such a disturbance, and inferences are discussed.

KEYWORDS: psychiatry, jurisprudence, insanity defense

Confusion and discontent surround the insanity defense. To reduce perceived excessive application of the insanity defense, legislatures across the nation enacted new insanity laws. While mollifying antipathies of the moment, resulting lack of conformity between various insanity laws now in existence may in the long run create more confusion and resentment over unequal applications of this defense.

The diverse insanity tests have two elements in common. Insanity tests require presence of a mental disorder. "Mental disease or defect" is one of several commonly used terms in insanity laws. And, secondly, insanity tests contain one or more functional criteria, which, if present, would absolve the mental state (mens rea) that is essential to the criminal offense. Much discussion and writing on insanity tests focuses on functional criteria. Tests of insanity are known by eponyms, but also by their distinguishing functional criteria; for example, right-wrong test, product test, irresistible impulse tests, and so on. Functional elements of the American Law Institute test are referred to as the "volitional prong" and the "cognitive prong."

We shall concern ourselves here with the first element of insanity tests, presence of mental disorder. Functional criteria are met when particular inabilities are the result of a mental disorder. Because of his knowledge, skill, and experience, the psychiatrist should be most useful in helping to establish whether a mental disorder exists. The art and science of psychi-

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atry risks diminished credibility in the collective popular mind when psychiatrists disagree on the criterion which lies most squarely within their expertise, and which ought to be more objectively determined than the functional criteria of insanity.

Mental disorder, and its nominal equivalents in various insanity laws, has acquired legal significance within the context of insanity law, much as was once the case for the terms: lunacy, insanity, and idiocy. Even if defined by medical terms, mental disorder is a legal term when it is incorporated into statutes and judicial decisions for purposes of the insanity defense. There is potential for confusion on this semantic issue, because mental disorder, mental disease, mental illness, mental defect, and mental retardation are also used as medical terms. In the present discussion, we will use the term mental disorder in the legal context of the insanity defense. To distinguish this term from diagnosable mental disorders which, without further qualifications, serve only clinical purposes, that is, all *Diagnostic and Statistical Manual of Mental Disorders* (DSM) III disorders, we will use the term "clinical disorders" to denote the latter.

In a not atypical trial scenario, the defense attorney will ask the witness, "Doctor, in your opinion, did the defendant whom you examined have a mental disorder?" Presence of a mental disorder is logically established before the functional criteria are addressed. If the insanity defense is asserted, usually one of the experts believes the defendant had a mental disorder. Through questions in cross-examination of the witness, the prosecutor makes a point of equating mental disorder as used in insanity law with clinical disorder of psychiatric nosologies such as DSM III. By reductio ad absurdum, the prosecutor notes that many clinical disorders, for example, Tobacco Dependence, would have little application to the insanity defense. Unless qualifying terms exist in the relevant insanity law, the trier-of-fact, often a jury, is disposed to equate mental disorder in the legal context with the same term used strictly for clinical purposes.

The American Psychiatric Association (APA) has taken a position that psychiatrists should not be expected to testify on the ultimate legal issue of insanity. Neither should psychiatrists be invited to render opinions on functional criteria of insanity tests such as cognitive and volitional elements of the American Law Institute (ALI) Test. Testimony on functional criteria amounts to a "leap in logic" involving speculations on "the 'probable relationship' between medical concepts and legal or moral constructs such as free will" [*1*]. Psychiatrists should be permitted to testify regarding the defendant's psychiatric diagnosis and mental state. However, the APA did not clarify whether it disapproved testimony on whether the requisite (legal) mental disorder is present. Presence of a mental disorder is a legal and moral question as well as an operational one.

Presumably, a common practice for the consulting psychiatrist is to first ascertain whether a clinical disorder exists, but to offer findings supportive of an insanity defense only if functional criteria are also met. This would not be consistent with the APA's caution against relating psychopathology to functional criteria. If the psychiatrist is to decide whether the defendant's clinical disorder qualifies as a mental disorder, without taking into account the functional criteria, then he must either have other guidelines for making this determination, or he must contribute a purely clinical report and make no attempt to relate psychological understanding to the mental disorder of insanity law.

