ESSAY

CRIMINAL COURT'S DISABILITY

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Do criminal courts meaningfully accommodate psychiatric disability? A review of competency proceedings across the United States suggests not. In competency to stand trial (CST) proceedings, criminal courts offer a narrow vision of psychiatric disability that excludes many defendants. Ultimately, the institutional context of criminal court under-mines even the meager accommodations that the competency framework provides.

CST proceedings are the constitutional accommodations available to disabled defendants if they can establish that they are unable to consult with their lawyers or if they do not have a rational or factual understanding of the proceedings against them.

Criminal court judges and examiners systematically deny recognition to one group of diagnoses: personality disorders (PDs). Even when defense attorneys argue that defendants' PD symptoms impede their ability to collaborate, courts and some forensic experts insist that the defendants are competent. Examiners and courts reframe these difficulties as deliberate acts of subversion and conclude that defendants with PDs choose to be uncooperative. In doing so, they give PDs an exceptional and paradoxical status: They are considered psychiatric conditions, yet their expressions are deemed volitional. This Essay argues that the outcomes of CST proceedings reveal court actors' preoccupation with determining responsibility rather than advancing defendants' trial rights. In the process, courts selectively apply the competency standard, discounting its interpersonal dimensions and prioritizing the accused person's cognitive capacities.

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CST proceedings illustrate that it may not be possible for criminal courts to embrace and adapt to the reality of neurodivergence while also pursuing criminalization.

INTRODUCTION

A national review of competency to stand trial (CST) proceedings reveals that criminal court actors persistently exclude one category of psychiatric conditions, namely personality disorders (PDs), from consideration. Their repeated exclusion betrays a central tension criminal court actors face between recognizing the reality of neurodiversity[1] and pursuing criminalization.

1. Neurodiversity is a term that seeks to describe one of many aspects of human biodiversity, namely the diverse ways humans understand and relate to themselves and the

Any person facing criminal charges can assert that they are unfit to stand trial due to their mental or intellectual disability.[2] In *Dusky v. United States*, the Supreme Court enunciated the minimum capacities a person accused of a crime must possess before they can be prosecuted.[3] The Court fashioned this procedural protection to enforce a basic intuition: As a matter of due process, a defendant must be able to participate in their own defense.[4] The *Dusky* test asks courts to determine whether the accused has "sufficient present ability to consult with [their] lawyer with a reasonable degree of rational understanding" and whether they have "a rational as well as factual understanding of the proceedings."[5] Usually, competency assessments rely on mental health experts, like psychologists and psychiatrists, to produce knowledge about the defendant and their neurodiver-

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world around them. Understanding Neurodiversity: Exploring Differences in Brain Function, Nw. Med. (Apr. 2024), https://www.nm.org/healthbeat/healthy-tips/Understanding-Neurodiversity [https://perma.cc/VX7Q-WWMH]; see also Monique Botha, Robert Chapman, Morénike Giwa Onaiwu, Steven K. Kapp, Abs Stannard Ashley & Nick Walker, The Neurodiversity Concept Was Developed Collectively: An Overdue Correction on the Origins of Neurodiversity Theory, 28 Autism 1591, 1592–93 (2024) (discussing the origins and coinage of the term neurodiversity); Martijn Dekker, A Correction on the Origin of the Term 'Neurodiversity', Martijn "McDutchie" Dekker's Blog (July 13, 2023), https://www.inlv.org/2023/07/13/neurodiversity-origin.html [https://perma.cc/7G8N-EWJV] (same). The word first emerged from the autistic community, intended to describe autism without pathologizing the condition. Botha et al., supra, at 1593. The term now refers to the full spectrum of mental, psychiatric, and intellectual differences that are reflected in the human species. See Understanding Neurodiversity: Exploring Differences in Brain Function, supra ("[Neurodivergence] refers to people who process information in a way that is not typical . . . ."). The terms "neurodivergent" or "neurodivergence" refer to someone whose emotional state or cognitive and adaptive functioning diverge from dominant norms, standards, and expectations. Id. The terms can apply to a person with autism, epilepsy, schizophrenia, or a personality disorder. See Kiera Lyons, Note, The Neurodiversity Paradigm and Abolition of Psychiatric Incarceration, 123 Colum. L. Rev. 1993, 1996 n.12 (2023) (listing common conditions associated with neurodivergence); Kassiane Asasumasu (@sherlocksflataffect), Tumblr, PSA From the Actual Coiner of "Neurodivergent" (2015), https://sherlocksflataffect.tumblr.com/post/121295972384/psa-from-the-actual-coiner-of-neurodivergent [https://perma.cc/GJR4-V4HS] (listing a variety of conditions that fall under the umbrella of "neurodivergent").

2. See Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam) (reversing and remanding a case due to insufficient evidence of a defendant's competency); see also Pate v. Robinson, 383 U.S. 375, 378 (1966) ("[T]he conviction of an accused person while he is legally incompetent violates due process . . . ." (citing Bishop v. United States, 350 U.S. 961 (1956) (per curiam))).

3. *Dusky*, 362 U.S. at 402.

4. See Drope v. Missouri, 420 U.S. 162, 171 (1975) (discussing when a defendant lacks the capacity to stand trial); Richard J. Bonnie, The Competence of Criminal Defendants: A Theoretical Reformulation, 10 Behav. Scis. & L. 291, 293 (1992) [hereinafter Bonnie, A Theoretical Reformulation] ("The relevant dimensions of a defendant's 'competence' in most situations are [their] capacity to assist counsel[,] conduct an adequate investigation of the case[,] and . . . make whatever decisions a defendant is required or expected to make in order to defend and/or resolve the case without a trial.").

5. *Dusky*, 362 U.S. at 402 (internal quotation marks omitted) (quoting J. Lee Rankin, U.S. Solic. Gen.).

gence.[6] If a court finds the defendant unfit, it can institutionalize them until it finds that they have been restored to legal capacity.[7] The CST framework following *Dusky* and *Drope v. Missouri*, which modified *Dusky*, posits that legal equality can be achieved for individuals with disabilities through short-term treatment in carceral settings.[8]

Broadly defined, disability is a "chronic impairment that significantly impacts the daily life of a given individual."[9] It is a fluid and complex category.[10] Its recognition in different domains has always depended on ascribed institutional, cultural, social, and political meanings, and its impact has varied with context.[11] In CST proceedings, examiners parse through defendants' neurodivergence, which may include psychiatric conditions. The experts determine whether the defendants have demonstrated impairments that merit recognition as disabilities under the *Dusky–Drope* standard.

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6. See, e.g., Mark Walker, How Court-Ordered Competency Evaluations Work, Argus Leader, https://www.argusleader.com/story/news/2015/11/14/how-court-ordered-competency-evaluations-work/75493920/ [https://perma.cc/BZX9-YM9W] (last updated Nov. 14, 2015) ("The psychiatrist submits a report recommending whether a person is competent to stand trial.").

7. See 1 Wayne R. LaFave, Substantive Criminal Law § 8.1(b) (3d ed. 2024) ("[I]n most jurisdictions the practice has been to institutionalize because of incompetence to stand trial . . . without reference to the legal criteria for civil commitability (generally, whether the person is dangerous to society or is in need of treatment and unable to care for himself)."); Substance Abuse & Mental Health Servs. Admin., Foundation Work for Exploring Incompetence to Stand Trial Evaluations and Competence Restoration for People With Serious Mental Illness/Serious Emotional Disturbance 56–99 (2023), https://store.samhsa.gov/sites/default/files/pep23-01-00-005.pdf [https://perma.cc/3H4Z-5E5C] (providing a state-by-state survey of adult CST procedures, including whether outpatient restoration is a possibility); Amanda Wik, Vera Hollen & William H. Fisher, Nat'l Ass'n of State Mental Health Program Dirs., Forensic Patients in State Psychiatric Hospitals: 1999–2016, at 29 (2017), https://nri-inc.org/media/1318/tac-paper-9-forensic-patients-in-state-hospitals-final-09-05-2017.pdf [https://perma.cc/G966-BE96] (reporting that twenty-three of thirty-seven states surveyed indicated that "their state psychiatric hospitals accepted both misdemeanants and felons for those evaluations").

8. In this Essay, the form of neurodivergence discussed is also generally considered a psychiatric disability. As a result, the terms are used interchangeably.

9. Cassandra Hartblay, Disability Expertise: Claiming Disability Anthropology, 61 Current Anthropology S26, S26 (2020).

10. See Tanya Titchkosky, The Question of Access: Disability, Space, Meaning 24–27 (2011) (arguing that the social construction of disability emerges from a collective perspective grounded, in part, in how members of a group understand themselves, their bodies, and their access to shared spaces, literal and figurative).

11. See Syrus Ware, Joan Ruzsa & Giselle Dias, It Can't Be Fixed Because It's Not Broken: Racism and Disability in the Prison Industrial Complex, *in* Disability Incarcerated: Imprisonment and Disability in the United States and Canada 163, 165 (Liat Ben-Moshe, Chris Chapman & Allison C. Carey eds., 2014) ("[W]e consider the stories of criminalized, racialized, and disabled prisoners, intentionally making a connection between the experience of ableism and racism/colonialism and the [prison industrial complex].").

This Essay reveals a hierarchy of psychiatric disabilities embedded in the competency standard.[12] State and federal courts frequently recognize psychotic disorders (such as schizophrenia) and the cognitive impairments they produce (like hallucinations and disorganized thoughts) as grounds for incompetency.[13] Meanwhile, judges and forensic examiners have tended to discount PDs, a group of disabilities that manifest as personality traits that frustrate interpersonal relations and court administration.[14] PDs are characterized as enduring patterns of inner experience and behavior that deviate from cultural expectations.[15] One cluster of PDs discussed at length in this Essay includes antisocial, borderline, histrionic, and narcissistic personality disorders.[16] Clinical literature describes that people with these disorders may appear dramatic, emotional, or erratic.[17] Even in the face of evidence that an accused struggles to collaborate with their attorney because of a diagnosed PD, courts have been reluctant to recognize such claims of disability as triggering incompetency protections.[18] They have asserted that these conditions are different from psychotic disorders because defendants retain control over their behavior.[19] They characterize these defendants as intentionally uncooperative, ascribing the challenges they face with their attorneys as instances of misconduct, not the product of disability.[20] Examiners have explained and courts have declared that defendants with PDs are more likely to manipulate proceedings to their advantage and feign disability.[21] In turn, courts have gone as far as to categorically reject PDs as a basis for incompetency claims.[22]

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12. See infra Part III.

