

Law and Psychiatry

Delusional Disorder and the Law

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A recent panel at the annual meeting of the American Academy of Forensic Sciences highlighted “pure paranoid delusions.” People with delusional disorder sometimes seem to be in a grey area of criminal forensic psychiatry, somewhere between frank psychosis (such as that found in some patients with schizophrenia, which is often associated with incompetence to stand trial or lack of responsibility for one’s actions) and paranoid personality traits (which generally do not affect competence or responsibility). The chronic delusions associated with some types of delusional disorder sometimes endanger others to a significant extent; other types are not commonly associated with violence. Most of this article refers to delusions with prominent *erotomanic, jealous, or persecutory* features.

DIAGNOSING DELUSIONAL DISORDER AND ASSESSING RISK OF VIOLENCE

Case 1. Erotomania and Stalking

Ms. A, a woman with no known history of psychiatric treatment, but with longstanding paranoia and mild social dysfunction, developed a delusional belief that a very popular, married, local television weatherman (Mr. B) was secretly in love with her. She believed that he communicated his love through particular signals during his broadcasts. They had not met in person before the events described below.

When the weatherman’s wife became pregnant, the television station developed a human interest feature around the family. They mentioned the pregnancy every week or so. Soon after the birth, they televised photos of the infant and announced that he would be “introduced to the world” during an upcoming news broadcast.

During the period that the pregnancy was being highlighted, Ms. A began to tell her coworkers that she was pregnant. She mysteriously and somewhat coquettishly kept the name of the “father” a secret.

After Mr. B’s child was born, Ms. A called his wife, “confessed” her delusional affair with Mr. B, and said

that she, too, had just borne his child. The wife immediately called Mr. B, who called the police. The police were unable to determine Ms. A’s identity at that time.

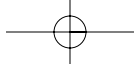
The infant’s appearance on the newscast was cancelled; however, on the evening on which it had been scheduled, Ms. A came to the television station, ostensibly to confront Mrs. B with the “affair” and to appear on the show with “her” baby. She was detained by station security for trespassing, transferred to police custody, and taken to a psychiatric crisis evaluation center, where she was determined not to be imminently dangerous. She was then released by the police.

A temporary restraining order was later obtained prohibiting Ms. A from contact with the weatherman’s family or the television station. She repeatedly violated the order, was arrested, and was eventually hospitalized involuntarily. She was soon released and began making upsetting (but not overtly threatening) telephone calls to Mr. B’s home. When her behavior continued in spite of several episodes with the police and the local mental health agency, Mr. B and his family moved to another city.

Recognizing signs of risk. Although function is a better measure of behavior and risk than diagnosis alone, the risk of violence from individuals with these three subtypes of delusional disorder—erotomanic, jealous, and persecutory—is significantly higher than that from the general population. People who have come to the attention of a court or law enforcement tend to be at even higher risk. It is important to assess several factors.

Simply recognizing the disorder is a first step. People with delusional disorder usually function fairly well out-

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side the realm of their delusions. Their delusions are not usually experienced by them as a problem in reality testing, and when they do seek medical help the complaint tends to be nonpsychiatric (such as one related to a somatic delusion, which may or may not be referred to a psychiatrist or psychologist). Those with persecutory thoughts may seek protection from the police, but often do not cooperate with their routine deflection to a mental health resource. Others are suspicious of clinicians, perhaps because of a past commitment, and hide their fears and delusions. For some, the delusions themselves demand secrecy.

Case 2. Fluctuating Religious Delusions, Filicide, and Legal Insanity

Mrs. P was a housewife with stable and loving relationships with her husband and children. She had no history of psychiatric diagnosis or treatment and appeared happy with her family and social life. She was active in her church and closely involved in her children's schooling. The family church was somewhat evangelical, and her devoutness and demonstrative behavior during Sunday worship were not viewed as unusual. There is no indication that her behavior was particularly different from that of many other worshippers.

