The Insanity Defense & Diminished Capacity: How Should We Judge Criminal Responsibility When an Offender's Mental State is in Question?

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The Insanity Defense & Diminished Capacity: How Should We Judge Criminal Responsibility When an Offender's Mental State is in Question?

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Currently there is a push toward standardization of mental defects or diseases that can be used to show diminished capacity in a court of law. Diminished capacity is an avenue by which an offender may claim that while he or she did commit a crime, he or she should not be held criminally responsible because his or her mental state was impaired at the time the crime was committed. Offenders often use diminished capacity to support a defense of insanity. Experts, lawmakers and attorneys are seeking to determine which disorders should be acceptable in the judicial proceedings, as being debilitating enough to deter personal responsibility and therefore be causal factors in a crime. This is a surprisingly difficult thing to determine. Sociologists argue that deviance is socially constructed, thus ever-changing. A standard for diminished capacity in the judicial system has never been set, and because deviance is so fluid, it probably never will be. Looking at the history of the insanity defense it is clear that there is no conclusion to this widely debated issue. There must be a broad, inclusive test of diminished capacity available to every offender, regardless of level of previously diagnosed mental illness. This test should be based only on an offender's condition at the time the crime was committed.
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Introduction

According to sociologists, deviant behavior is socially constructed, therefore ever changing. Social interpretation of deviance, based on preconceived notions of what is right and wrong, is at the forefront of diminished capacity and the insanity defenses. Diminished capacity offers an avenue to the accused, who may not be diagnosed mentally ill, to argue that they should not be held criminally responsible for a crime because their mental state at the time of the crime was in question for reasons ranging from drug use to a tumor positioned around the amygdale in the brain. Defendants who claim they were suffering from diminished capacity can, in some cases, receive treatment or a reduced sentence for a crime they allegedly committed, because they can avoid sometimes mandatory institutionalization that mentally ill patients must endure. The insanity defense is still used by mentally ill individuals whose defense is their inability to reason because of mental illness or defect. For the purpose of this paper, I will discuss the insanity defense and diminished capacity as common defenses used in the judicial system which are both in need of similar reform.

When someone commits a grievous act such as killing his or her children, the media inevitably muse, “how could a sane person murder his or her own children?” People do not want to believe that a regular person could do such a thing, so we label the offender: “she is crazy or he is a sociopath,” based on society’s current perception of right and wrong. However, society is not so quick
to put all offenders in such a category, whether they appear mentally ill or not. There are those who cannot or will not believe that personal reality is fluid, that what one person perceives another may not. For example, a battered woman might act with premeditation and kill her abusive husband. Some people will believe she suffered from Battered Woman's Syndrome and killed her husband under extreme duress (Walker 1980). Others will refuse to believe that her abuse changed her ability to reason and hold her completely responsible for her crime. Examples like this of society's vague understanding of mental illness and mental defect make the insanity defense and diminished capacity highly debated issues. “Public perception of the insanity defense as a loophole through which criminal defendants often escape is at odds with the reality of life-long confinement- the fate of so many acquitted.” (Moran 1987, p.208)

Of those who recognize insanity or diminished capacity there exists another divide. While united in singling out and ostracizing the mentally impaired, we become divided when it comes to what to do with them if they have committed a crime. Do they pay for their crime as any other would? Should they be committed to a mental institution for the duration of their punishment? What about an abused woman? If she acted under mental impairment, she is still not what we would call mentally ill. Is she a threat to society? Does she need to be punished? Should she go to prison or should she seek counseling for her abuse? These questions create vast interpretation when it comes to diminished capacity and insanity defenses.
The media has elevated the public interest in diminished capacity and the insanity defenses. Recent crimes, like the Andrea Yates case in which she drowned her five children and claimed that God had told her to do it, have distressed the social order and darkened the stark line between those who believe diminished capacity or mental illness can serve as adequate defense for criminals, and those who believe a person should pay for his or her crime whether or not they had knowledge or intent when committing it.