13. See infra Part III.

14. See infra section III.D.2.

15. Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 733 (5th ed., text rev. 2022) [hereinafter DSM-5-TR].

16. Id.

17. Id. at 734.

18. See infra section III.D.2.

19. See infra section III.C.

20. See infra section III.C.

21. See infra section III.D.1 (discussing cases in which a personality disorder was treated as evidence of malingering).

22. See, e.g., United States v. Clements, 522 F.3d 790, 795 (7th Cir. 2008) ("Clements has not provided us with a single example of his conduct that would suggest incompetence; instead, Clements has focused his argument on the statements . . . which do nothing more than acknowledge that Clements exhibited behavior consistent with Antisocial Personality Disorder."); United States v. Savage, 505 F.3d 754, 759 (7th Cir. 2007) (finding that the defendant did not prove "why either [post-traumatic stress disorder or dependent personality disorder] would necessitate a finding of incompetence"); United States v. Teague, 956 F.2d 1427, 1432 (7th Cir. 1992) (affirming the conviction because the defendant did not have any diagnoses "that would prevent a defendant from understanding the proceedings against him and interfere with his ability to confer with his attorney on his own behalf"); United States v. Rosenheimer, 807 F.2d 107, 112 (7th Cir. 1986) (per curiam) (affirming the district court's finding of competency and sanity because "the defendant did not suffer

But clinical research does not support the neat conclusion that PDs are categorically distinct from psychotic disorders, and there is no evidence to establish that the symptoms of PDs are simply the product of bad choices.[23] Clinicians and bioethicists note PDs' ambiguous status in psychiatry[24]: They pose a genuine moral and scientific dilemma.[25] Neither psychologic nor psychiatric expertise can authoritatively answer whether someone with a PD can exercise control over their behavior. Where to draw the line between the person and the disorder, between deviance and ability, is a normative—rather than strictly descriptive—question.[26] When a criminal defendant refuses to speak to their lawyer, and the defense alleges that this refusal is consistent with their chronic incapacity to trust others, to conclude that the accused chose not to control their symptoms is a moral judgment.

While expert forensic examiners do not explicitly confront this vexed issue of responsibility, they do so implicitly when they pronounce such defendants competent.[27] When experts opine on the accused person's competency, their testimony effectively stretches clinical expertise and the rules of evidence.[28] Their approach in these moments is empirically

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from any mental disease or defect, but rather from a narcissistic personality disorder which is separate and distinct from suffering from a mental disease or defect"); United States v. Mitchell, 706 F. Supp. 2d 1148, 1220 (D. Utah 2010) ("[T]he court finds that Mitchell's personality disorders do not affect his ability to rationally understand the proceedings against him or his ability to consult with his lawyers with a reasonable degree of rational understanding."); State v. Walther, 581 S.W.3d 702, 709 (Mo. Ct. App. 2019) ("Viewing the evidence in the light most favorable to Appellant establishes, at best, Appellant suffered from a personality disorder and not from a statutorily cognizable mental disease or defect."); Emily Stork, Note, A Competent Competency Standard: Should It Require a Mental Disease or Defect?, 44 Colum. Hum. Rts. L. Rev. 927, 957 (2013) (arguing against the inclusion of "mental disease or defect" in competency determinations because "it invites unnecessary line-drawing and battles of the experts").

23. See Robert Kinscherff, Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act, 38 J.L. Med. & Ethics 745, 750 (2010) ("The functional impairments associated with personality disorders can be severe and similar to the functional impairments associated with mental disorders that would be permitted for consideration of nullification of criminal responsibility." (emphasis omitted)).

24. See infra section II.B.

25. See Jill Peay, Personality Disorder and the Law: Some Awkward Questions, 18 Phil. Psychiatry & Psych. 231, 242 (2011) (describing the "acute" dilemma posed by those with personality disorders).

26. See Ben Bursten, Beyond Psychiatric Expertise 55 (1984) (arguing that distinctions in legal standards about what counts as a cognitive impairment are ultimately a matter of policy that implicates fairness and moral responsibility); Jonas B. Robitscher, Tests of Criminal Responsibility: New Rules and Old Problems, 3 Land & Water L. Rev. 153, 173 (1968) ("[T]he test [of criminal responsibility] is less important than the spirit and wisdom with which it is applied and the climate in which the determination is made[,] . . . [and it] is of concern not only to lawyers, psychiatrists and malefactors, it is also a matter of public concern.").

27. See infra section IV.A.

28. Rules 702(c) and (d) of the Federal Rules of Evidence authorize an expert to offer their opinion if, inter alia, the proponent can show that the expert's testimony is "the

suspect, subjective, and confused.[29] Expert conclusions elicited in CST proceedings launder weighty deontological and substantive considerations about moral responsibility.[30] At their most extreme, examiners' opinions trigger miniature trials about the accused person's character.[31] In CST proceedings, experts opine not simply about whether the accused is incompetent but about whether they deserve to be held incompetent.[32] In so doing, their interventions transform a modest procedural protection into a substantive decision point.[33] That is, examiners focus more on defendants' moral responsibility, a core concern in substantive criminal law, than on defendants' ability to fairly contribute to their defense, the procedural concern ostensibly underlying the *Dusky–Drope* standard. Experts enjoy this wide latitude in CST proceedings because courts have abdicated their adjudicative function.[34] The problem is systemic rather than individual.

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product of reliable principles and methods" and that their "opinion reflects a reliable application of the principles and methods to the facts of the case." Fed. R. Evid. 702. The *Daubert* standard requires courts to critically assess the reliability of expert opinions by scrutinizing the methods they use to arrive at their conclusions. Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 593–95 (1993). Factors that courts evaluate under *Daubert* inquiries include: (1) whether the technique or theory in question can be and has been tested; (2) whether it has been subjected to publication and peer review; (3) whether the technique has a known or potential error rate; (4) whether there are standards controlling its operation; and (5) whether it is widely accepted within a relevant scientific community. Id.

29. See Michael L. Perlin, The Hidden Prejudice: Mental Disability on Trial 5–9 (2000) [hereinafter Perlin, Hidden Prejudice] (discussing the way courts distort disability, both factually and conceptually, across areas of law).

30. See id. at 15 (arguing that experts rely on nonclinical factors, such as personality characteristics or a crime's seriousness, when making competency decisions).

31. See, e.g., People v. Berg, No. B236694, 2013 WL 492553, at *3 (Cal. Ct. App. Feb. 11, 2013) ("Dr. Dudley diagnosed appellant with having longstanding problems with social interactions, e.g. the capacity to read social cues and respond appropriately. As a result, appellant consistently misperceived the behavior of other people, and responded inappropriately."); see also Michel Foucault, Lecture of 15 January 1975, *in* Abnormal: Lectures at the Collège de France 1974–1975, at 39–41 (Valerio Marchetti & Antonella Salomoni eds., Graham Burchell trans., Verso 2003) (1999) [hereinafter Foucault, Jan. 15 Lecture] (narrating the historical evolution of the relationship between psychiatry and law from one of antagonism to embracing one another, culminating in a consolidated medico-judicial power where "both justice and psychiatry are adulterated" in the expert opinion commissioned to describe abnormal individuals).

32. See infra section IV.A.

33. Substance refers to the rules that govern conduct outside courtrooms and specifically the prohibitions of the criminal law; procedure denotes the rules that govern legal actors. See Jenny S. Martinez, Process and Substance in the "War on Terror", 108 Colum. L. Rev. 1013, 1020–21 (2008) (defining substance as "rules that control the primary conduct of human beings outside the litigation or lawmaking process" and procedure as questions of process "within courts" and "among different government actors"); see also infra section IV.B.

34. See Patricia A. Zapf, Karen L. Hubbard, Virginia G. Cooper, Melissa C. Wheeles & Kathleen A. Ronan, Have the Courts Abdicated Their Responsibility for Determination of Competency to Stand Trial to Clinicians?, 4 J. Forensic Psych. Prac. 27, 39 (2004)

Understanding examiners' motivations is beyond the scope of this Essay. Rather, this Essay expounds on the *function* that examiners' opinions and courts' rulings play in the wider system of criminal court.[35] Specifically, it looks at how the knowledge examiners produce facilitates criminalization[36] and contributes to an epistemology of criminalization.[37] More precisely, when examiners conclude that defendants with PDs are engaged in procedural misconduct, and hence are competent to stand trial, their decisions mimic outcomes in insanity litigation.[38] Courts and legislatures have typically denied both incompetency claims and insanity defenses to defendants diagnosed with PDs because their symptoms too closely resemble traits of criminality, like lack of empathy,[39] manipulation, and deceit.[40] Across both insanity and competency law, courts and examiners interpret misconduct as prima facie proof of capacity, not disability.[41] The apparent consistency in experts' findings across these two distinct areas of law is remarkable because each serves a very different purpose. This consistency reveals the insertion of substantive concerns

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[hereinafter Zapf et al., Have the Courts Abdicated?] ("The courts tend to ignore the rule that experts cannot give evidence on the ultimate issue in relation to competency evaluations." (citation omitted) (citing Gary B. Melton, John Petrila, Norman G. Poythress & Christopher Slobogin, Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 20 (2d ed. 1997))).

35. See generally Mark B. Couch, Causal Role Theories of Functional Explanation, Internet Encyc. Phil., https://iep.utm.edu/func-exp/ [https://perma.cc/A2QX-597W] (last visited Oct. 16, 2024) (explaining that functional explanations are ones in which "researchers appeal to the functions that a structure or system has" but that such accounts can "commit us to problematic views about the existence of teleology").

36. See Michel Foucault, Lecture of 8 January 1975, *in* Abnormal: Lectures at the Collège de France 1974–1975, supra note 31, at 1, 15 [hereinafter Foucault, Jan. 8 Lecture] ("[E]xpert psychiatric opinion allows the offense . . . to be doubled with a whole series of other things . . . presented in the discourse of the psychiatric expert as the cause, origin, motivation, and starting point of the offense.").

37. For another example of a contribution to an epistemology of criminalization, see generally Anna Lvovsky, Vice Patrol: Cops, Courts, and the Struggle Over Urban Gay Life Before Stonewall 17–23 (2021) (describing "the history of antihomosexual policing" as "provid[ing] a useful case study of the politics of knowledge underlying the administration of the criminal law—what we can think of as the epistemology of law enforcement").