One night, acting on what she believed to be instruction from God, Mrs. P methodically killed her two children, aged 6 and 8 years. She then called 911, guided police to the bodies, and was arrested. After refusing psychotropic medication in jail for several months, during which she had marked religious delusions but was otherwise affectively and cognitively intact, she finally agreed to take an antipsychotic medication. Her delusions then subsided over several weeks and were replaced by severe grief and depression. She eventually became competent to stand trial and was found not guilty by reason of insanity.

In retrospect, Mrs. P had been delusional for several years, with at least two exacerbations of a strong belief that God was going to kill various members of her family. She believed this was God's plan, which she should not reveal to others (based on her idiosyncratic interpretation of a Bible verse). She was to be the instrument of that plan, and if she did not carry it out, her soul and those of her children would be forfeited. She did not hear the voice of God directly, but rather interpreted ordinary events around her as God's communications with great meaning.

None of her symptoms or behaviors was related to pregnancy or childbirth, nor to any other apparent psychiatric or general medical condition. There was no indication of any personal (secular) benefit that she might have derived from the children's deaths.

Fluctuation of risk is an important consideration in risk assessment. The person may appear to be doing well at times, but delusions or dangerous behaviors may increase with little warning. This unpredictability of behavior substantially increases risk. In addition, the signs or precursors of escalation may be idiosyncratic and may not be linked to things an ordinary observer would associate with stress or risk. In Case 2, some of the most important influences on Mrs. P's decision to carry out God's "instruction" were a child's throwing pebbles and squeezing a toy, to which she attached special and ominous meaning.

Risk increases with increasing delusions, with decreasing encapsulation and organization of delusions, and with increasing encapsulation and organization. The apparent conflict in the last sentence is easily resolved.

When the delusion is less encapsulated and organized, the person's condition becomes more diffuse and harder to manage internally. Impulses are harder to define and control; day-to-day functioning is more difficult to contain. When the delusional person perceives a threat or conflict, it is harder for him or her to create a "safe" solution, one that does not require some physical action, within the delusion. The behaviors used to decrease the feelings of threat or confusion are less well organized and more likely to be broadly dangerous.

On the other hand, when the delusional system is more encapsulated and organized, a new danger arises. Given delusions that include threats or impulses that create danger to others, the more organized person is better able to focus on them, plan his or her actions, and carry them out. The more organized person doesn't outwardly appear as disordered as the less organized one. He or she can more easily conceal psychotic fears, plans, and impulses, and usually knows they must be concealed in order to carry out the "necessary" actions.

Several things routinely make delusions, and/or the risk that may flow from them, worse. Many are environmental; some are controllable to some extent. Intoxication from any source usually makes things worse, as does perceived threat, unfamiliar settings, confusing or chaotic surroundings, and stress. The definition of "stress" varies greatly among individuals; it is very important to remember that many "stresses" for

delusional people are idiosyncratic, such as ordinary events imbued with special meaning or reference.

Once the risk is high in a person with delusional disorder (as established, for example, by past assaults), it is reasonable to assume that it will remain high, particularly in unmonitored (e.g., outpatient) settings, unless something happens to create measurable, lasting mitigation of that risk. Whether or not a patient's good treatment response may be relied upon to reduce risk is discussed below.

REDUCING RISK

There are three primary means of reducing danger to others: 1) changing the person through treatment; 2) controlling the person, largely by limiting his or her environment, and 3) reducing the vulnerability of the person's target. Treatment will be discussed in a separate section. Ways of limiting the potential perpetrator's environment include arrest, hospitalization, and legal orders to behave in a certain way (such as temporary restraining orders or outpatient commitment, neither of which is always effective). Known target victims can be warned or educated about the potential perpetrator (such as a stalker), guided toward protective measures (such as filing a police complaint or obtaining a temporary restraining order), or encouraged to relocate to a safer place (such as a battered women's shelter or another community).

Treatment

Treatment is difficult. Their self-perpetuating nature makes delusions hard to treat in most mental illnesses, but particularly so in delusional disorder, in which they are central, chronic, resistant to change, and usually don't disable the person enough to lead to hospitalization. When the patient accepts antipsychotic medication, positive response is likely; however, the disorder is not cured. Medication adherence is often poor once the patient is out of the hospital.

