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The Phenomenology of Insanity Acquittees

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(*This paper was withdrawn, at the last minute, as I received a subtle threat by a top NY clinical official intimating that without their permission to present this, there may be consequences. I had another month left before I retired and did not want to chance being terminated and lose my retirement benefits. Revised, 2009, 2012.)*

This presentation originally started out as a research proposal. My original intent was to present subjects with a questionnaire designed to elicit feelings and thoughts since their incarceration or hospitalization, subject these responses to a phenomenological analysis, reduce them to their common experiential themes with an eye towards preserving the anonymity of the clients, and present them here. [1] [2] [3] [4] [5] All clients to be surveyed were committed as "mentally ill and dangerous" individuals. Just before the submission deadline, I was told I could not receive approval for the study from the IRB in time for this conference. As a poor substitute I'll share some of what I've learned and experienced of the emotional and psychological impact on these class of clients and the folks who work with them. Experience accumulated since I had contact with my first insanity acquittee in 1980. Since that time I worked in 3 forensic hospitals, one in the Midwest, two in New York, an outpatient clinic and 'civil' hospital. Currently, my clinical work is limited to one 2 hour character analytic group (with insanity acquittees) per week. My main focus is on program evaluation.

The Oxford English Dictionary defines phenomenology as:

> "A method or procedure, originally developed by the German philosopher Edmund Husserl (1859-1938), which involves the setting aside of presuppositions about a phenomenon as an empirical object and about the mental acts concerned with experiencing it, in order to achieve an intuition of its pure essence."

I came to integrate the frame of reference contained in the concept of *epoche*, into my style of approaching clients in psychotherapy. *Epoche*, central to phenomenology, in essence, means a bracketing of any and all pre-conceived notions or thoughts about the thing being studied so as to relate to it as itself. In psychotherapy with human beings, it translates as the suspension of all preconceived theoretical notions, moral judgments and biases when relating to a client. Each production of the client is seen as a unique and novel experience to be explored. We find this same line of thinking in Carl Jung, among many, who advised his students to relate to each conceptualization of a client's dream or fantasy as if they had no idea what it meant. In that way the essence of the client's true meaning could possibly arise, ostensibly as free as possible from contamination by the projections and/or theoretical orientation of the clinician. As many of you know, to paraphrase R.D. Laing's once famous statement: the doctor sitting across the desk from the so-called "sick" 'schizophrenic,' is frequently projecting his or her own unconscious dynamics onto the so-called "patient" sitting on the other side. That clinical assessment is nothing more than a reciprocal projection system, rings especially true in the "mental health" system. I use the qualifier, so-called in speaking of "mental illness" and "schizophrenia," as I personally do not believe there is sufficient scientific evidence, to this day, to identify the

complex or way of be-ing of psychosis, mis-named "schizophrenia," as a disease. A careful review of the literature will bear me out.[6]

The use of the phenomenological approach in research and in psychotherapy conveys the essence of meaning from the subject; the experience of experience so to speak. This is the antithesis of what is found in much mechanistic research, mechanistic psychiatry and psychology, where an attempt is made to attribute or place a subject's presentation into a pre-conceived category or classification of symptoms.

While in graduate school in San Diego throughout most of the 1970's, I was imbued with a humanistic zeal. During that era the school was considered to be the hotbed of humanistic psychology. When I applied, Carl Rogers was the psychology department chair. I had the opportunity to study with many of the best in the humanistic and existential psychology fields. While there I had a number of classes with Rollo May, Ashley Montague, Viktor Frankl and a host of other notable psychologists, psychiatrists, philosophers and sociologists embracing the model of humanistic, phenomenological and existential psychology. Everett Shostrom, my dissertation chair was one of the first to publish instruments assessing self-actualization, as well as the producer of the "Laura films" the films comparing the therapeutic styles of Frederick Perls, Albert Ellis and Carl Rogers working with the same client, Laura. All of these experiences influenced me to devote my career towards understanding this most complex problem of psychosis. A professor for our dissertation preparation seminar, Roger Kaufman, impressed upon us that we should conceptualize the most difficult, unresolved problems of mankind and attempt to discover answers or solutions for them, in our choice of a topic. At the time I chose a dissertation topic of cancer and personality. But for life, I decided to learn and study this poorly defined and much maligned entity of " schizophrenia". To accomplish this I got the best psychotherapy training I could afford, in addition to graduate school (>10 years).