38. See infra section IV.A.

39. See Catherine Young, Janice Habarth, Bruce Bongar & Wendy Packman, Disorder in the Court: Cluster B Personality Disorders in United States Case Law, 25 Psychiatry, Psych. & L. 706, 707 (2018) (noting that some researchers have argued that "the predominant theme" of Cluster B personality disorders—such as antisocial, borderline, histrionic, or narcissistic personality disorders—"is a lack of empathy" (citing George Kraus & David J. Reynolds, The "A-B-C's" of the Cluster B's: Identifying, Understanding, and Treating Cluster B Personality Disorders, 21 Clinical Psych. Rev. 345 (2001))).

40. See, e.g., United States v. Gabrion, 719 F.3d 511, 533 (6th Cir. 2013) (noting that people with certain personality disorders "tend to be highly manipulative"); State v. Dahl, 783 N.W.2d 41, 46–49 (N.D. 2010) (describing the accused person's vandalism of his jail cell as an attempt to manipulate the judicial system rather than irrational behavior stemming from mental illness).

41. See infra section III.D.1.

into procedural law. Criminality acts as a foil for disability when examiners and courts undertake competency decisions. They frame disability as a limited deviation from the normative figure of the able-bodied, free-willed perpetrator.

The story here is not about a clash between law and psychiatry, commonly treated in the literature as two incommensurable forms of knowledge.[42] Nor does this Essay seek to expose forensic psychiatry as a junk science; rather, it illuminates the unavoidable moral dimensions of the practice of forensic psychology as it animates legal doctrine.[43] It concludes that the ultimate task of distinguishing between those disabilities that deserve recognition and those that do not is best reserved for legal actors rather than forensic experts.[44]

These observations suggest that the CST framework fails on its own terms: Even the fiction of formal legal equality for neurodivergent defendants is out of reach for those diagnosed with a PD. There are groups

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42. See Holloway v. United States, 148 F.2d 665, 667 (D.C. Cir. 1945) ("A complete reconciliation between the medical tests of insanity and the moral tests of criminal responsibility is impossible."); Sheila Jasanoff, Science at the Bar: Law, Science, and Technology in America 7–8 (Harvard Univ. Press paperback ed. 1997) (1995) (discussing common tropes in law, science, and technology studies); Gary B. Melton, John Petrila, Norman G. Poythress, Christopher Slobogin, Randy K. Otto, Douglas Mossman & Lois O. Condie, Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 32–33 (4th ed. 2018) (discussing the conflict between law and psychiatry regarding standards of evidence); David L. Bazelon, The Interface of Law and the Behavioral Sciences: The Lowell Institute Lecture, 271 NEJM 1141, 1141 (1964) ("The recurrent problem at the interface of law and the behavioral sciences . . . can be put this way: which of us, lawyer or psychiatrist, has primary responsibility for determining the issue of responsibility? Who is responsible for responsibility?").

43. See Foucault, Jan. 8 Lecture, supra note 36, at 18 ("Expert psychiatric opinion makes it possible to transfer the point of application of punishment from the offense defined by the law to criminality evaluated from a psychologico-moral point of view."); Lyons, supra note 1, at 1998 ("Science, however, is characterized by subjective, value-laden choices made at every step of the process, from data collection to experimental design and result interpretation."); see also Sandra Harding, Whose Science? Whose Knowledge?: Thinking From Women's Lives 81 (1991) ("[M]odern science has been constructed by and within power relations in society, not apart from them."); Jonathan M. Metzl, The Protest Psychosis: How Schizophrenia Became a Black Disease, at xi–xvii (2010) (critiquing the influence of racial bias in the psychiatric definition of schizophrenia and interrogating its pathological conceptualization); Heather Douglas, Inductive Risk and Values in Science, 67 Phil. Sci. 559, 563–64 (2000) ("First, values (both epistemic and non-epistemic) play important roles in the selection of problems to pursue. Second, the direct use to which scientific knowledge is put in society requires the consideration of non-epistemic values. . . . Third, non-epistemic values place limitations on methodological options . . . .").

44. See Bruce J. Winick, Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie, 85 J. Crim. L. & Criminology 571, 623 (1995) [hereinafter Winick, Reforming Incompetency to Stand Trial and Plead Guilty] ("Moving competency determinations from clinicians to defense attorneys should increase the accuracy of competency decisionmaking, . . . [and] would recognize that competency in the criminal process is more a legal than a clinical question, involving legal and normative judgements and not merely clinical ones.").

of people who claim disability but are excluded.[45] Recognition is the minimum in any effort to combat the marginalization of those who are differently abled. But if the problems this Essay exposes are excluded defendants, unprincipled analyses, and usurped roles, the solution is more difficult than the diagnosis. It is both undesirable and untenable to demand that all neurodivergent defendants, including those who are diagnosed with PDs, be recognized in CST proceedings.

It is undesirable because asking examiners and courts to recognize a greater diversity of mental disabilities in CST proceedings would lead to more people being forcibly committed to underfunded state hospitals. Scholars and advocates have noted the harsh conditions of those settings.[46]

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45. It is unclear how often this occurs. But even if it is a small number of people, their exclusion reveals the deeper workings of the competency standard. See, e.g., United States v. Wayt, 24 F. App'x 880, 882–83 (10th Cir. 2001) (affirming that the accused person's personality disorder did not meet the statutory standards for incompetency and that the defendant was competent to stand trial).

46. Since the 1930s, state mental hospitals and residential facilities that housed individuals with intellectual or developmental disabilities have been mired in abuse scandals. See, e.g., Albert Q. Maisel, Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace, LIFE, May 6, 1946, at 102, 102 https://www.jerrycookearchives.com/photo-essays/bedlam-1946/ (on file with the *Columbia Law Review*) ("Through public neglect and legislative penny-pinching, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Belsen pattern."); Ben Cosgrove, Strangers to Reason: LIFE Inside a Psychiatric Hospital, 1938, LIFE, https://www.life.com/history/strangers-to-reason-life-inside-a-psychiatric-hospital-1938/ [https://perma.cc/LKN4-82VK] (last visited Jan. 28, 2025) (featuring Alfred Eisenstaedt's photographs of patients at Pilgrim State Hospital, whom he described as "the most neglected, unfortunate group in the world" (quoting Alfred Eisenstaedt, LIFE photographer)). By the 1960s, the steady stream of grievances and complaints had culminated in political momentum to shutter these types of institutions, leading to deinstitutionalization. See Peter Nolan, Mental Health Nursing in the 1960s Remembered, 28 J. Psychiatric & Mental Health Nursing 462, 467 (2021) ("The institutions were to be replaced by care in the community, thus ending mass incarceration, facilitating civic inclusion and recovery, and empowering patients to become active participants in their own care."). Today, despite the far smaller number of individuals segregated on account of their mental disability, the institutions remain haunted by neglect. See Liat Ben-Moshe, Decarcerating Disability: Deinstitutionalization and Prison Abolition 3 (2020) [hereinafter Ben-Moshe, Decarcerating Disability] ("The population of people with intellectual and/or developmental disabilities (I/DD) in large residential institutions . . . peaked at 194,650 in 1967. By 2015, this number had declined to 69,557." (citing David L. Braddock, Richard E. Hemp, Emily S. Tanis, Jiang Wu & Laura Haffer, The State of the States in Intellectual and Developmental Disabilities (11th ed. 2017))); see also Neil Bedi, You're Trapped. They're Cashing In., Tampa Bay Times (Sep. 18, 2019), https://projects.tampabay.com/projects/2019/investigations/north-tampa-behavioral-health/ [https://perma.cc/GLY5-X6VR] ("[North Tampa Behavioral Health] illegally cuts patients off from their families. Then it uses loopholes in the statute to hold them longer than allowed, running up their bills while they are powerless to fight back. Some patients describe getting virtually no psychiatric treatment."); Liz Kowalczyk, Families Trusted This Hospital Chain to Care for Their Relatives. It Systematically Failed Them, Bos. Globe (June 10, 2017), https://www.bostonglobe.com/metro/2017/06/10/arbour/AcXKAWbi6WLj8bwGBS2GFJ/story.html (on file with the *Columbia Law Review*) (exposing recent conditions in Massachusetts psychiatric facilities run by Arbour Health System, which has extracted "robust profits" while

Nonetheless, by outlining arguments for incompetency, this Essay intends to support a harm-reduction strategy in instances when a defense attorney can clearly discern a net benefit to their client being found incompetent. In many cases, however, there are no good choices for defendants with psychiatric disabilities in criminal court. Although both the disability justice and disability rights movements advocate for greater inclusion in public life,[47] that demand seems misguided here. Inclusion is a paradox in the carceral state.[48]

It may also be untenable to expect more expansive accommodations because criminal courts may not be able to recognize all psychiatric disabilities. Even if a person's disability shapes their chances in court, recognizing the manifestations of some disabilities could undermine criminal law's core commitments to assigning blame and responsibility. Furthermore, courts may be drawing lines to produce a narrow exception out of "a fear of too much justice."[49] That is, courts may be drawing a firm rule to prevent a proliferation of incompetency claims.[50] Among people in state and federal prisons in 2016, an estimated 40.4% reported having a psychiatric disability.[51] Of those diagnoses, PDs are among the most overrepresented in carceral settings.[52] Examiners' exclusion of PDs in CST proceedings preserves the rapacious administration of criminal law.[53] There are strong institutional incentives to define disability narrowly.

CST proceedings should also serve as a cautionary tale for ongoing efforts to address neurodivergence in criminal court, particularly those

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"repeatedly and sometimes egregiously shortchanging patient care"); Public Crisis, Private Toll: The Hidden Costs of the Mental-Health Industry's Expansion, Seattle Times (Aug. 23, 2019), https://projects.seattletimes.com/2019/public-crisis-private-toll-prologue/ [https://perma.cc/N2Z7-XQTM] (investigating the harms of the expansion of private psychiatric care, designed to address inadequate state capacity, in Washington).

47. See infra section I.B.

48. But see Jamelia N. Morgan, The Paradox of Inclusion: Applying *Olmstead*'s Integration Mandate in Prisons, 27 Geo. J. on Poverty L. & Pol'y 305, 312–17 (2020) [hereinafter Morgan, Paradox of Inclusion] (arguing that although the legal mandate to integrate individuals who have disabilities conflicts with the central features and functions of the American punishment system, this paradox is potentially productive for those seeking to transform the carceral state).