Two main implications emerge when discussing diminished capacity and insanity as they relate to criminal activity:

1. Under what circumstances can one claim she or he was suffering from insanity or diminished capacity? (i.e., intoxication, depressive rage disorder, schizophrenia.)

2. How should the level of diminished capacity or insanity be evaluated, or, at what point can a jury relinquish an offender completely of responsibility for a criminal act?

Current evaluations of diminished capacity and/or insanity for the purposes of determining criminal responsibility offer an unfair advantage to those suffering from severe mental disorders. While some defects or conditions may be more severe than others, each case should be examined on an individual basis as each has its own characteristics and manifestations which may be linked to the diminished capacity of an offending individual. Simply rating intent and voluntariness, which is currently practiced, must be rethought as it offers no
avenue for those who intended to commit a crime and had knowledge, but suffered from a delusion which led them to believe the crime they committed was somehow justifiable (McSherry 2003). Furthermore, offering no standard leaves too broad an area for judgment. For example, people who believe a woman in a battering relationship is stupid for not just leaving her abuser would judge her diminished capacity while committing a crime against her abuser more harshly than they would a mentally ill offender (Walker 1980). Conversely, the current practice leaves little room for a prosecutor to prove that while an offender may be mentally ill, he or she knew what he/she was doing at the time of a crime. Accepting mental illness in a blanket way, to the exclusion of other forms of diminished capacity creates problems on both sides.

This research includes the history of the insanity defense, a look at current state laws regarding the insanity defense, and a literature review of articles written by experts in the field of criminal responsibility as it relates to the insanity defense and diminished capacity. Over the passed 100 years, the western judicial system has been highly reactive to the issues of diminished capacity and the insanity defense. No standard of evaluation has emerged. Sociologist Emile Durkheim would argue society lacks a collective conscience on these issues, which is necessary to generate an appearance of fairness and consistency when sentencing a criminal suffering from diminished capacity. This research has given me an understanding of widespread practices and a has drawn me to the conclusion that creating a "unifying test of criminal
responsibility," for all offenders, would be the most fair course to streamline the
determination of criminal responsibility when mental state is called to question
(McSherry 2003, p. 127).
History

The insanity defense has been present in western law doctrine since the 16th century. The introduction of mental state into criminal responsibility was written into legal treatise as early as 1581, distinguishing those who understood the difference between good and bad and those who did not. “If a madman or a natural fool, or a lunatic in the time of his lunacy do [kill a man], this is no felonious act for they cannot be said to have any understanding will” (Frontline 2002 p.1). This treatise was clarified by British courts in the 18th century:

[They] developed what became known as the “wild beast” test: If a defendant was so bereft of sanity that he understood the ramifications of his behavior "no more than in an infant, a brute, or a wild beast," he would not be held responsible for his crimes. (Frontline 2002 p.1)

Modern rules for determining insanity, when a defendant’s mental state is in question, date back to a 19th century case in which defendant M'Naughten murdered Edward Drummond, private secretary of Prime Minister Sir Robert Peel of Britain. M'Naughten suffered from a delusion that he was being persecuted and believed it would only end if he killed the Prime Minister, for whom he mistook Drummond. M'Naughten was found "not guilty by reason of insanity," and the opinion handed down has since been known as the M'Naughten Rule:

To establish a defense on the grounds of insanity, it must be clearly proven that, at the time of the committing of the act, the party accused was laboring under such defect of reason, from a disease of the mind, as not to know the nature and quality of the act [or she] was doing; or, if he [or she] did know it, that he [or she] did not
know he [or she] was doing what was wrong. (McSherry 2003, p.584)

The M’Naughten Rule became the legal foundation by which all defendants, whose mental state had been in question, were evaluated. These rules were inherited by virtually all western courts and remained largely unchanged for nearly 100 years. “In 1998, 25 states plus the District of Columbia still used versions of the M’Naughten Rule to test for legal insanity” (Frontline 2002 p.1).