Early on I learned that the most disturbed but most intelligent of those folks were found, not in clinics and civil hospitals, but in forensic hospitals. In forensic hospitals one gets the grateful opportunity of working with these folks for years. While in civil hospitals, the clients may only be around for a few months to a year or so, especially if they have sufficient intellectual capacity. So, early on, I decided to work behind the razor wire as a psychotherapist, clinical psychologist and neuropsychologist Each subsequent day began by going through a metal scanner or having my bag searched by a security guard dressed as a cop.

I recall one early experience at a relatively large forensic hospital where I worked for nine years. It was a bright sunny winter morning following an evening snow storm that dropped more than a foot of snow. The white powdery snow blanketed everything but the shoveled walks. I was walking across the large yard with another psychologist. He stopped walking and gestured up towards the razor wire surrounding the facility and said: "Jasenn, just look at that. Isn't it beautiful?" I said: what are you talking about Richard. He said, "look at how beautiful the sunlight appears, glistening off the razor wire against the snow covered hillside." We both laughed. Yet our laughs belied a deeper meaning or perhaps a reaction formation. Following an evaluation meeting with a client, we had just been talking about how futile and useless the clients must feel; having their lives of freedom essentially ended most often with one misstep or misdiagnosis. We began to feel our own futility and helplessness, as clinicians.

For many of these clients, the actions that precipitated the instant offense, were singular exacerbations in severe violence or crimes against another, over the course of the lifetime. While I am certainly not an apologist for violence against others, I believe our Age-of-Enlightenment-propelled legal system, in an attempt to introduce understanding and compassion, did not realize the consequences and subsequent applications of what they created. Something akin to a monster. A monster that captures an individual's total being, against their will, leaving their fate to others. The "others" who sometimes demonstrate themselves to be as equally or more disturbed than the clients they are judging. Sometimes less conscious. More often exhibiting an otiose consciousness than not. These others who will invade their collection of

captured individuals, now referred to as "patients, "against their now-diminished individual wills with debilitating chemicals that biochemically alter and dull consciousness, cause debilitating disease and on some occasions, death. Many of these "patients" will find their consciousness invaded by electric currents that destroy neurons and memory. All for the sake of pursuing a professional delusion that the "patient" is in the throe of a "disease" that has to be eliminated at all cost, and especially to render him or her " non-dangerous" again.

Jacque Lacan, the post-modern French psychoanalyst divided human communication into four human discourses. The Master-Slave Discourse, the University discourse, the Hysteric Discourse and the Discourse of the Analyst. Of relevance here is The Master-Slave Discourse, based on Hegel's master/slave paradox. It essentially defines the predominating discourse in maximum security psychiatric institutions housing insanity acquittees.[7, 8, 9, 10, 11, 12]

Given the confusing disarray of research on the "mentally ill," and the fact that there is no physical test for "mental illness," the estimates of an actual brain disease, metabolic disease or illness, with those diagnosed with mental illness ranges from 2%-20%. The majority are living through the experience of their own functional psychosis that, given a proper milieu with understanding humans trained in procedures like existential phenomenology, can be moved through relatively quickly with minimal resort to any of the debilitating treatments. The research literature supports this.[13,14]

New York's Criminal Procedure §330.20 law, established in 1980, takes a three pronged or tri-level approach towards the insanity defense:

1. An individual can be committed as "mentally ill and dangerous," and remanded to a secure State or Office of Mental Health forensic psychiatric facility.
2. When the court renders a finding of "mentally ill" but not "dangerous" the individual is generally remanded to a so-called "non-secure" or "civil" facility. So-called because the non-secure facility is almost as secure as the razor wire rimmed forensic facilities. In place of razor wire the "non-secure" facilities are surrounded by curved fences that are ostensibly impossible to climb as the mesh is too narrow for finger holds and the inside curve is too steep. Most clients, though, are kept within the buildings, with brief, supervised recreation periods in the "yards."
3. The third prong consists of having been found not mentally ill and not dangerous (a rarity, indeed). These clients are released from the Office of Mental Health custody, usually with an order of conditions.