Even if the psychiatrist declines to testify as to whether the defendant's clinical disorder qualifies as a mental disorder, he should have some notion about what legalists mean by terms such as "mental disease or defect." On the other side of the coin, legalists turn to experts on mental illness to better understand the nature of various clinical disorders, some of which might qualify as a mental disorder. If psychiatrists, jurists, and lawyers are unclear about which clinical disorders qualify as a mental disorder, and if there are no legal guidelines as to what constitutes a mental disorder, borderline psychiatric conditions are bound to be viewed differently and with much disagreement.

Legal Definitions of "Mental Disorder"

Some insanity laws have provided definitions of mental disorder. In *Durham v. United States*, 1954, Judge Bazelon, Circuit Court of Appeals, District of Columbia, defined mental "disease" as ". . . any condition which is considered capable of either improving or deteriorating. . . ." The term "defect" denotes a "condition which is not considered capable of improving or deteriorating and which may be either congenital, or traumatic, or the residual effect of physical or mental disease" [*2,3*]. Together these two definitions would embrace a wide range of clinical disorders. The same court later supplanted these definitions with another: "A mental disease or defect includes any abnormal condition of the mind which substantially affects behavior controls" [*4*]. Much discretion was thusly permitted in the interpretation of "substantially."

Today, insanity laws that define mental disorder vary considerably. In its model insanity law, the American Law Institute advocated explicit exclusion of disorders characterized only by repeated criminal conduct [*5*]. This caveat, which was incorporated into various state laws [*6*] and judicial decisions [*7*], would appear to exclude Antisocial Personality Disorder, if not all personality and impulse disorders (though the volitional prong of the ALI Test arguably would include impulse disorders). A second level explicitly excludes all personality disorders, not just those manifested by criminal behavior [*8*]. Less specific, but ostensibly more restrictive, some states require presence of "*severe* mental disease or defect" [*9*].

Recent proposals offer still other guidelines about what should constitute a mental disorder. The American Bar Association's Standing Committee on Association Standards for Criminal Justice defined the legal term of "mental disease or defect" as ". . . either (*i*) impairments of the mind, whether enduring or transitory; or (*ii*) mental retardation, either of which substantially affected the mental or emotional processes of the defendant at the time of the alleged offense" [*10*]. This broad definition recalls the first definition of the Bazelon court.

Much more restrictive, on the other hand, is the definition proffered by Professor Bonnie. Mental disease or defect should refer to ". . . only those severely abnormal mental conditions that grossly and demonstrably impair a person's perception or understanding of reality and that are not attributable primarily to the voluntary ingestion of alcohol or other psychoactive substances" [*11*].

The position of the American Psychiatric Association advocates the Bonnie proposal, and adds that qualifying disorders generally ought to be "psychotic." This represents still another attempt to bridge clinical understanding with the legal criterion of mental disorder. The various proposed, enacted, and judicially determined guidelines overlap, but they are by no means congruent.

Schizotypal Personality Disorder

Most psychiatrists and legalists would probably agree that a manifestly active Schizophrenic Disorder, with pervasive loss of reality contact, constitutes a mental disorder for purposes of the insanity defense. Similar consensual opinion should hold that an Antisocial Personality Disorder does not. But several diagnosable DSM III disorders do not fall into either of these extremes, leaving much cause for disagreement in the courtroom. Some notorious offenders appear to have acted on irrational impulses and idiosyncratic fantasies, if not delusions; yet their acts were skillful and purposeful enough to suggest a measure of functioning ego.

Through the instrument of DSM III, the American Psychiatric Association in 1980 advanced diagnostic criteria for Schizophrenic Disorders that were more specific and exacting than the various criteria used by most American psychiatrists heretofore [*12*]. Use of DSM III criteria should limit the diagnosis to those cases wherein symptoms are severe and

chronic, and thus where psychiatrists are likely to be in agreement. Consequently, disagreements regarding this diagnosis for purposes of the insanity defense should be infrequent when requisite DSM III criteria are manifest.