The M’Naughten Rule began to be criticized with the emergence of modern psychiatry because, among other things, it fails to address the issue of control. “Psychiatrists agree that it is possible to understand that one's behavior is wrong, but still be unable to stop oneself” (Frontline 2002, p.2). In the early 20th century, some states introduced an “irresistible impulse” stipulation to the M’Naughten Rule recognizing that, when in the midst of a psychotic episode, some people can still understand right from wrong, but cannot control their impulses.

Soon to follow the M’Naughten rule with the attached “irresistible impulse” clause was a broader, medically based, test of criminal responsibility known as the Durham rule. As the field of psychiatry continued to develop, professionals called for a medically based claim to support the insanity defense, which M’Naughten did not offer. “In Durham v. United States, the U.S. Court of Appeals for the District of Columbia ruled that a defendant could not be found
criminally responsible "if his unlawful act was the product of mental disease or mental defect" [emphasis added] (Frontline 2002, p.2).

This decision moved away from the notion of knowing right from wrong, the foundation of the M’Naughten Rule, and took a psycho-analytical approach. The court supported the addition of medical analysis to prove diminished capacity was present. However, critics believed it put too much power into the hands of forensic psychologists and psychiatrists. And, there was no clarification defining mental disease or defect. Was it meant to include all mental defects laid out in the Diagnostic and Statistical Manual of Mental Disorders, or only those that included psychosis? How would it be determined if a defendant’s mental defect was causal in their crime? Would alcoholics or those suffering from depressive rage syndrome be able to claim their disease led them to commit their crime?

Because of so many uncertainties, "twenty-two states explicitly rejected the Durham test, and in 1972 a panel of federal judges overturned the ruling in favor of the Model Penal Code test of the American Law Institute." (Frontline 2002, p.2)

In 1962 the American Law Institute developed a standard for the insanity defense which, like Durham, introduced forensic psychiatry and medical evidence into the court:

The A.L.I. formulation provides that a defendant will not be held criminally responsible if at the time of the behavior in question "as a result of a mental disease or defect, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." (Frontline 2002, p.3)
Unlike M'Naughten, the new A.L.I. standard does not require that defendants have no knowledge of right or wrong when they committed a crime, but only that they lack a "substantial capacity" to understand the severity of the crime, or the ability to control themselves. (Frontline 2002, p.3)

States remain split between M'Naughten and A.L.I. standards. In 1998, twenty-six states still followed the standard set forth by M'Naughten, while twenty-two adhered to the A.L.I. standard. Over the past two decades, state legislatures have also addressed the issue of human rights for the mentally ill by calling for review of mental conditions over indefinite confinement in institutions.

In 1981, after shooting President Ronald Reagan, James Brady, a secret service agent, and a Washington police officer, John Hinkley's acquittal brought stricter standards for the insanity defense to Federal Courts. The Insanity Defense Reform Act of 1984 was introduced abolishing the A.L.I. standard, which all but one federal court had adopted. It required a defendant to prove his or her mental defect was severe and returned the right/wrong clause brought forth by M'Naughten. States followed suit, toughening the standards of the A.L.I. and reintroducing M'Naughten. Three states, Montana being the first, struck the insanity defense all together, introducing a sentence of guilty but mentally ill. A defendant found guilty but mentally ill is held responsible for his or her crime but is entitled to receive medical treatment for the underlying condition. If he or she
is found to be medically recovered from the mental defect, the defendant must still serve the rest of their sentence in a correctional facility. “In 2000, at least 20 states had instituted Guilty but Mentally Ill provisions.” (Frontline 2002, p.3).

Reviewing the history of the insanity defense shows the wide range of judicial opinion imposed on the issue. The system has been particularly reactive to the matter over the past 100 years. As new cases continue to set precedent, the law continues to change. With no standard by which to gauge diminished capacity, the issue is set in a state of normlessness. Society is without a solid answer for an ever-growing problem. There is no solid understanding of what pleading insanity really means and the confusion leads to further stigma imposed on the mentally ill.
Literature Review

Professionals in the fields of psychiatry and law have written extensively about the issues of diminished capacity and the insanity defense. Examining the literature on these issues reveals a stark contrast of opinions on these issues.