In New York, a crucial step in determining the degree of freedom, once an insanity plea is accepted is the §330.20 exam where the degree of "mental illness" and "dangerousness" is determined. In New York, as in most States, the 'experts' called to testify in insanity exams to determine dangerousness are usually the institutional psychologists and psychiatrists who staff the wards. Rarely is testimony rendered to release a client to a non-secure facility in such initial exams In 30 years of working in these facilities, I have knowledge of only a few of these cases resulting in release following the exam. The crucial element here is that the future life of an insanity acquittee is at the mercy of a system that is as far removed from science as are the professions of "palm readers" and "psychics." The decision most often depends on the "beliefs" and "clinical opinion" of the individual conducting the evaluation.

Say, for example a student in graduate school, being prosecuted for a non-dangerous, questionable crime, receives a 330 exam order after being convinced by their attorney that the insanity defense would be the best course to avoid incarceration. They are examined. If the finding is non-dangerous, they are released with conditions to be admitted into a civil hospital or clinic. From that point on, the prosecutor is no longer involved with the case. The treating facility or clinic makes decisions for placements in least restrictive environments. In the case of our student it is likely they will be permitted to attend their classes and continue their career, if not overtly disturbed.

On the other hand, if found dangerous, the student's possibility of a career and continuance of education are essentially destroyed. They will be remanded to a secure facility with little if any opportunity to attend classes, especially outside of the hospital. The prosecutor or district attorney will follow them and appear at each step of their movement to a least restrictive environment. After a period of years, they may reach a civil hospital. They will then be subject to the treatment there. After a period of a year or more, they may be released to society. At that point the District Attorney follows them for five subsequent years. Any violation of the conditions of release, even minor violations, can result in a hearing and recommitment back to the forensic hospital where the cycle begins all over again.

Once granted the insanity defense and judged to be "mentally ill and dangerous" in New York, a client is burdened, not only by having to prove his or her "non-dangerousness" to the treatment teams within the hospital, but also must convince an elected State Supreme Court judge to sign the order of release or reduce the level of commitment. Under §330.20, there is no preponderance of evidence in the statute. A dozen unimpeached expert witnesses can present testimony that a client does not suffer from a "dangerous mental disorder." The judge in such a case can still render the finding of dangerous and mentally ill; or at least maintain the commitment so that the client remains within the confines of the security hospital, surrounded by razor wire. While the law permits a trial by jury in a rehearing and review or appeal, regardless of the conclusions of a jury, the elected judge has the final say. I have spent days on the witness stand in NY Supreme Courts before juries who decided and advised, based on the testimony, that the client should be transferred to a non-secure facility, only to see the elected judge over-ride or dismiss the jury's conclusion and remand the client back to the secure facility. Some of you legal scholars might correct me but I believe this is one of the only laws in NY criminal court that a judge's decision can overrule the findings of a jury. For a more technical understanding of the workings of New York' s insanity acquittee §330.20 law a recent February, 6, 2006 appellate court decision, 1 No. 12 In the Matter of Jamie R. can be found at: http://www.law.cornell.edu/nyctap/I06_0002.htm.

I'm sure many of you are aware that the subject of dangerousness prediction, at the core of insanity acquittee evaluations and court testimony, has been an issue of contention in the professional literature. The concept of " dangerousness" is an elusive and poorly defined concept, at best. But one used to tear away an individual's constitutionally guaranteed freedoms, especially with insanity acquittees. Today, typing " clinical dangerous prediction", in a search engine, will yield more than 260,000 entries. However, what might be missed are some decades old attempts that began to bring hope to clients and those frustrated, experienced forensic clinicians who worked with this group of clients; believing in their hearts and minds, to the best of their assessment abilities refined by years of practice, that many of these folks retained as "mentally ill and dangerousness" insanity acquitees, were, in fact, not dangerous and could easily be managed in non-secure or "civil" hospitals or, in some cases, in the community.