DSM III introduced a disorder new at least in name to most clinicians—Schizotypal Personality Disorder (SPD) [*12*]. Before DSM III, cases that would be considered SPD today were labeled variously: latent schizophrenic character, abortive schizophrenia, pseudopsychopathic schizophrenia, pseudoneurotic schizophrenia, psychotic character, subclinical schizophrenia, borderline schizophrenia, occult schizophrenia, schizophrenic spectrum disorder, simple schizophrenia, and schizoid personality disorder. There must have been some interchangeable use of terms for other borderline conditions as well, because the concept of SPD derived in part from attempts to distinguish this disorder from unstable or borderline personality disorder [*13*]. Of the various borderline conditions that can create confusion and disagreement in the courtroom, SPD is quintessential. SPD also has symptoms suggestive of a schizophrenic process; hence, the term schizotypal [*13,14*]. We might say that SPD is an amphibious condition, because it appears to be both a disorder of personality and a disorder of perception-cognition.

Although the DSM III criteria for SPD are clear, because of its amphibious nature and preceding nosology, the degree of crossrater reliability for this diagnosis today may not be great. Reider, who advocates the term "borderline schizophrenia" instead of SPD, found, not surprisingly, that five out of eleven patients with this diagnosis had been previously diagnosed as schizophrenic. Although most borderline schizophrenics would not be diagnosed differently at a later age, schizophrenia would be the most likely diagnosis if the diagnosis were changed. Perceptual and cognitive abnormalities are common to both schizophrenia and borderline schizophrenia, and empirical evidence indicates a genetic link between the two disorders. Reider postulates that many American psychiatrists would probably apply the diagnosis of schizophrenia to patients with borderline schizophrenia [*15*]. Siever and Gunderson acknowledge the potential usefulness of the concept of SPD, but warn that its best diagnostic criteria may not yet be identified. Their review of the literature on SPD illustrates that various investigators stress different, albeit overlapping symptoms [*14*].

The nosology for which Spitzer et al. developed Research Diagnostic Criteria uses the term, "schizotypal features." Even though RDC nosology refers to the Antisocial Personality, it does not present schizotypal features as a personality disorder [*16*]. The term can refer to a time-limited or lifelong condition [*17*], but it is to be used only to qualify another diagnosis, not as a diagnosis sufficient in itself [*18*]. "Despite a large literature on the borderline patient, syndrome, personality, state, or condition and on ambulatory, pseudoneurotic, or latent schizophrenia, there is no consensus as to how to define these concepts, and it is unlikely that they represent one distinct condition" [*17*].

The present inquiry does not question the considerable interrater reliability demonstrated when evaluators follow strict criteria and procedures for arriving at the diagnosis of SPD [*13,16,19,20*]. The important questions are whether clinicians who are not bound to research protocol apply these same criteria and whether these criteria identify a disorder that is uniformly recognized as qualitatively distinct from Schizoid Personality Disorder and from the Schizophrenic Disorders. Then there is the question of whether SPD qualifies as a mental disorder for the insanity defense.

Some might prefer consensual agreement among psychiatrists even for the most ambiguous clinical disorders. Distinctions between overdetermined ideas, magical thoughts, and delusions are not always equally perceived by competent psychiatrists. To insist that all experts agree upon the procrustean presence or absence of criteria of such clinical disorders would be arbitrary, artificial, and pseudoscientific. If it were desirable for several psychiatrists to agree in their diagnostic understanding of a given defendant, regardless of the variable and fluctuating manifestations of his disorder, then perhaps courts should empanel insanity commissions as was the custom in an earlier era. This might satisfy the hackneyed

criticism that disagreements between psychiatrists in the courtroom prove they do not know what they are talking about when they address the insanity issue. But the adversarial process is a truth-seeking one which often relies upon experts, including but not limited to psychiatric experts, who articulate differing findings and opinions.

It might be argued that the state of psychiatric diagnosis and nosology is such that there ought to be open, vigorous disagreement as to whether a defendant had a borderline condition and the nature of his particular disturbance. The psychiatric expert may be tempted to exaggerate the strength and extremity of his findings to be properly polemic in the courtroom.