Bernadette McSherry (2003) explains how mental disorders are presently being used to avert criminal prosecution by showing that criminal actions were involuntary and uncontrollable. McSherry presents background, current practice and a well developed argument regarding diminished capacity and the law.

McSherry (2003) outlines the requirements of serious crime as voluntary conduct, plus fault element, minus relevant defense. In most courts, the prosecution holds the burden of proving that an act was voluntary and that there was an element of intent, knowledge, recklessness or negligence involved, -- therefore fault element exists. Defense for reason of insanity or diminished capacity eschews voluntary conduct and fault element.

McSherry (2003) discusses the emergence of the guilty but mentally ill (GBMI) verdict, and the effect it has had on the defense of those claiming diminished capacity. Under such law "evidence of mental disorder became relevant only to the question as to whether or not the accused acted with the requisite intention" (McSherry 2003, p.591). Therefore, someone claiming insanity or diminished capacity can do so only if he/she is claiming no prior intent to commit a crime. This ignores those cases where the accused did intend
to commit a crime but were under some delusion that they were justified in doing so.

McSherry questions how we define voluntary conduct for the purpose of criminal proceedings. She points out that experts in the field are divided on whether it is linked to the notion of control or if it is purposeful and goal oriented. In other words there is no distinction whether an act was voluntary if it was goal oriented and purposeful or if the person committing the act exhibited complete control, or both. There is no empirical approach to determining whether an act was voluntary or involuntary. Substantial lack of control is generally accepted, though again, determining such a state is not evidentiary.

The functionalist approach to criminal mindedness and diminished capacity takes much more into account than any set of laws. Distinct functions such as “sensory input, neural mechanisms and resulting behavior [are seen as] a complex set of interactions” (McSherry 2003, p. 595). McSherry (2003) argues that this approach views behavior and the mind as much more complex than the legal system which focuses only on voluntariness and intent.

Recent technological advances such as brain imaging are adding even more questions as to what should be considered conclusive evidence when determining criminal responsibility. Ruben Gur, professor of psychology at the University of Pennsylvania recently testified in court that a PET scan of accused rapist Bobby Joe Long’s brain showed extensive damage, resulting from a motorcycle accident and ensuing coma, to his amygdala, a group of neuron’s
shown to process memory and emotional reaction. While Long was convicted, Gur’s expert testimony has been in high demand ever since (Rosen 2007).

Of course there are critics of this emerging “neurolaw.” Stephen Morse, professor of law and psychiatry at the University of Pennsylvania insists using brain imaging to explain behavior is nothing new and should not be used to deter criminal responsibility. Morse cites the case of Charles Whitman who, in 1966, killed his mother, and wife and then climbed to the bell tower at the University of Texas and killed thirteen others before being shot by police. An autopsy revealed that Whitman had a large tumor in his brain that was putting pressure on his amygdale. “Even if his amygdala made him more angry and volatile, since when are anger and volatility excusing conditions? Some people are angry because they had bad mommies and daddies and others because their amygdalas are mucked up. The question is: When should anger be an excusing condition” (Rosen 2007, p.6)?

McSherry believes that looking at criminal acts in the realm of diminished capacity as intentional or not and voluntary or not, is not sufficient. She believes each case should be viewed in the context of the mental disease or defect, each with its own biological and physiological effects. She includes her attempt at inclusive language for the insanity defense or diminished capacity. “A person is not criminally responsible for an offense if he or she was suffering from a mental disorder at the time of commission of the offense such that his or her ability to reason was substantially impaired” (McSherry 2003, p.598).
McSherry recommends a “unifying test of criminal responsibility” rather than a determination of voluntariness or intention when investigating mental defect and criminal responsibility (McSherry 2003, p.599).