Reaching back 40 years ago in Baxstrom v. Herold (383 U.S. 107, 1966), the United States Supreme Court held that Baxstrom was "denied equal protection under the law" as he was "detained beyond his maximum sentence" in a forensic hospital without benefit of a new hearing to determine his current dangerousness.[15] Following the Federal Supreme Court decision, New York transferred about 1000 individuals, considered to be some of the most "dangerous" mental patients in the state, from hospitals for the "criminally insane" to "civil" hospitals. The subsequent analysis of violent rates in the 4 year follow-up by Steadman and Cocozza, (1974)[16] found 20% were assaultive to others in the civil hospitals. Only 3% were found to be sufficiently dangerous to be transferred back to the forensic hospitals. Of note is that the 1000 patients contained in the maximum security hospitals for the "criminally insane," prior to Baxstrom, were done so mainly at the behest of *clinical* decisions and clinical predictions of future dangerousness. In that study, 800 of the 1000 were not subsequently assaultive on release to the

"civil" hospitals. As an aside, the term " criminally insane" was no longer de rigueur, after Baxstrom.

Steadman and Keveles (1972)[17] cited in the Monohan monograph, provided follow-up data on 121 Baxstrom patients who had been discharged from both the criminal and civil mental hospitals. The authors found that only 8% or 9 of the 121 patients, during an average of 2 ½ years of freedom, were convicted of a crime. Only one of these convictions was for a violent act. This is consistent with other state hospital post discharge recidivism rate follow-up studies following Baxstrom (e.g., Pennsylvania in Monahan, 1981 p. 47). A sampling of subsequent studies found no violent recidivism or felony crimes committed against others on a 2 year followup of 44 clients.[18] A 6 year followup of 763 NGRI clients on conditional release in Ohio in 2004 reported a 3% felony arrest rate.[19] Compare this with the Department Of Justice 1994 statistics on criminal recidivism from prison:

> "Of the 272,111 persons released from prisons in 15 States in 1994, an estimated 67.5% were rearrested for a felony or serious misdemeanor within 3 years, 46.9% were reconvicted, and 25.4% resentenced to prison for a new crime."[20]

These DOJ statistics, the latest available, are most likely greater, today. Keep this in mind when considering arguments advanced for insanity acquittee retention or release. Insanity acquittees have been found ***Not Guilty*** by Reason of Mental Disease or Defect (The NGRI definition. in New York) for the crime they committed. Prisoners were all found guilty. Insanity acquittees are legally guilty of nothing except a disturbance in thinking, perception and/or volition, depending on the legal test that is in use in the particular state (McNaughton, ALI, etc.), and, most importantly, on the clinical skills or lack thereof from the examiner. States change their criteria from time to time. The insanity acquittees are diagnosed by an 'expert' to determine the presence or absence of a so-called "mental disease" and associated level of dangerousness, if any. Many 'experts' review the available records, conduct an interview that can be as short as 30 minutes, or a series of interviews for hours in length, formulate a report and render the diagnosis. The controversy surrounding the process of the diagnosis is so great and fractious that a week long conference would not do it complete justice. There is substantial support in the literature that most psychiatric diagnoses are based on pseudoscience, at best.[21] A neuropsychology colleague once shared the anecdote he uses, in court, to describe the Diagnostic & Statistical Manual of the American Psychiatric Association. He testifies it is akin to what Mark Twain once said about a camel: It's a horse designed by a committee. I once borrowed that anecdote to illustrate a point in a court. Needless to say, there were a few chuckles, even from the judge.

For a glimpse at how these judgements of our insanity acquittees are effected, the 2001 Macarthur Violence Risk Assessment Study, an attempt to define dangerousness, can be found with the complete data set and results at http://www.macarthur.virginia.edu/read_me_file.html.[22]

Accurately predicting future dangerousness is fraught with problems, including poor reliability and validity.[23] The extreme consequences, if judged as dangerous and mentally ill, bring it into the arena of constitutional and human rights arguments. Statistically, there are so few subsequent dangerous acts committed by these folks, following their instant offense e.g., a low or extremely low base rate of dangerousness, that it is difficult, if not impossible to make a prediction that any one will become violent again without risking false positives, or identifying many individuals as violent who probably never will succumb to violence. As we saw above, 800 of approximately 1000 Baxtrom patients were held in secure facilities as dangerous when, in fact, they were not.