Treatment to restore competence to stand trial (fitness to proceed) is often successful, with success rates as high as 70%–80% on some forensic units.¹ Treatment to competence is a special case which is not directly comparable to other clinical goals. Its purpose is narrow, with the goal solely to render the patient able to understand the upcoming trial and work with his or her lawyer. While the treatment that provides such competence is likely to be helpful if continued under clinical circumstances, patients often do not continue to receive

the same level of care when returned to jail, sent to prison, or released.

In ordinary, nonforensic treatment, risk to others must be considered. Clinicians treating outpatients should be prepared to protect potential victims when necessary and reasonably within their abilities. Those who see these patients should either have access to involuntary hospitalization themselves or be able to refer to a colleague who can accomplish it.

Psychotherapy and Counseling Have Limited Usefulness in Delusional Disorder

Psychotherapy may decrease anxiety and could temporarily reduce a patient's need to escalate delusions or act on them, but I am unaware of any psychotherapeutic technique that is reliably effective in ameliorating the delusional system itself. A recent paper by Moorhead and Turkington suggests that rigorously applied cognitive-behavioral therapy may be useful.² Simple counseling may help reduce anxiety or monitor the condition, but little else. Inexperienced therapists and counselors may not recognize the potential for rapid worsening and impulsive behavior found in many delusionally jealous, persecutory, or erotomanic patients.

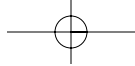
Countertransference may be substantial and may give rise to either inappropriate optimism or inappropriate pessimism in the clinician. Unsupervised therapists should be fairly experienced and mature. It goes without saying that some delusional patients present a danger to their psychiatrists and patients.

COMPETENCY TO STAND TRIAL (FITNESS TO PROCEED)

Competency Criteria

The elements of trial competency are similar in most state and federal jurisdictions. Detailed procedures and evaluation issues are a little more complicated, but in general a person must meet two broad requirements to be found competent: He or she must have a rational and factual understanding of the trial proceedings (e.g., charges, participants, procedures, possible consequences) and must have the ability to work rationally with his or her defense attorney. All that is required is *ability*; voluntary refusal to cooperate does not suggest incompetence.

When applied to people with delusional disorder associated with alleged criminal behavior, the principles include an ability to work with one's attorney toward a



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rational defense goal. Sometimes a delusional defendant has other goals in mind, such as publicizing a delusional theme or philosophy. The so-called Unabomber, for example, demanded that he be able to go to trial so that he could use the witness stand as a pulpit for his political rantings. His probable inability to participate rationally in his defense itself was a significant concern for trial, but was rendered moot when he was allowed to plead guilty in order to escape the death penalty.

Forcing Treatment to Restore Trial Competence

Most people referred for treatment to restore competence participate voluntarily. For those who refuse, a decision must be made about whether the treatment is required for some critical clinical purpose (for which all states have a procedure which can be followed to allow involuntary medication) or is needed primarily for the purpose of rendering the person competent to stand trial. Since delusional disorder rarely involves a need for emergency treatment, those who refuse usually cannot be said to have a clinical requirement sufficient to force medication. Several legal cases have addressed this conundrum of incompetence preventing a trial while treatment refusal prevents return to competence. The decisions have tried to reach a “balance” of defendants’ rights versus the State’s interest, which says that when the alleged crime involves significant danger to others, the State can demand reasonably safe and appropriate psychotropic medication to restore competence.

But what happens when the alleged crime is not “dangerous”? Such a case was recently decided by the U.S. Supreme Court.

Case 3. Refusing Treatment to Restore Trial Competency

Dr. Charles Thomas Sell is a dentist with a long history of paranoid delusions and psychiatric hospitalization. In 1997, he was arrested on charges of submitting fictitious insurance claims and indicted on many counts of mail fraud, Medicaid fraud, and other charges. He was eventually found incompetent to stand trial and sent to a federal prison medical facility, where he was diagnosed with delusional disorder, persecutory type, and offered antipsychotic medication. He refused the medication but was found not to be so mentally ill that treatment was crucial to his clinical well-being. From a legal viewpoint, the primary reason for the medication was simply to allow him to be tried for a “non-dangerous” crime.