In their article, *Depressive Rage and Criminal Responsibility* (2005) Carroll and Forrester contrast more defined affective mental disorders with the symptomology of *depressive rage disorder* to determine whether depressive rage constitutes diminished capacity, or the option of pleading insanity. They present a recent study which found lowered impulse control and disordered reasoning when an individual is in a depressive rage, as well as similarities between those enduring severe mental illness and those with fleeting mental states.

They outline a case study in which defendant Genmill murdered his wife and sought a defense of temporary insanity. A forensic specialist called to testify at Genmill’s trial asserted his depression was severe enough to trigger a depressive rage which could lead to a loss of capacity to reason, as evidenced by his suicide attempt immediately following the murder. He stated that while there was no evidence of insanity before or after the crime, Genmill may have been psychotic at the time of the murder. While Genmill was found guilty of murder, Carroll and Forrester argue that his defense brings out two important points to consider regarding criminal responsibility and depressive rage:

1. Does loss of impulse control necessarily mean loss of capacity to reason?
2. Can a very brief mental state constitute mental impairment for the purpose of criminal defense?

On the first point, the authors conclude that simply the nature of a crime and the presumption that no one in his or her right mind would commit such an act, is not enough to infer diminished capacity. The A.L.I. standard supports this claim as it "excludes those defendants, whose mental illness or defect only manifests itself in criminal or antisocial conduct, thus addressing the conundrum of the serial killer whose only symptom of mental illness is the killing of his victims" (Frontline). On the second point they conclude that the notion of uncontrollable impulse, with no other symptoms of mental impairment attached, is problematic at best, and point to newer jury instructions in some states which direct jurors that mental illness must extend over a period of time, not just for the duration of a criminal act.

Ultimately, Carroll and Forester (2005) believe that there must be solid distinctions between mental illness and diminished capacity and the onset of fleeting depressive rage. Most often, crimes committed by those suffering from deep seated mental illness and clearly diminished capacity are not the sort of short-lived psychosis described in the Genmill case. The authors use the example of severely depressed mothers who kill their children and then attempt to kill themselves. These crimes generally seem premeditated and the perpetrator does not usually feel a sense of remorse immediately following the act, rather they felt they were fulfilling some sort of duty. Carroll and Forester
conclude that extending the definition of diminished capacity to include those who suffer severe mood disorders, such as depressive rage, would be detrimental to society, particularly to those suffering from affective mental disorders that benefit from social programs. Clogging mental hospitals with offenders who deny responsibility for their criminal behavior would worsen an already strained system.

In his article *Addictions and the Law*, (2000) Miller explains how drug and alcohol use fit into the scope of diminished capacity and the insanity defense. He examines the role of forensic psychology in criminal proceedings and diagnosis of criminal’s mental states.

Many states, Montana being the first, have done away with the traditional insanity defense and have adopted the application of *mens rea* which means literally *guilty mind*. Essentially, the option of a verdict of *not guilty by reason of insanity* has been replaced with *guilty but insane*. The greatest implication is that while offenders can still receive treatment while incarcerated, or can be sentenced to a psychiatric facility, if and when they are found to be mentally competent and no longer a danger to themselves or to others, they must serve the duration of their sentence in a correctional facility. This has had a tremendous impact on the diminished capacity defense and drug and alcohol abuse. The first inference is that drug and alcohol abuse must be recognized as a disease. This may depend on the expertness of forensic testimony offered by the defense. Under *mens rea*, the prosecution must prove “specific and general intent.” Miller
explains: “Specific intent pertains to conduct that is committed purposely and knowingly... conduct is committed purposely when it is the offender’s conscious object, and knowingly when the offender is aware of the circumstances that make the conduct criminal” (Miller 2000, p.609).