49. McCleskey v. Kemp, 481 U.S. 279, 339 (1987) (Brennan, J., dissenting).

50. See id. ("The Court next states that its unwillingness to regard petitioner's evidence as sufficient is based in part on the fear that recognition of McCleskey's claim would open the door to widespread challenges to all aspects of criminal sentencing.").

51. Laurin Bixby, Stacey Bevan & Courtney Boen, The Links Between Disability, Incarceration, and Social Exclusion, 41 Health Affs. 1460, 1462 (2022).

52. See Janet I. Warren, Mandi Burnette, Susan Carol South, Preeti Chauhan, Risha Bale & Roxanne Friend, Personality Disorders and Violence Among Female Prison Inmates, 30 J. Am. Acad. Psychiatry & L. 502, 507 (2002) (finding antisocial, borderline, and paranoid PDs to be common diagnoses among women incarcerated at a maximum security prison).

53. See Perlin, Hidden Prejudice, supra note 29, at 72 ("The legal system selectively—teleologically—either accepts or rejects social science evidence depending on whether or not the use of that data meets the *a priori* needs of the legal system.").

that propose mental health expertise as a key ingredient for decarceration. Across jurisdictions, criminal court actors have embraced alternatives to incarceration, particularly for those with psychiatric needs.[54] In such cases, a person can accept a plea to a criminal charge and can undergo treatment, broadly defined, as their sentence.[55] To implement these alternatives, courts have assembled teams of interdisciplinary experts to identify those who stand to benefit from softer penal interventions. Mental health specialists play a critical role in these efforts, drawing on their diagnostic expertise to educate judges, prosecutors, and defense attorneys about neurodivergence and appropriate interventions.[56] Many progressive reforms treat mental health expertise as a humanizing antidote to criminalization.[57] But CST proceedings suggest that the diagnostic

54. See Amy J. Cohen, Trauma and the Welfare State: A Genealogy of Prostitution Courts in New York City, 95 Tex. L. Rev. 915, 923–25 (2017) (detailing the rise of "socialized courts"); Erin R. Collins, The Problem of Problem-Solving Courts, 54 U.C. Davis L. Rev. 1573, 1575 (2021) [hereinafter Collins, Problem of Problem-Solving] (describing the proliferation of "mental health courts" and other specialized courts); Allegra M. McLeod, Decarceration Courts: Possibilities and Perils of a Shifting Criminal Law, 100 Geo. L. J. 1587, 1605–11 (2012) (describing the movement for specialized criminal courts, which began to combat "the miscarriages of justice" occurring in regular criminal court); see also Michela Lowry & Ashmini Kerodal, Ctr. for Ct. Innovation, Prosecutor-Led Diversion: A National Survey, at v (2019) https://www.innovatingjustice.org/wp-content/uploads/2019/03/prosecutor-led_diversion.pdf [https://perma.cc/P98G-VXU5] ("Across both urban and rural counties, the most commonly available mandates and services were community service (77%), substance abuse education (69%), substance abuse treatment (59%), and individual therapy (42%).").

55. See Collins, Problem of Problem-Solving, supra note 54, at 1582 ("Problem-solving courts are specialized criminal or quasi-criminal courts that often offer treatment and enhanced supervision in addition to or in lieu of incarceration."); Erin R. Collins, Status Courts, 105 Geo. L.J. 1481, 1488–89 (2017) (stating that, for example, "[d]rug courts embrace the idea that . . . treating the [drug] addiction instead of incarcerating the defendant is a more effective and long-lasting response to drug-related criminal behavior"); Leah Wang & Katie Rose Quandt, Building Exits off the Highway to Mass Incarceration: Diversion Programs Explained, Prison Pol'y Initiative (July 20, 2021), https://www.prisonpolicy.org/reports/diversion.html [https://perma.cc/2AUN-2N4Y] (discussing the benefits and limitations of alternatives to incarceration).

56. See Council on Psychiatry & L., Am. Psychiatric Ass'n, Resource Document on Mental Health Courts 5 (2020), https://www.psychiatry.org/getattachment/b808a481-c996-4c88-8afe-41605412dd48/Resource-Document-2020-Mental-Health-Courts.pdf [https://perma.cc/U3R6-Z9VU] (noting the important role of mental health professionals in mental health courts).

57. See, e.g., Renée Binder, Mental Health Courts: An Effective Alternative to Incarceration, Psychiatric News, Nov. 20, 2015, at 8, 8 ("Mental health courts take a therapeutically oriented approach. . . . They use a harm-reduction model and try to facilitate treatment adherence."); see also Akhi Johnson & Mustafa Ali-Smith, Vera Inst. of Just., Diversion Programs, Explained 2 (2022), https://vera-institute.files.svdcdn.com/production/inline-downloads/diversion-programs-explained.pdf? [https://perma.cc/39LJ-CDHU] (discussing pre- and post-arrest diversion programs, including diversion to mental health services); Wang & Quandt, supra note 55 (enumerating the types of diversion offered by various criminal legal actors).

framework mental health experts deploy is not necessarily distinct from criminal law's deontological framework.[58]

This Essay engages with four intellectual currents. First, legal scholars have recently illuminated the central but underappreciated role of disability in jurisprudence governing search and seizure,[59] state–federal relations,[60] and family law.[61] Second, law-and-social-movement scholars have expanded scholarly horizons by applying the insights of prison abolition to legal doctrine and reform.[62] This body of work shakes foundational myths about criminal legal institutions and conventional modes of reform.[63] If criminal legal institutions operate as tools of social

58. See infra section IV.B.

59. See, e.g., Jamelia Morgan, Disability's Fourth Amendment, 122 Colum. L. Rev. 489, 516 (2022) [hereinafter Morgan, Disability's Fourth Amendment] ("[T]he reasonable person standard in the Court's test for whether a seizure has occurred does not adequately take into consideration disability. . . . As a result, this test fails to adequately protect the Fourth Amendment rights of disabled people.").

60. See, e.g., Katie Eyer & Karen M. Tani, Disability and the Ongoing Federalism Revolution, 133 Yale L.J. 839, 845 (2024) ("In the 1970s and 1980s, disability cases regularly provided the site for the Court's early revival of federalism doctrines, as well as its development of new ones.").

61. See, e.g., Sarah H. Lorr, Disabling Families, 76 Stan. L. Rev. 1255, 1262–64 (2024) (arguing that the family regulation system constructs the social category of disability, renders people disabled or more disabled, and reinforces the belief that people with disabilities are categorically unable and unfit to parent).

62. See, e.g., Amna A. Akbar, An Abolitionist Horizon for (Police) Reform, 108 Calif. L. Rev. 1781, 1788 (2020) ("By contending with abolitionist critique and organizing, we deepen our understanding of policing and cogenerate strategies that have the potential for political, economic, and social transformation."); Amna A. Akbar, Toward a Radical Imagination of Law, 93 N.Y.U. L. Rev. 405, 464 (2018) (unpacking the movement for prison and police abolition's "critique of traditional criminal law reforms"); Jocelyn Simonson, Police Reform Through a Power Lens, 130 Yale L.J. 778, 800–01 (2021) (noting a shift in recent scholarship toward "self-governance, or at least . . . reduc[ing] the subjugating effects of policing"). These authors' works draw on a rich scholarly tradition of highlighting the often underappreciated role that social movements play in legal reform. See Amna A. Akbar, Sameer M. Ashar & Jocelyn Simonson, Movement Law, 73 Stan. L. Rev. 821, 826 (2021) (describing the methodology of "movement law" as one that "approaches scholarly thinking and writing about law, justice, and social change as work done in solidarity with social movements, local organizing, and other forms of collective struggle"); Scott L. Cummings, The Puzzle of Social Movements in American Legal Theory, 64 UCLA L. Rev. 1554, 1559 (2017) (discussing "movement liberalism," in which "social movements are positioned as leaders of progressive legal reform in ways that promise to reclaim the transformative potential of law while preserving traditional roles for courts and lawyers"); Lani Guinier & Gerald Torres, Changing the Wind: Notes Toward a Demosprudence of Law and Social Movements, 123 Yale L.J. 2740, 2749–50 (2014) (advancing demosprudence, which "focuses on the ways that ongoing collective action by ordinary people can permanently alter . . . democracy by changing the people who make the law and the landscape in which that law is made," over jurisprudence, which focuses on "the work of judges").

63. Professor Amna Akbar notes the distinctions leftist organizers make between reformism and nonreformist reforms. Amna A. Akbar, Non-Reformist Reforms and Struggles Over Life, Death, and Democracy, 132 Yale L.J. 2497, 2518–30 (2023) [hereinafter Akbar, Non-Reformist Reforms]. In the legal academy, reformism is the mainstay. Id. at 2502. Reformism, according to Akbar, "assume[s] the legitimacy of the prevailing political,

control instead of providing safety, and if procedural safeguards actually entrench state violence,[64] then legal scholars may need to rethink their favored solutions and consider shrinking rather than fixing criminal law and its institutions.[65] By engaging with this literature, this Essay hopes to challenge legalist modes of reform, like the CST framework.

Third, this account also draws on the insights of an older intellectual tradition, the antipsychiatry movement, which emerged in the 1960s.[66] Spurred by the neglect, cruel experimentation, and abuse in state mental hospitals, scholars and organizers in this tradition argued that these institutional excesses were features of a system of knowledge that constructed and enforced psychological normality and enabled deprivations of liberty.[67] Theorist Michel Foucault drew and expanded on these insights

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economic, social, and juridical order," involving mere "tweaks" to doctrine and policy. Id. "Reformism telegraphs to the public that the system, institution, or set of relations it seeks to tweak are here to stay; that the problem is not structural or symptomatic but stray." Id. at 2519. Nonreformist reforms, by contrast, "aim[] to undermine the political, economic, and social system or set of relations as [they] gesture[] at a fundamentally distinct system or set of relations in relation or toward a particular ideological and material project of worldbuilding." Id. at 2527. Such a program of transformation "draws from and builds the popular strength, consciousness, and organization of revolutionary or agential classes or coalitions—most clearly, in doctrinaire Marxism, for example, the working class." Id.