One might review Professor John Monahan's research citations at http://www.macarthur.virginia.edu/risk.htm.[24] The professor has been at the forefront of dangerous prediction for the past few decades. As a result of his research, which I will grossly simplify here, he maintains that a singular predictor of subsequent violent behavior is past

violence. The statistics bear him out. So does common sense. The "ordinary common sense" that perpetuates the prejudicial "sanism" to be discussed below from Perlin.[25] But those statistics minimally consider intervening, interpersonal growth factors, or receptivity to specific psychotherapeutic or other measures that can effect characterological change. Does that not put our insanity acquittees in a catch 22? Regardless of what they do or how much effort they devote to the process of their own psychotherapy or characterological restructuring, this past behavior cannot be erased. This is the dilemma they face. With the post Baxtrom research findings, a glimmer of hope began to arise. Yet, subsequent attempts appeared to dash those hopes.

In our east and west coast states of New York and California, their state offices of mental health encourage and/or require the use of Dr. Robert Hare's Psychopathy Checklist (PCL & PCL-Revised) as a component of a dangerousness assessment. In an in-press copy of a paper submitted to the Am J. of Psychiatry and Law in 2001, Freeman argues that: "The evidence of intra-group statistics indicate poor prediction capacity concerning violence. The rate of false positives associated with use of the PCL-R, while often unreported in favor of inter-group data, are strikingly consistent and very high, worse than a coin toss in predictive ability." [26] A review of this paper cited in the endnote, is suggested when evaluating the utility of this instrument in predicting dangerousness, as well as the ethics of its use for such an endeavor.

The length of stay for insanity acquittee's and forensic patients at maximum security forensic facilities in this country and others ranges from a year or less to as much as 52 years. Some, in this country have been in the system since I was in graduate school in the 1970's.[27,28,29]

Secure facilities restrict freedom of movement and refuse the usual privileges we take for granted , including visits to society. These restrictions are universally applied, in most cases, regardless of the crime resulting in the Insanity defense plea, The lengths of commitments, reported by states and countries, are generally regional averages, not facility averages. Within states or countries, the average length of stay is highly variable, by as much as 5-7 years between facilities. Some facilities, in the same state, report length of stays approximately double between one facility and the other. All have the same class of clients, undergoing the same legal proceedings in the same courts. For facilities reporting something like 10 year averages, when factoring out those with, say less than a 3 year length of stay, the averages may jump to 12-13 years or more for the remaining majority. Other countries report similar averages and ranges. Why are the constitutional freedoms of these individuals restricted for so long?

In Forensic Hospitals, the concept of "dangerousness" is the ideal factor that should account for the LOS. However, many factors affect LOS, including pre-hospital employment history, gender, differing staff diagnostic criteria or biases, countertransference issues, the characterological presentation of the client, e.g., if he or she is not very talkative, shy, and retiring, or verbal, argumentative; institutional pressure or lack of pressure to discharge; delays, legal and otherwise before court filings, etc.[30, 31, 32, 33]

Michael Perlin, a legal scholar and law professor has argued that society has a "virulent antipathy" towards insanity acquittees.[34] Another possible reason for these long lengths of hospitalizations for insanity acquittees is suggested in his 2003 paper. While not specifically addressing this class of clients, he establishes the concept of "sanism," not unlike racial prejudice or ethnic bigotry; an invisible, socially acceptable element prejudicing the courts and legal system where insanity acquittees and other cases are heard. "Sanism" with its irrational presuppositions, enable the overt or covert acceptance by the courts of what he refers to as "testimonial dishonesty" where expert witnesses show a "high propensity to purposely distort their testimony in order to achieve desired ends."[35] Most often, this testimony is provided by the holding facilities in initial exams to determine dangerousness, appeal, review, or release hearings.

A 1993 paper in the Bulletin of the American Academy of Psychiatry and Law entitled: *Informed decision making in persons acquitted not guilty by reason of insanity*.[36] cautions that, especially in misdemeanor cases, an insanity acquittee will be incarcerated far longer than if

convicted of the original crime. Or, I would add, with an acceptable plea bargain in many of the capital cases with extenuating circumstances.

These class of clients suffer, every day, upon awakening to the same walls, the same room-mates or dorm-mates not of their choosing; the same routine of mass movements from ward to treatment mall or treatment setting; to the same small yard enclosed by double fences and razor wire; the same supervised visits from family members with staff eyes never leaving them; the same food, not much different than airline food; the same meetings with the same psychiatrists, the same physicians; the same psychologists; the same social workers, nurses, year in and year out. By law, folks are entitled to at least an hour of "fresh air" per day. That, in many hospitals, is all an insanity acquittee receives, regardless of how nice the day. Staff cite scheduling problems, security, the weather, interference with treatment or other specious reasons to delimit the insanity acquittee to perhaps 7-16 hours of fresh air per week, sometimes less.