Over the next several years, legal proceedings finally led to a hearing before the U.S. Supreme Court. The issues raised along the way included whether or not his delusions were likely to respond to treatment, the potential benefit-to-risk ratio, and the possibility that forcing medication would interfere with Sell’s constitutionally protected rights (including the right not to have side effects possibly compromising his behavior during trial). The American Psychiatric Association filed an amicus brief supporting medication for such conditions. The American Psychological Association filed a brief recommending against medication in this situation and suggesting psychotherapeutic approaches instead.

The Supreme Court reversed an earlier Eighth Circuit approval of forced medication for Dr. Sell, then provided important requirements that a court must follow in order to make such treatment constitutional (see below).

The *Sell* decision (*Sell v. U.S.* 2003³) permits the State to administer antipsychotic medications to restore competency on “serious criminal charges” if a court of proper jurisdiction determines that

- The treatment is medically appropriate;
- It is substantially unlikely to produce side effects that may undermine the fairness of the trial;
- Less intrusive alternatives have been considered; and
- The involuntary medication is necessary to further significant governmental interests.

What are “significant governmental interests”? They are defined differently in different jurisdictions. In particular, the kinds of criminal cases that are of sufficient State interest to allow the question of forced medication to be raised solely for competency purposes (separate from clinical need) vary somewhat. Some federal circuits, for example, may consider trial for fraud a sufficient State interest, whereas others may not. In all jurisdictions, however, the Supreme Court expects courts to realize that having a fair trial is an important right in itself, whether or not the defendant wishes to postpone or avoid it. In addition, refusing medication often means lengthier confinement of some kind without any trial, negating any likelihood that the defendant may be found not guilty and simply released. Further, once a State interest is established, the trial court must find that involuntary medication will promote that interest by being “substantially likely” to render the defendant competent to stand trial, and “substantially unlikely” to produce side effects that

would interfere with his or her ability to work with defense counsel.

Practicality and Trial Competence

Finally, as a practical matter, the criteria for psychiatric competence to stand trial are often less important than what happens to defendants in mental hospitals during and after the process. Many years ago, the U.S. Supreme Court in *Jackson v. Indiana* (1972)⁴ ruled it unconstitutional to hold mentally incompetent defendants for long periods of time without a trial. All states and federal jurisdictions have limits on how long defendants may be held for evaluation and/or treated for competency before they must be either tried or released. The various statutes provide for civil commitment if the defendant does not become competent within some reasonable period and meets appropriate clinical criteria. Sometimes the process is an ordinary mental health commitment; in other jurisdictions there is a special process that uses similar criteria but keeps the commitment decision in the criminal court.

That looks fine on paper, but the result is often far from the protections envisioned in *Jackson*. My experience in one Texas forensic hospital, for example, indicates that indigent defendants sent for restoration of competency rarely have attorneys who can monitor their hospital care or their rights (a defense attorney is usually appointed after the defendant returns to jail). Local judges often view the state forensic hospital as a place where a troublesome defendant—who may or may not have engaged in very dangerous behavior (many cases are misdemeanors or minor felonies)—can be kept away from the community at state rather than county expense. With the defendant in a state hospital, the

judge and prosecutor don't have to worry about further inconvenience to the community or the cost of local mental health care. Sometimes there is a humanitarian aspect to such decisions. Lots of chronically ill defendants would do poorly outside the hospital; many have better lives in almost every respect, except with regard to their liberty, in a hospital with compassionate staff, pleasant grounds, food, shelter, and day-to-day activities. Nevertheless, for many patients/defendants who would not otherwise be committable, the *de facto* "sentence" is many years, or life, on a hospital campus.

THE LAST WORD

Several forms of delusional disorder are associated with increased risk of violence or damage to others' property. Treatment is often effective in controlled environments, but outpatient approaches are limited. Those patients who come into contact with the law should be evaluated and treated with considerable attention to the risks they may represent. When violence or other disruptive behavior leads to arrest, competence to stand trial (fitness to proceed) is a common problem, with both legal and practical ramifications.

References

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