64. See, e.g., Zohra Ahmed, Bargaining for Abolition, 90 Fordham L. Rev. 1953, 1955–58 (2022) (arguing that criminal legal actors engage in violence work); Dorothy E. Roberts, The Supreme Court, 2018 Term—Foreword: Abolition Constitutionalism, 133 Harv. L. Rev. 1, 7 (2019) (stating that abolition posits that "the expanding criminal punishment system functions to oppress black people and other politically marginalized groups in order to maintain a racial capitalist regime"); Marbre Stahly-Butts & Amna A. Akbar, Reforms for Radicals? An Abolitionist Framework, 68 UCLA L. Rev. 1544, 1550 (2022) ("For an abolitionist, the criminal legal system does not seek justice, repair harm, neutrally arbitrate between good and bad, or create public safety. . . . It maintains and legitimizes unequal and exploitative power relationships.").

65. See Ruth Wilson Gilmore, Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California 242 (2007) (developing the heuristic of nonreformist reforms in the context of antiprison organizing); see also Akbar, Non-Reformist Reforms, supra note 63, at 2529–31 (discussing the emergence of nonreformist reforms in the context of battles for decarceration).

66. See David J. Rissmiller & Joshua H. Rissmiller, Evolution of the Antipsychiatry Movement Into Mental Health Consumerism, 57 Psychiatric Servs. 863, 863 (2006).

67. Psychoanalysts, psychiatrists, and sociologists formed the first generation of antipsychiatry activists who came together in opposition "to what were perceived as biological psychiatry's abuses in the name of science." Rissmiller & Rissmiller, supra note 66, at 863. Thomas Szasz, a psychiatrist in the United States and one of the prominent proponents of this view, criticized the foundational precepts of psychiatry and abnormal psychology in his 1960 seminal essay. See Thomas S. Szasz, The Myth of Mental Illness, 15 Am. Psych. 113, 113 (1960) ("My aim in this essay is to raise the question 'Is there such a thing as mental illness?' and to argue that there is not."). Namely, in Szasz's view, the fields drew a false equivalence between bodily disease and mental illness. Id. According to mental health experts, Szasz explained, *"[a]ll problems in living* are attributed to physicochemical processes which in due time will be discovered by medical research." Id. This view, he posited, mystified the true source of psychological distress: So-called mental illnesses were at base difficulties with living, rooted in "differences in personal needs, opinions, social

aspirations, values, and so on." See id. at 113, 118. Szasz thus called for social intervention rather than biological remedies. See id. at 115 ("Since medical action is designed to correct only medical deviations, it seems logically absurd to expect that it will help solve problems whose very existence had been defined and established on nonmedical grounds."); see also id. at 114 ("The norm from which deviation is measured whenever one speaks of a mental illness is a *psychosocial and ethical one*. Yet, the remedy is sought in terms of *medical* measures which—it is hoped and assumed—are free from wide differences of ethical value."). Because of the unacknowledged ethical and hence political content of psychiatric practice, "Szasz argued for a similarly clear division between 'psychiatry and state,'" and helped establish the Libertarian Party. Rissmiller & Rissmiller, supra note 66, at 864.

Szasz also wrote at a time when psychiatry and psychology were under attack from other social groups. Ken Kesey's 1962 novel, *One Flew Over the Cuckoo's Nest*, invited the public into the conditions of psychiatric institutions. See Ken Kesey, One Flew Over the Cuckoo's Nest (Penguin Books 1962). In Britain, R. D. Laing was an influential critic of psychiatry. See R.D. Laing, The Divided Self: An Existential Study in Sanity and Madness (Penguin Books 1965) (1960) (providing a phenomenological account of schizophrenia, madness, and sanity). In Italy, Franco Basaglia founded the democratic psychiatry movement and helped to bring about deinstitutionalization. See generally John Foot, The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care (2015) (narrating the evolution of the movement Basaglia founded to close mental institutions in Italy). The antipsychiatry movement accompanied deinstitutionalization, which involved the closure of both psychiatric hospitals and large state institutions for those with developmental disabilities from the 1950s through the 1980s. See Ben-Moshe, Decarcerating Disability, supra note 46, at 38 (noting that "antipsychiatry . . . advanced a new conceptualization of human worth and difference that made deinstitutionalization necessary and possible").

In the 1970s, the professional-led antipsychiatry movement waned, and patients took up the mantle of activism. See Beatrice Adler-Bolton & Artie Vierkant, Health Communism 137–38 (2022). For example, in Germany, the Socialist Patients' Collective championed an ethos of turning illness into a weapon in the fight against capitalism, the most important determinant of health, in their view. Id. at 136–39. In their efforts to liberate themselves from medical paternalism, activists described themselves not as patients but as consumers, clients, or even survivors. See Nancy Tomes, Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients Into Consumers 263 (2016) (describing the debate between the terms "consumer," "client," "survivor," and "patient" (internal quotation marks omitted)). Instead of medical therapies, radical groups that opposed psychiatry proposed peer support and mutual aid for individuals who were neurocognitively different. See Judi Chamberlin, On Our Own: Patient-Controlled Alternatives to the Mental Health System 18–19, 86–87 (McGraw-Hill Book Co. 1979) (1978) (articulating nonmedical and peer mechanisms to improve the lives of people who are neurodivergent).

This upheaval coincided with the LGBTQ movement's challenge to the psychiatric profession's hostility to homosexuality. From 1952 to 1973, the American Psychiatric Association classified homosexuality as a "sociopathic personality disturbance." Robert Paul Cabaj, Working With LGBTQ Patients, Am. Psychiatric Ass'n, https://www.psychiatry.org/psychiatrists/diversity/education/best-practice-highlights/working-with-lgbtq-patients [https://perma.cc/6FY6-8ED6] (last visited Feb. 15, 2025); see also John J. Conger, Proceedings of the American Psychological Association, Incorporated, for the Year 1974: Minutes of the Annual Meeting of the Council of Representatives, 30 Am. Psych. 620, 633 (1975) ("The American Psychological Association supports the action taken on December 15, 1973, by the American Psychiatric Association, removing homosexuality from that Association's official list of mental disorders."). In 1970, gay activist Frank Kameny interrupted an American Psychiatric Association meeting, declaring that "[p]sychiatry is the enemy incarnate" and that "[p]sychiatry has waged a relentless war of extermination against us. You may take this as a declaration of war against you." Donald Beaulieu, 50 Years

in his meticulous study of forensic psychiatry.[68] Psychology and abnormal psychology were not neutral disciplines that illuminated the truth of the human mind but rather techniques of governance.[69] The antipsychiatry movement in turn sought to denaturalize the study of the brain and of human behavior.[70] This Essay takes inspiration from this line of critique, uncovering the political, moral, and normative dimensions to the practice of psychiatry and psychology.[71] But it does not fully embrace antipsychiatry in that it does not suggest that psychiatry ought to be abolished, nor does it contend that the brain, human behavior, and psychopathology cannot be meaningfully examined. This Essay does, however, embrace antipsychiatry's invitation to critically scrutinize the discipline and profits from the hermeneutical space that the antipsychiatry movement created. Indeed, the "Mad Pride" and "Crip" movements, antipsychiatry's intellectual descendants, have illuminated the recalcitrant ableism that permeates law and medicine.[72]

Ago, Psychiatrists Stopped Calling Homosexuality a Mental Illness, Wash. Post (Dec. 15, 2023), https://www.washingtonpost.com/history/2023/12/15/homosexuality-disorder-dsm-apa-psychiatry/ (on file with the *Columbia Law Review*) (internal quotation marks omitted) (quoting activist Frank Kameny).

In courts, individuals with psychiatric disabilities also pushed to change the standard of care, so as to force medical and therapeutic institutions to prioritize care in community settings rather than in segregated warehouses. See, e.g., Lake v. Cameron, 364 F.2d 657, 660 (D.C. Cir. 1966) (en banc) ("Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.").

68. See generally Abnormal: Lectures at the Collège de France 1974–1975, supra note 31 (using criminal cases to demonstrate the moral and political dimensions of psychiatry and psychology); Michel Foucault, Madness and Civilization: A History of Insanity in the Age of Reason (Richard Howard trans., Vintage Books 1988) (1965) (offering a genealogy of the construction of madness in Western societies).

69. See Foucault, Jan. 15 Lecture, supra note 31, at 39–41 (describing the ways in which, for example, medico-psychological services are used in prison to monitor detainees).

70. See supra note 67.

71. As Judi Chamberlin argued:

> Although many psychiatrists claim that their training gives them the expertise to detect symptoms of the various mental illnesses, it is the very existence of mental illness that is in question. Leaving the determination of whether mental illness exists strictly to the psychiatrists is like leaving the determination of the validity of astrology in the hands of professional astrologers.

Chamberlin, supra note 67, at 9; see also Szasz, supra note 67, at 116 (stating that the author seeks "to criticize and counter a prevailing contemporary tendency to deny the moral aspects of psychiatry"). Professor Liat Ben-Moshe summarized Chamberlin's argument, stating: "Altered states, anger, and pain should not be characterized as illness but as a consequence of a system of power and inequality that denies people their basic human needs." Ben-Moshe, Decarcerating Disability, supra note 46, at 96. It is psychiatry, not stigma, that is "the force that most oppresses those psychiatrized." Id. On Szasz, she added: "Szasz's goal was to untie the knot between deviance/abnormality and biomedicalization, leading to psychiatric confinement." Id.

72. As Ben-Moshe explains:

The fourth area of new scholarship that this Essay draws on comes from social science scholars examining the underappreciated connections between carceral expansion and other areas of law and policy, such as municipal finance, taxation, land use, and community economic development.[73] Professor Liat Ben-Moshe has persuasively exposed the logic of incarceration as it permeates the treatment of individuals with disability.[74] This Essay brings these scholarly threads together, attending to the logic of criminalization as it trespasses into other areas of public policy and fields of inquiry.

> Probably the most pervasive way in which alternatives to psychiatry are conceptualized, imagined and practiced are through national and international networks and organizations created by psychiatric survivors, ex-patients, and consumers, as well as people within the anti-psychiatry movement more generally (and those who don't fit neatly into any of these categories). The importance of such organizations is that they build an alternative community to psychiatry, one that is supportive, caring, and often defiant. As in the critique of restorative justice, the point of these networks is not to restore the person to some sort of normative mental health but to discuss the social conditions that led to distress and, in many instances, to increased distress and oppression caused by attempts to biomedically "treat" a perceived behavior or outcome. People who self identify as Mad, for example, claim the category as a form of difference, one in which they find community and home, culture and pride. In a similar fashion to other disability rights and disability justice advocates, madness is seen as an identity, and not a disease. As such, it is a source for frustration, pride, and an entry point into a political stance.