Most of these clients are told by treatment personnel, when first admitted and thereafter, that if they follow the rules, are active in their therapy and cooperate with treatment, they will gain their release. Most of these clients follow the rules, are active and cooperative with treatment. In those in facilities with greater than a 10 year average LOS the majority followed the rules for at least a decade, yet they awake to the same razor-wire enclosed environment, every day. The freedom to engage in the love relationships we are all free to engage in, on the outside, is prohibited or prevented by institutional policies. The treatment teams continue to opine "dangerously mentally ill" on each subsequentevaluation. Their legal representatives do little to object to this. I often wondered if they (the acquittee's lawyers) are at all interested in promoting their client's freedom. Many of the clients have expressed this wonder, after seeing repeated acquiescence by their attorneys in the court room. Some legal scholars like Gary Melton and associates speak of the persistent paternalism of lawyers for the mentally ill who hold presuppositions and biases that their clients are better off within the institutions that the "experts" opine are proper places for them.[37] They therefore withhold an adequate defense. This seems to be in contrast to the legal ethic to represent a client's interest to the best of one's ability, does it not? There are repeated attempts to go back to court for release. The clients are consequently subjected to the same 'forensic evaluators' on each such occasion. Many or most of those same evaluators made a previous case in court, throughout a dozen pages or more of forensic reports, amplifying and focusing mostly on the negative to justify retention as "mentally ill and dangerousness." Or they consult with their daily colleagues or others who evaluated the client. Rarely, if ever, in court, do we see an objection raised to this biased process. What does common sense dictate here?

The acquittees are represented by the same lawyers. If they object to a particular lawyer, and they don't have funds to hire one, they are seldom able to obtain different counsel, or counsel that would take a more aggressive stance in representing them. I've known many indigent clients with no family support to contact many mental disability advocate lawyers, some of which I referred them to, only to be deferred or told they could not represent them pro bono. In wonderment, I've observed lawyers to sit quietly without a word in the court room, while an 'expert' is presenting an obviously exaggerated or false representation of an event concerning their client. While he might correct me if I misinterpret him, this, too, is a component of the "sanism" that Perlin portrays.

I've experienced many genuine displays of remorse, sadness and tears, in therapy sessions over the instant offense perpetrated by a client. Then, in court, the client is presented in the most egregious and inhuman fashion by the 'expert' evaluator in spite of the fact that the instant offense was not a capital crime. Or, seeing the 'expert' minimize, disregard or ignore the expressions of remorse proliferating throughout the client's record, in their report. Clients present realistic discharge plans to their teams. They are then told, by the team members, the plans are not realistic (read believable). The team's disbelief frequently has no basis in fact other than a refusal to accept the client's statement as valid. Once a disbelief is cited and agreed upon,

the facts are rarely checked. Imagine how you'd feel when you know that you're sincere, only to be portrayed as "lacking remorse and sincerity" or being "untruthful." You're being so judged by someone referred to by the courts as an 'expert,' who spends, at best, a few hours in interviewing you. Can this process not plunge one into the depths of despair and to a point where Tolstoy, at fifty contemplated suicide when he wrote:

> "What will come from what I am doing now, and may do tomorrow?...Why should I live? Why should I wish for anything? Why should I do anything? Is there any meaning in my life which will not be destroyed by the inevitable death awaiting me?"[38]

This system is crazy making at it's best; an "invented reality."[39] The system, in itself, promotes massive despair and feelings of what the existential psychotherapists refer to as a dissolution of existence and meaninglessness in those who are unlucky to have found themselves in its grip. Fifty years after he first posited it, Gregory Bateson's double bind hypothesis, involved in the creation of psychosis, certainly has found validation in this forensic system.[40]

This crazy making is the exact opposite of what we have learned is essential in promoting healing in psychosis. The essence of the healing environment is a warm, supportive, trusting contact where one's experience, regardless of how bizarre it is, is validated and accepted as an expression of their be-ing, not discounted as a disease or illness.

In a closing thought, I hope some of you might take up the dire need here for adequate legal counsel and effective treatment of this underserved group of non-citizens. Non-citizens deprived of the same constitutional rights we have all come to take for granted.

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