An alternative approach would be to openly acknowledge borderline areas in the classification of mental disorders. The application of borderline conditions to the legal concept of mental disorder for purposes of the insanity defense is inexact. Rather than debate whether SPD represents essentially a nonpsychotic personality disorder or an incompletely expressed schizophrenic process, psychiatrists should more accurately recognize that there are gray diagnostic areas even between major groupings of psychiatric disorders.

The trouble in applying this perspective to the legal issue of insanity is that the law prefers observations and interpretations that facilitate absolute decisions. The defendant is to be found guilty or not guilty. The defendant is sane or insane. The defendant either has a mental disorder or he does not. The adversarial process encourages attorneys to advocate presence or absence of a mental disorder. When a psychiatrist diagnoses a psychotic disorder or an unequivocally nonpsychotic personality disorder, he appears to help in the determination of whether a mental disorder is present. Diagnosis of an amphibious condition does not so readily contribute to establishing whether a mental disorder required by the insanity defense exists.

Legal Approaches to Gray Areas

There have been attempts to change the law to take into account less extreme forms of psychopathology and to allow verdicts other than guilty, not guilty, and not guilty by reason of insanity. Psychopathology can affect mental elements of a crime without fulfilling requirements for an insanity defense. The doctrine of diminished responsibility evolved from a series of state supreme court decisions in California [*21–24*]. Unhappy with apparent unequal applications of this principle, the California Legislature enacted law to eliminate the diminished responsibility defense in 1982.

Another attempt to consider mental illness that falls short of insanity was the "guilty but mentally ill" option enacted by a number of states in recent years. A clinical disorder may be so patent that it manifestly requires treatment, yet its resulting deficiencies were not severe or pervasive enough at the time of the offense to meet functional criteria of insanity. The American Psychiatric Association [*1*], the American Bar Association [*10*], leading forensic psychiatrists, and legal scholars [*11*] have argued against this concept, contending that the GBMI verdict would allow juries to compromise, hedge, or, in stronger terms, "cop out" when faced with the difficult question of guilt or innocence. This argument conforms to the legal notion that a defendant is either criminally responsible or he is not. Like pregnancy, criminal responsibility is not a condition that one has incompletely. Schizophrenia best serves the criterion of mental disorder if present or absent, not if it is present to some degree, but not absolutely.

The American Medical Association recommended the so-called "mens rea" approach [*25*] already adopted by several states [*26–28*]. This approach eliminates functional criteria of insanity. Even with the mens rea approach, presence or absence of a mental disorder should pertain. The AMA Committee report recommended that psychiatric testimony be limited to ". . . severe mental disability that interferes substantially with the defendant's reality testing

function" [25], but the committee did not explicitly advance this as a definition of "mental disease or defect" for the mens rea approach.

Conclusions

The question of whether a significant clinical disorder exists will pertain to criminal intent for the foreseeable future. Some clinical disorders will typically limit criminal intent more often than others will. And the diagnosable presence and applicability of some disorders, such as SPD, will remain arguable even among experts who are best able to make psychiatric assessments.

Legislators should thoughtfully consider codifying legal guidelines as to what constitutes a mental disorder. Uniformity of definitions is preferred over diverse variety. Equating mental disorders to all diagnosable clinical disorders collectively is illogical, but if such is the legislative intent, the law should be explicit on this point in order to reduce unnecessary confusion.

If a psychiatrist is to address the insanity defense or the mens rea defense, he must first establish presence of a clinical disorder. When criteria of a well recognized clinical disorder are plentiful and manifest, this task will be accomplished with ease and confidence. But when he encounters an amphibious disorder that can lend itself to variable findings and conclusions, the diagnosis is not so simple and absolute.

Moreover, the question of whether some disorders, such as SPD, should constitute a mental disorder, is not facilely resolved. Some insanity laws provide guidelines based on diagnosis. Other laws and proposals advance functional guidelines. Many insanity laws provide no guidelines.

The psychiatrist's reasoning about whether a particular disturbance does or does not qualify as a mental disorder can be helpful; but, similar to the functional criteria of insanity, the presence of a mental disorder is ultimately determined by trier-of-fact. When the psychiatrist encounters an amphibious disorder that does not clearly qualify or disqualify as a mental disorder required for the insanity defense, the psychiatrist should feel free to so state, if he is to opine on the presence of mental disorder.

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