Liat Ben-Moshe, Alternatives to (Disability) Incarceration, *in* Disability Incarcerated: Imprisonment and Disability in the United States and Canada, supra note 11, at 255, 262; see also Ryan Thorneycroft, Crip Theory and Mad Studies: Intersections and Points of Departure, Canadian J. Disability Stud., Feb. 2020, at 91, 95, 107–08 (explaining that disability activists have sought to reclaim terms such as "crip" and "mad").

73. See, e.g., Gilmore, supra note 65, at 28 ("[R]esolutions of surplus land, capital, labor, and state capacity congealed into prisons . . . ."); Jasmine Heiss, A Quiet Jail Boom, *in* The Jail Is Everywhere: Fighting the New Geography of Mass Incarceration 19, 19–24 (Jack Norton, Lydia Pelot-Hobbs & Judah Schept eds., 2024) (describing the jail boom in small cities and rural areas as the consequence of municipal resource concentration in jails and prisons, fragmentation of the social safety net, hollowing-out of industry, and prioritization of the criminal legal system to solve social problems).

74. See Ben-Moshe, Decarcerating Disability, supra note 46, at 1–2 (discussing the "carceral archipelago" as the "variety of enclosures, especially prisons, jails, psychiatric hospitals, and residential institutions for those with intellectual or developmental disabilities" that make apparent the interconnections between practices of incarceration and psychiatry (internal quotation marks omitted) (quoting Chris Chapman, Allison C. Carey & Liat Ben-Moshe, Reconsidering Confinement: Interlocking Locations and Logics of Incarceration, *in* Disability Incarcerated: Imprisonment and Disability in the United States and Canada, supra note 11, at 3, 10, 14, 18)). For further elaboration on the logic of incarceration, see Dylan Rodríguez, Abolition as Praxis of Human Being: A Foreword, 132 Harv. L. Rev. 1575, 1587 (2019) ("[I]ncarceration *as a logic and method of dominance* is not reducible to the particular institutional form of jails, prisons, detention centers, and other such brick-and-mortar incarcerating facilities . . . .").

This Essay also addresses the relative dearth of scholarly writing about disability and criminal procedure.[75] The insanity doctrine has captivated generations of academics,[76] but it is a substantive rule that excuses

75. For two important exceptions, see Perlin, Hidden Prejudice, supra note 29, at 206 ("The public's obsession with the use of the insanity defense is matched by its profound disinterest in the role of incompetency in the criminal trial process."); Morgan, Disability's Fourth Amendment, supra note 59, at 494–95 (arguing that disability is undertheorized in the Supreme Court's Fourth Amendment jurisprudence, demonstrating how "disability mediates interactions with law enforcement" and exposing how Fourth Amendment doctrine renders individuals with disabilities further vulnerable to police violence).

76. For comparison, a search to find secondary literature, like law review articles, on CST turns up 1,611 articles, while a search responsive to insanity delivers 2,339 law review articles. Memorandum from Zohra Ahmed to Columbia L. Rev. (Jan. 22, 2025) (on file with the *Columbia Law Review*). For the literature on the insanity defense, see generally ABA, Insanity Defense, 16 Mental & Physical Disability L. Rep. 266 (1992) (surveying legislative and judicial developments in insanity defense law; examining shifts in legal standards, including the narrowing of the irresistible impulse test and the exclusion of volitional impairments in some jurisdictions; and discussing due process concerns regarding competency evaluations and post-acquittal commitment of insanity acquittees); Carl Cohen, Criminal Responsibility and the Knowledge of Right and Wrong, 14 U. Mia. L. Rev. 30 (1959) (critiquing and describing the history of the *M'Naghten* Rules in insanity determinations); Federica Coppola, Motus Animi in Mente Insana: An Emotion-Oriented Paradigm of Legal Insanity Informed by the Neuroscience of Moral Judgments and Decision-Making, 109 J. Crim. L. & Criminology 1, 50 (2019) (proposing a neuroscience-based reform of the insanity defense that expands traditional cognitive and volitional prongs to include an emotional capacity test and advocating for a tripartite insanity standard that integrates cognitive, volitional, and emotional impairments as grounds for legal insanity); R.J. Gerber, Is the Insanity Test Insane?, 20 Am. J. Juris. 111, 119–31 (1975) (analyzing empirical data on how different insanity defense standards influence juror perceptions and verdicts and emphasizing inconsistencies in lay evaluations of legal insanity); Jerome Hall, Mental Disease and Criminal Responsibility, 45 Colum. L. Rev. 677, 695, 708–09 (1945) (analyzing the philosophical and legal foundations of the insanity defense and defending the *M'Naghten* Rules as grounded in traditional, commonsense psychology while critiquing the inconsistencies in psychiatric challenges to legal standards of responsibility); Stephen J. Morse, Diminished Rationality, Diminished Responsibility, 1 Ohio St. J. Crim. L. 289, 299–301 (2003) (proposing a partial responsibility doctrine that takes into account degrees of diminished responsibility and advocating for a "Guilty But Partially Responsible" verdict to achieve more proportional justice in criminal law (internal quotation marks omitted)); James R.P. Ogloff, A Comparison of Insanity Defense Standards on Juror Decision Making, 15 L. & Hum. Behav. 509, 522–26 (1991) (empirically evaluating how different insanity defense standards influence juror decisionmaking, finding that jurors struggle to comprehend legal insanity instructions and rely more on their own perceptions of mental illness and culpability than on formal legal standards); Walter Sinnott-Armstrong & Ken Levy, Insanity Defenses, *in* The Oxford Handbook of Philosophy of Criminal Law 299 (John Deigh & David Dolinko eds., 2011) (providing a comprehensive philosophical analysis of the insanity defense, examining its historical development, legal justifications, and moral underpinnings, while critiquing both retributive and consequentialist objections to excusing mentally ill offenders from full criminal responsibility); Laura Reider, Comment, Toward a New Test for the Insanity Defense: Incorporating the Discoveries of Neuroscience Into Moral and Legal Theories, 46 UCLA L. Rev. 289 (1998) (arguing for a neuroscience-informed reform of the insanity defense, contending that traditional tests inadequately account for the role of impaired emotional processing and moral reasoning in criminal responsibility, and proposing a broader standard that incorporates empirical findings on brain function and decisionmaking).

defendants from criminal liability. Despite the popular fascination with the insanity defense, it is invoked far less often than one might expect, in fewer than 1% of cases.[77] By contrast, public defenders express concerns

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For the literature on competency, see generally Henry J. Steadman, Beating a Rap?: Defendants Found Incompetent to Stand Trial (1979) (filling in the profile of defendants found incompetent to stand trial); Bonnie, A Theoretical Reformulation, supra note 4, at 291–316 (proposing a two-part framework for criminal competency by distinguishing between "competence to assist counsel" and "decisional competence," arguing that current legal standards conflate these distinct constructs, and advocating for competency evaluations that consider the specific cognitive and decisional demands of each stage of criminal proceedings); Alison J. Lynch & Michael L. Perlin, "I See What Is Right and Approve, but I Do What Is Wrong": Psychopathy and Punishment in the Context of Racial Bias in the Age of Neuroimaging, 25 Lewis & Clark L. Rev. 453 (2021) (examining the legal and psychological distinctions between psychopathy and ASPD; critiquing the use of psychopathy labels in federal sentencing as reinforcing racial bias; and exploring how neuroimaging research challenges assumptions about psychopathy, punishment, and recidivism in criminal justice policy); Robert A. Nicholson & Karen E. Kugler, Competent and Incompetent Criminal Defendants: A Quantitative Review of Comparative Research, 109 Psych. Bull. 355 (1991) (conducting a meta-analysis of thirty studies comparing competent and incompetent criminal defendants; identifying key predictors of incompetency, including poor performance on forensic competency tests, psychotic diagnoses, and severe psychiatric symptoms; and highlighting potential biases in competency determinations based on demographic and legal history factors); Michael L. Perlin, Beyond *Dusky* and *Godinez*: Competency Before and After Trial, 21 Behav. Scis. & L. 297, 300–09 (2003) (critiquing the narrow application of competency standards in criminal proceedings; arguing that competency determinations should extend beyond trial participation to include pretrial, sentencing, appeal, and post-conviction processes; and highlighting due process concerns arising from inconsistent judicial treatment of mentally ill defendants across different procedural stages); Gianni Pirelli, William H. Gottdiener & Patricia A. Zapf, A Meta-Analytic Review of Competency to Stand Trial Research, 17 Psych. Pub. Pol'y & L. 1 (2011) (conducting a comprehensive meta-analysis of sixty-eight studies spanning four decades and examining demographic, psychiatric, and psycho-legal factors distinguishing competent from incompetent defendants); Christopher Slobogin, Mental Illness and Self-Representation: *Faretta*, *Godinez* and *Edwards*, 7 Ohio St. J. Crim. L. 391, 391–93, 399–402, 406–10 (2009) [hereinafter Slobogin, Mental Illness and Self-Representation] (arguing that Indiana v. Edwards, 55 U.S. 164 (2008), improperly limited defendants' autonomy by allowing courts to deny self-representation even when defendants are competent to stand trial and proposing a competency standard that differentiates between adjudicative and decisional competence to ensure fair trial rights for defendants with psychiatric disabilities); Patricia A. Zapf & Ronald Roesch, Future Directions in the Restoration of Competency to Stand Trial, 20 Current Directions Psych. Sci. 43, 43–47 (2011) (reviewing research on competency restoration, identifying key predictors of restorability, critiquing the effectiveness of existing treatment programs, and advocating for competency restoration approaches tailored to specific psychiatric and cognitive deficits rather than broad diagnostic categories); Patricia A. Zapf, Tina M. Zottoli & Gianni Pirelli, Insanity in the Courtroom: Issues of Criminal Responsibility and Competency to Stand Trial, *in* 2 Psychology in the Courtroom 79, 89–95 (Daniel A. Krauss & Joel D. Lieberman eds., 2009) (overviewing doctrine, history, and literature related to the competency to stand trial); Stork, supra note 22, at 927–69 (describing how federal courts treat PDs in CST proceedings).

