Difficult Defenses in the Courtroom

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Guest Editor

For centuries, Courts have afforded leniency to people suffering from diseases of the mind. However, it was the 1843 case of Daniel M'Naghten that was seminal to conceptualization of the legal standards for insanity defense in Anglo-American law. Daniel M'Naghten, a Scottish woodturner shot and killed Edward Drummond under the mistaken belief that he was Sir Roger Peel, leader of the Tory party. Evidence presented in the case revealed that M'Naghten was affected by morbid delusions that overpowered his own control, depriving him of moral perception of right and wrong. M'Naghten was acquitted on the grounds of insanity and the furious aftermath of this trial led to formulation of the "M'Naghten Rules," which rapidly became the most accepted test of insanity in England and the United States. Today, the insanity defense is available in all but four states (Idaho, Montana, Utah, and Kansas), and all jurisdictions in the US afford some form of mitigation of sentence based on presence of mental illness.

If M'Naghten were to be tried today, he would perhaps be diagnosed with schizophrenia. Schizophrenia is by far the most common diagnosis encountered in those acquitted on the grounds of insanity. This is probably because abnormal mentation (delusion, hallucinations) leading to impaired judgment and on occasion violence occur in a plausible continuum in such scenarios. Experts providing opinions in these cases are able to provide a cohesive narrative that is all too familiar and palatable for the Courts.

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However, a wide array of clinical conditions can lead to deviant behavior where violence is an occasional accompaniment. People implicated in such acts are frequently charged with commission of violent crimes. In many of these conditions, such as dissociation in posttraumatic stress disorder or automatisms in parasomnias, the relationship between the disease and the criminal offence is not readily evident. In these cases, Courts rely heavily on psychiatric experts to clarify the degree and extent to which the deviant behavior of the defendant was related to underlying psychopathology.

Psychiatric testimony related to criminal responsibility is introduced in the trial phase of the case. Its purpose is to assist the Court when the question of insanity or that of diminished capacity is at hand. However, psychiatric opinions may be elicited at any stage of the legal proceedings to help the Court answer specific questions related to the illness or the mental state of the defendant. For example, in the pretrial phase, the court may ask the expert for an opinion regarding the defendant's capacity to proceed to trial. Alternately, psychiatric testimony introduced in the postconviction phase may offer the Court grounds for mitigation or modification of the sentence.

This issue of *Psychiatric Annals* aims to inform the clinician about diagnoses other than schizophrenia that are associated with violence, and that frequently become the subject of expert testimony in the courtroom. Authors have reviewed five diverse clinical conditions where violence is a rare, albeit known occurrence. The conditions discussed in this issue are scattered all over the neurobehavioral spec-

trum and range from purely neurological diagnoses, like epilepsy to largely psycholegal constructs, like battered woman syndrome. I have grouped these conditions together under the broad umbrella of "Difficult Defenses in the Courtroom" for two reasons. First, even though violence is a well-documented occurrence in these conditions (for example in epilepsy and autism spectrum disorder), we continue to be limited in our understanding of the underlying neurobehavioral mechanisms. Consequently, experts who testify in forensic cases pertaining to these conditions often struggle to provide reasoned opinions that are rooted in sound scientific evidence. Second, all of these conditions are encountered rarely in the courtroom, and most practitioners are not accustomed to routinely answering questions about them. In light of this, all articles in this issue present an up-to-date review of the state of the science for each corresponding condition, and have been written with the intent of providing useful guidelines to clinicians who practice in the forensic setting.

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about the guest editor

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Dr. Gulrajani attended medical school at the University of Delhi in New Delhi, India. He completed residency training in psychiatry at the University of Delhi, University of Missouri-Columbia, and Yale University. Subsequently, he graduated from fellowship training in forensic psychiatry at Yale University. He was the recipient of the Lily Young Investigator in Bipolar Disorder Fellowship in 2003 and was awarded Fellowship of the American Psychiatric Association in 2014.

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