In the case of an addict or alcoholic, scientific evidence has shown that intoxication can inhibit an individual’s ability to form necessary intent in order to commit a crime (Miller 2000, p.609). However, if the perpetrator were intoxicated at the time of the crime, the defense must still provide convincing evidence that it caused diminished capacity; diminished capacity cannot be presumed by a jury. Certainly, the level of intoxication has been a factor in some of these cases.

Increasingly, the judicial system is recognizing the all too frequent association between crime and addictive behavior. It is still widely held, however, that the individual must bear the burden of responsibility for the criminal consequences associated with abuse.

In his look at the insanity defense in Washington State, Trowbridge (2001) offers a background and explanation of diminished capacity defense. He explains why diminished capacity has become a more popular defense than insanity.

In Washington, intent and knowledge of a crime must be proven by the prosecution; they cannot be presumed (Trowbridge 2000, p.3). If a problematic mental state or mental illness were present at the time of a crime, they can be
used by the defense to imply that the perpetrator had no knowledge or intent to commit a crime. The diminished capacity defense, unlike the insanity defense, offers a new avenue for defense due to mental defect or impairment. While someone claiming insanity would admit he or she intended to commit a crime, but felt justified in doing so by reason of mental impairment, someone with diminished capacity would claim no intent to commit a crime. This can be the difference between a perpetrator spending the full duration of his or her sentence in a mental hospital, or walking away from the courtroom free and clear.

Forensic pathologists as well as character witnesses can be called to testify to a defendant’s lack of intent in committing a crime. Juries are instructed to take a witness’s personal credentials to heart when evaluating their testimony.

Mental state, including intoxication and dissociative identity disorder, if proven, can be admissible in asserting that a defendant did not have the mental intent necessary to commit a crime. This is where diminished capacity defense becomes gray. No scientific principles can be applied to show a causal relationship between mental state and unintentional criminal action. It is simply a case by case analysis and relies heavily on convincing expert testimony. Trowbridge contends that this is a very broad area and that “the expert must be able to show to the trial court’s satisfaction that his diagnosis of the defendant is forensically applicable to the legal test involved.” However, “reasonable medical certainty” is not necessary. An expert must only prove that the defendant is
suffering from a disorder which could have "produced the asserted impairment" (Trowbridge 2000, p.9).

Trowbridge concludes by reemphasizing the importance of forensic testimony in cases of diminished capacity. Experts, however, cannot identify a completely causal relationship between mental state and diminished intent; they can only prove it may be the source. The more pathological evidence provided by expert testimony, the more likely an educated decision can be made by a jury.
Discussion

The short history of the insanity defense makes clear the broad opinions expressed through our judicial past. Three main implications emerge:

1. What factors constitute diminished capacity and/or the insanity defense? Is it a specific set of diseases and disorders? A specific set of circumstances? Or can it differ case by case?
2. If diminished capacity can be proven, under what circumstance can it, or insanity, be viewed as causal in a crime?
3. How should an offender be treated and/or punished for their crime if diminished capacity or insanity is present? Should that depend on the severity of the crime, severity of the mental defect or disorder, or both?

There are no codified answers for these questions and, as evidenced by the ever-growing Twinkie defense, there may never be. The Twinkie defense refers to the 1979 case of Dan White, who assassinated Mayor Moscone and Supervisor Harvey Milk in November, 1979 in San Francisco. His defense argued that his diet, which consisted primarily of Coca-cola and Twinkies, had elevated his level of depression (Frontline 2002). The Twinkie defense is a pejorative term still used to explain a defense constituting of some biological factor that caused diminished capacity. With no precedent by which we can set mental disease or defect or diminished capacity, publicized defenses such as this draw attention away from otherwise serious mental problems. As Maeder (1985) points out, Americans
have a poor opinion of the insanity defense and as defense strategists continue to expound the *Twinkie defense*, it is easy to see why.