77. Henry J. Steadman, Margaret A. McGreevy, Joseph P. Morrissey, Lisa A. Callahan, Pamela Clark Robbins & Carmen Cirincione, Before and After *Hinckley*: Evaluating Insanity Defense Reform 149–51 (1993) (reporting results from a four-state study over a ten-year period and finding that the defense was raised in 0.9% of cases).

about clients' competency in 10% to 15% of cases.[78] Competency assessments are a central feature of criminal litigation in a way that insanity is not. With a few notable exceptions, existing legal scholarship has not engaged in a granular critique of CST proceedings.[79] This Essay aims to do just that, while offering constructive guidelines for reform.

To make its critique, this Essay dives into the disciplines of psychology and psychiatry—and their constructions of disease and ability—to assess forensic practices on their own terms. Psychology and psychiatry are fields of knowledge oriented toward understanding and treating what they discern to be mental diseases.[80] But the term "disease" is an awkward fit for neurodivergence. As a general matter, when a branch of medicine labels something an "illness" or "disease," this involves identifying an undesirable "cluster of characteristics" that has a rational explanation and an expected course.[81] Furthermore, to label something an illness is to root the problem in the individual's biology rather than powerful social forces that often determine health. Psychiatric diagnoses trouble these biomedical definitions of disease—none more so than PDs, in part because their biological origins are uncertain.[82] These disciplinary uncertainties seep into CST determinations too.

One problem with embracing psychology and psychiatry's framework is that these fields of knowledge describe certain differences as abnormal, disordered, and ill, whereas the disability justice movement rejects such

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78. See Melton et al., supra note 42, at 193 ("Surveys of public defenders indicate that defense lawyers have concerns about their clients' competence in between 10 and 15% of their cases."); Wik et al., supra note 7, at 43 (showing a national average of over two hundred patients per state in state psychiatric hospitals institutionalized for being incompetent to stand trial in 2014).

79. Cf. Perlin, Hidden Prejudice, supra note 29, at 205–08 (discussing general public disinterest in CST proceedings, despite their broad implications).

80. See DSM-5-TR, supra note 15, at 21 ("The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of mental disorders as part of a case formulation assessment that leads to an informed treatment plan for each individual."); About APA, Am. Psych. Ass'n, https://www.apa.org/about [https://perma.cc/9SRY-X3N5] (last visited Feb. 21, 2025) ("Psychologists study both normal and abnormal functioning and treat patients with mental and emotional problems."); What Is Psychiatry?, Am. Psychiatric Ass'n, https://www.psychiatry.org/patients-families/what-is-psychiatry [https://perma.cc/G8QM-NQZW] (last visited Feb. 21, 2025) ("Psychiatry is the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders.").

81. Bursten, supra note 26, at 5, 27; see also W. Miller Brown, On Defining 'Disease', 10 J. Med. & Phil. 311, 312 (1985) (describing the prominent view that "disease may be an impairment, i.e., deviation from the normal structural or functional integrity of the body, organ-system, or biosynthetic process").

82. See Robert F. Krueger, Continuity of Axes I and II: Toward a Unified Model of Personality, Personality Disorders, and Clinical Disorders, 19 J. Personality Disorders 233, 245–47 (2005) ("[G]enetic influences do not provide the entire story with respect to the etiology of psychopathology."); G. E. Partridge, Current Conceptions of Psychopathic Personality, 87 Am. J. Psychiatry 53, 64 (1930) (describing Robert Gaupp's view that "[t]he psychopathic is something that lies between mental normality and mental disease, which is not dependent upon a purely physical condition").

discourse as ableist and dehumanizing.[83] This Essay will use the terms "disorder," "illness," "disease," "symptom," and "impairment," not because these are correct ways to frame neurocognitive difference, but because these are the terms that actors in CST proceedings use.

Critically, while experts in psychology and psychiatry approach their epistemic practices as scientific, this Essay underscores the underappreciated moral dimension of the knowledge they produce. Assembling a diagnostic typology, or nosology, involves discerning undesirable traits and abnormal conditions and identifying who deserves compassion and accommodation.[84] These normative endeavors require more than merely identifying statistical deviations in human experience.[85] Not all psychological differences establish a psychiatric diagnosis. Those cognizable psychiatric conditions are enshrined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)—the most recent edition of which is the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, Text Revision* (*DSM-5-TR*)—which serves as these disciplines' authoritative catalog.[86] This Essay relies on the *DSM-5-TR*'s categories of disorders, but it does not assume that these accurately capture a stable constellation of behaviors and experiences.

This Essay proceeds as follows. Part I traces the origins of the competency process, describes how it typically unfolds, and surveys the pertinent critiques of competency assessments. Part II examines the controversial status of PDs in psychology and psychiatry, as well as in public life. Part III presents the results of a national survey of CST proceedings, which reveal that examiners abide by a hierarchical scheme of diagnoses. Case law and examiners' testimony establish disability as something that is externally verifiable and primarily acts on a person's perception of reality. Part IV probes examiners' conclusions to expose the buried moral dimensions of their epistemic practices. It draws on moral philosophy to expose the parallels between examiners' reasoning in insanity and CST proceedings and, after enumerating the distinct concerns animating these different areas of law, it asserts that such consistency is undesirable. Part V

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83. See Sins Invalid, Skin, Tooth, and Bone: The Basis of Movement Is Our People 5, 19 (2d ed. 2019) (noting that the disability justice movement rejects that disabled individuals are "deviant or aberrant" and instead sees disabled individuals as "powerful, not despite the complexities of [their] bodies, but because of them").

84. See Bursten, supra note 26, at 27–28 (describing the definition of illness via the identification of an undesirable "cluster of characteristics").

85. See, e.g., Ron Amundson, Against Normal Function, 31 Stud. Hist. & Phil. Biological & Biomedical Scis. 33, 52 (2000) ("[V]ersions of biological determinism have buttressed racist and sexist doctrines. Celebrated for their scientific objectivity, they had little objective biological foundation. Their plausibility was enhanced by their congruence with the social prejudices of their time.").

86. See Katia Romelli, Alessandra Frigerio & Monica Colombo, DSM Over Time: From Legitimisation of Authority to Hegemony, 11 BioSoc'ys 1, 12, 17 (2016) ("[T]he APA is positioning itself as the only legitimate actor that can establish the nature of valid knowledge in this domain.").

teases out the implications for reform, in and outside of court. This Essay concludes by suggesting that the study of CST proceedings should serve as a cautionary tale for ongoing efforts to address neurodivergence in criminal court.

I. AN OVERVIEW OF COMPETENCY PROCEEDINGS

This Part identifies the doctrinal foundations for CST proceedings, summarizes current research on how these proceedings tend to unfold in courts across the United States, and critically unpacks the assumptions about psychiatric disability that undergird the CST framework.

Deemed necessary to realize due process and Sixth Amendment protections, CST proceedings certify that the accused can contribute to their defense and is in the mental state to be held accountable.[87] A finding of incompetence denotes that the accused's disability prevents meaningful participation.[88] If a person is found incompetent, the proceedings are suspended or dismissed.[89] If the prosecution is suspended, the person is sent for restoration.[90] During restoration, the accused undergoes treatment.[91] In some jurisdictions, they attend classes to learn about the criminal legal process.[92] Although community-based restoration is gaining traction in some jurisdictions,[93] the default is that the accused is institutionalized in a state hospital and placed under carceral supervision,[94]

87. See Note, Incompetency to Stand Trial, 81 Harv. L. Rev. 454, 454–55 (1967) [hereinafter Note, Incompetency to Stand Trial] ("[T]he Supreme Court has held that where the circumstances at trial create doubt about the defendant's competency, due process requires a hearing on the issue.").

88. See id. at 454 ("The question of competency to stand trial relates rather to the appropriateness of conducting the criminal proceeding in light of the defendant's present inability to participate effectively.").

89. See, e.g., N.Y. Crim. Proc. Law § 730.40 (McKinney 2025) (providing for dismissal of the criminal case if the defendant is found unfit on a misdemeanor charge in local criminal court but pausing the proceedings in felony cases).

90. See Melton et al., supra note 42, at 187 ("If the criminal proceeding is not short-circuited through an arrangement of this type, the court often orders the defendant to a public-sector psychiatric hospital for treatment to restore competence.").

91. Id.

92. See Hallie Fader-Towe & Ethan Kelly, Council of State Gov'ts Just. Ctr., Just and Well: Rethinking How States Approach Competency to Stand Trial 1 (2020), https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf [https://perma.cc/5C9V-9CD3] (noting that some restorative processes focus on "legal education").

93. See *Trueblood et al v. Washington State DSHS*, Wash. St. Dep't Soc. & Health Servs., https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs [https://perma.cc/9HQV-4FXT] (last visited Aug. 4, 2025) (discussing the Department's responsibilities to provide competency evaluation services and restoration services).

94. See Wik et al., supra note 7, at 29 (reporting that twenty-three of thirty-seven states surveyed indicated that "their state psychiatric hospitals accepted both misdemeanants and felons for those evaluations").

where they may be forcibly medicated.[95] As of 2014, 58% of people in state hospitals were forensic patients, referred there by the criminal legal system.[96] Of those forensic patients, the largest proportion are restoration cases.[97] In some jurisdictions, if the person is charged with a misdemeanor and found unfit, the case is dismissed.[98] Today, some jurisdictions are witnessing a sudden increase in requests for competency assessments and a parallel surge in institutionalizations.[99] In Alabama and Georgia, for example, defendants face seemingly endless delays as they wait to be assessed.[100] This current institutional crisis is layered on top of more enduring problems that scholars have criticized: the Supreme Court's unsatisfactory legal guidance, trial courts' abdication of adjud-icative responsibility, and forensic practitioners' erratic practices.[101]

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95. See, e.g., Sell v. United States, 539 U.S. 166, 179 (2003) ("[I]n principle, forced medication in order to render a defendant competent to stand trial for murder was constitutionally permissible.").

96. W. Neil Gowensmith, Resolution or Resignation: The Role of Forensic Mental Health Professionals Amidst the Competency Services Crisis, 25 Psych. Pub. Pol'y & L. 1, 2 (2019).

97. Id.

98. See, e.g., N.Y. Crim. Proc. Law § 730.40 (McKinney 2025).

99. See, e.g., Trueblood v. Wash. State Dep't of Soc. & Health Servs., 101 F. Supp. 3d 1010, 1016, 1023 (W.D. Wash. 2015) (finding that Washington's delays in evaluation and restoration of CST were unconstitutional because the state did not have sufficient capacity to keep up with the 82% increase in competency evaluations between 2001 and 2011), vacated, 822 F.3d 1037 (9th Cir. 2021); Gowensmith, supra note 96, at 2, 4 (discussing the national increase in CST evaluations).