The dominant issues in determining diminished capacity of a perpetrator are currently intention and voluntariness. These factors should be assessed when determining criminal responsibility and warn that broadening the scope of mental defect, allowing for more offenders to claim diminished capacity, would be detrimental to society. However, McSherry (2002) offers an alternative approach to focusing on intent and voluntariness, one that she sees as very important to the fairness of diminished capacity defense. McSherry (2002) contends that each defense must be analyzed in the context of mental defect, each with its own physical and mental effects which may have contributed to diminished capacity. McSherry recommends a “unifying test of criminal responsibility,” to determine whether diminished capacity may be held in context of the crime (McSherry 2002, p.599).

Carroll and Forrester (2005) affirm that diminished capacity cannot be inferred based on the context of the crime. They contend that it is unfair to believe that just because someone committed an insane act, they were insane when they committed the act. Their argument actually strengthens the argument of McSherry, that offenses where diminished capacity is called into question must be analyzed on a case by case basis. Take the example of a mother who kills her children believing she is somehow morally obligated to do so because she heard the voice of God tell her to. Clearly, there is an element of
voluntariness and intent, but barring any strong evidence to the contrary, how can a judgment be placed on her for committing such a grievous act when she thought what she was doing was justified? Here is an example of where the crime *does* imply diminished capacity. Carroll and Forrester (2005) are too lackadaisical when making this blanket assumption. The most common and morally upright people have been driven to commit crime based on severe adverse circumstances. McSherry’s (2002) argument offers protection for all offenders, not just those people suffering from long term mental incapacity. It does not make sense to place offenders under such a rigid format of understanding when clearly, crime is so elusive.

McSherry offers a complete approach to the rising problems of the diminished capacity defense. In her words a “unifying test of responsibility,” is necessary in order to examine defendants without prejudice. The only way to attempt justice when approaching diminished capacity is to examine each case in its own context and each disorder with its own unique symptoms. Context and circumstance should replace intent and voluntariness.

McSherry’s (2002) view emphasizes the need for evenhandedness when determining diminished capacity. For example, Trowbridge believes that expert psychological forensic testimony is compulsory when arguing diminished capacity or insanity. As strain theory suggests, poverty is a breeding ground for crime so it isn’t surprising that our prisons are teeming with the poverty stricken and downtrodden. How can the poor support an adequate defense of
diminished capacity if they can not afford to pay for expert testimony? The development of a "unifying test of criminal responsibility," will level the playing field for those claiming diminished capacity or insanity (McSherry 2002, p.599).
Conclusion

The current view of diminished capacity and the insanity defense in the criminal justice system places emphasis on intent and voluntariness of a crime. It is clear that this excludes an entire set of perpetrators whose crimes were committed while they were suffering from diminished capacity but committed a crime voluntarily and with intent. The stigma attached to those who suffer from debilitating mental states is only furthered because there is no standardized test of criminal responsibility used in cases where mental state is called into question. There is no “norm” in place. Durkheim calls this breakdown or lack of norms, *anomie*. When norms are not in place to guide the activities of a society, individuals are unable to find their place. Constant changes lead to dissatisfaction and deviance in society. This cycle is especially challenging when dealing with those who suffer from mental disease or defect.

Durkheim argues that deviances, including murder, hold a positive function in society. Deviance creates a *collective conscience* within a society, that is, what is deviant is agreed upon by individuals and generates a unity among people. In this case, the collective conscience is unyielding to the fact that some circumstances are exceptional. Society must be willing to accept the extenuating circumstances of a murderer who cannot be held criminally responsible because of some mental disease or defect, in order to enable a “norm” to emerge when it comes to diminished capacity and the insanity defense.
As medical innovation continues, and new disorders emerge, society is becoming increasingly medicalized. We cannot continue to pass judgment based on preconceived notions about what constitutes insanity or diminished capacity. Each disorder and/or circumstance must be analyzed in its context. McSherry's argument advocating for a "unifying test of criminal responsibility," offers protection for offenders suffering from diminished capacity as well as an option for prosecutors to prove that offenders suffering from long term mental illness may have not been suffering from diminished capacity at the time a crime was committed (McSherry 2002, p.599).
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