100. See Mike Cason, Alabama Agrees to Speedier Mental Health Evaluations in Jails, AL.com (Jan. 26, 2018), https://www.al.com/news/2018/01/alabama_agrees_to_speedier_men.html [https://perma.cc/HS39-TG3K] (finding that "the state [of Alabama] failed to follow the Due Process Clause of the 14th Amendment because people were forced to wait up to nine months for evaluation and treatment after orders by a judge"); Andy Miller & Rebecca Grapevine, Long Wait for Justice: People in Jail Face Delays for Mental Health Care Before They Can Stand Trial, The Current (June 11, 2022), https://thecurrentga.org/2022/06/11/long-wait-for-justice-people-in-jail-face-delays-for-mental-health-care-before-they-can-stand-trial/ [https://perma.cc/22Z7-79PE] ("In Georgia . . . [m]ore than 900 [people] are waiting for just the first step in the process, a 'forensic evaluation.'"); see also Nathaniel P. Morris & Jacob M. Izenberg, Hidden Behind Bars—The Public Health Implications of Incompetency to Stand Trial, 389 NEJM 2314, 2315 (2023) ("In many states, hospital-admission wait lists for competency restoration have swelled to hundreds or thousands of defendants; at least a dozen states have faced litigation over these delays. We believe these backlogs represent a public health crisis . . . ." (footnotes omitted)).

101. See Richard Schwerner, State Just. Inst., Competence to Stand Trial 1 (2020), https://documents.ncsl.org/wwwncsl/Summit/2023/Session-Resources/Competence_to_Stand_Trial_Interim_Final.pdf [https://perma.cc/6XPK-YAE4] ("[D]efendants are often held involuntarily, or committed, either in jail or in a locked treatment facility . . . for periods of time that bear no rational or proportionate relationship to the nature of the offense they are alleged to have committed . . . or to their clinical needs."); Amanda Beltrani & Patricia A. Zapf, Competence to Stand Trial and Criminalization: An Overview of the Research, 25 CNS Spectrums 161, 169 (2020) (noting the shortcomings of approaches to mental health in the criminal legal system); Bonnie, A Theoretical Reformulation, supra note 4, at 293 ("The items listed in the most widely used protocols [for incompetency

A. Dusky *and Its Progeny*

The Court in *Dusky* declined to adopt a competency standard that required only that the defendant be oriented to time and place and have some recollection of events.[102] Instead, the standard asks courts to assess the capacities for participation. Subsequently, in *Drope*, the Court modified the standard: "[A] person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."[103] *Drope* enhances the *Dusky* standard by focusing on the accused person's capacity to assist, rather than simply consult with, their attorney. The federal statutory standard introduces another element, specifying that incompetence must stem from a "mental disease or defect."[104] State legislators and state courts have adapted their standards to approximate the federal constitutional standard.[105] In

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determination] have . . . not been derived either from a theory of competence or from empirical study of the difficulties encountered by attorneys representing defendants with mental disabilities."); Lisa Callahan & Debra A. Pinals, Challenges to Reforming the Competence to Stand Trial and Competence Restoration System, 71 Psychiatric Servs. 691, 691 (2020) ("There is little debate among mental health and justice professionals that the system that manages both competence to stand trial (CST) evaluation and competence restoration (CR) processes in criminal cases is in crisis."); Michael L. Perlin, Pretexts and Mental Disability Law: The Case of Competency, 47 U. Mia. L. Rev. 625, 653–54 (1993) [hereinafter Perlin, Pretexts and Mental Disability Law] ("Because of the ambiguities of the Supreme Court's test and the difficulties experienced in applying these standards . . . [t]he ultimate legal decision as to competence often has thus fallen, perhaps by default, to the examiner."); Winick, Reforming Incompetency to Stand Trial and Plead Guilty, supra note 44, at 572 (stating that the Supreme Court "has not examined the premises underlying the incompetency doctrine or the need for broad reform in [the] area"); Bruce J. Winick, Restructuring Competency to Stand Trial, 32 UCLA L. Rev. 921, 926 (1985) ("The lack of empirical studies in this area prevents our understanding the true costs imposed by the competency doctrine—the fiscal and administrative costs borne by society . . . and the severe burdens the doctrine places on mentally ill defendants."); Zapf et al., Have the Courts Abdicated?, supra note 34, at 30 ("[J]udges seldom disagree with mental health professionals about a defendant's competency . . . [but] research has indicated that the factors most related to clinical findings of incompetence were poor performance on psychological tests that specifically evaluate competence-related skills, psychotic disorders, and severe symptoms of psychopathology." (citations omitted)).

102. See Dusky v. United States, 362 U.S. 402, 402 (1960) (per curiam) (agreeing with "the suggestion of the Solicitor General that it is not enough for the district judge to find that 'the defendant [is] oriented to time and place and [has] some recollection of events'" (alterations in original) (quoting J. Lee Rankin, U.S. Solic. Gen.)).

103. 420 U.S. 162, 171 (1975).

104. 18 U.S.C. § 4241(a) (2018).

105. See, e.g., La. Code Crim. Proc. Ann. art. 641 (2025) ("Mental incapacity to proceed exists when, as a result of mental disease or defect, a defendant presently lacks the capacity to understand the proceedings against him or to assist in his defense."); N.Y. Crim. Proc. Law § 730.10(1) (McKinney 2025) ("'Incapacitated person' means a defendant who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense."); 1 LaFave, supra note 7, § 8.1(a) n.13 ("Most States have a statutory test at least approximating the *Dusky* test just quoted, although many in addition specify the kind of condition that must be the source of the incompetency . . . .").

practice, notwithstanding discrepancies in legislation and case law, states use the *Dusky–Drope* and statutory standards interchangeably.[106]

The *Dusky–Drope* test contains three key elements: (1) Does the accused lack the capacity to understand the proceedings against them?; (2) does the accused lack the capacity to consult with their attorney?; and (3) are these impairments the product of a mental disability? The first element focuses on the accused's cognitive capacities to make sense of their prosecution. The second envisions the possibility of a functional relationship between the attorney and defendant. The third focuses on attribution.

In *Drope*, the Supreme Court suggested the standard emerges out of the accused's right to be present at their prosecution "as a by-product of the ban against trials in absentia; the mentally incompetent defendant, though physically present in the courtroom, is in reality afforded no opportunity to defend himself."[107] The Court noted that the prohibition against prosecuting someone who is incompetent is "fundamental to an adversary system of justice."[108] Commentators have argued that competency enhances both the fairness and the accuracy of proceedings by ensuring defendants' participation and meaningful adversarial testing.[109] Professor Richard J. Bonnie explains that CST proceedings enhance the reliability of the process and respect the dignity of the accused.[110] To

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106. See Douglas Mossman et al., AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial, 35 J. Am. Acad. Psychiatry & L. S3, S59–67 & tbl.3 (2007) (surveying state and federal statutes); Stork, supra note 22, at 931 ("Courts and legal scholars have treated [the *Dusky* and the statutory] standards as if they are essentially interchangeable."). Further research would determine whether there are grounds to interpret state standards more expansively than the constitutional *Dusky* standard. See United States v. Mitchell, 706 F. Supp. 2d 1148, 1154 n.4 (D. Utah 2010) (discussing the difference between the Utah and federal competency standards).

107. *Drope*, 420 U.S. at 171 (emphasis omitted) (internal quotation marks omitted) (quoting Caleb Foote, A Comment on Pre-Trial Commitment of Criminal Defendants, 108 U. Pa. L. Rev. 832, 834 (1960)).

108. Id. at 172. The Supreme Court in *Faretta v. California* also noted:

> [T]he Confrontation Clause of the Sixth Amendment gives the accused a right to be present at all stages of the proceedings where fundamental fairness might be thwarted by his absence. This right to "presence" was based upon the premise that the "defense may be made easier if the accused is permitted to be present at the examination of jurors or the summing up of counsel, for it will be in his power, if present, to give advice or suggestion or even to supersede his lawyers altogether and conduct the trial himself."

422 U.S. 806, 816 (1975) (emphasis omitted) (quoting Snyder v. Massachusetts, 291 U.S. 97, 106 (1934)).

109. See Note, Incompetency to Stand Trial, supra note 87, at 458 ("The adversary form of the criminal proceeding necessarily rests on the assumption that defendant will be a conscious and intelligent participant; the trial of a defendant who cannot fulfill this expectation appears inappropriate and irrational.").

110. Christopher Slobogin, Minding Justice: Laws that Deprive People With Mental Disability of Life and Liberty 192 (2006).

prosecute an individual who is incompetent, Bonnie argues, "offends the moral dignity of the process because it treats the defendant not as an accountable person, but as an object of the state's effort to carry out its promises."[111]

To "jealously guard[]" the right to a fair trial and the promise of due process of law, the Supreme Court has asked trial courts to inquire if there were doubts about the accused person's capacities.[112] The law presumes that people accused of crimes are competent.[113] Generally, defense counsel can raise the issue of competency or the court can do so sua sponte.[114] Due process dictates that the person accused and their lawyer have "a reasonable opportunity to demonstrate" incompetency.[115] Defendants are expected to establish their incompetency by a preponderance of the evidence,[116] but a heavier standard of proof would violate due process.[117]

More recent Supreme Court decisions have underscored that the *Dusky–Drope* doctrine sets minimal standards for capacities. In *Godinez v. Moran*, the Rehnquist Court considered a capital case in which the defendant wanted to waive counsel and go to trial pro se.[118] The Court rejected the Ninth Circuit's attempt to create a higher competency threshold for when a person wants to proceed to trial without an attorney.[119] Rejecting that rule, the Supreme Court also clarified that

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111. Id. (internal quotation marks omitted) (quoting Richard J. Bonnie, The Competence of Criminal Defendants: Beyond *Dusky* and *Drope*, 47 U. Mia. L. Rev. 539, 551 (1993)).

112. Pate v. Robinson, 383 U.S. 375, 385 (1966).

113. See Medina v. California, 505 U.S. 437, 440 (1992) (stating that California's penal code presumes that a defendant is competent to stand trial unless the defendant proves otherwise). The federal courts of appeals disagree about which party carries the burden of proving competency or incompetency. Compare United States v. Robinson, 404 F.3d 850, 856 (4th Cir. 2005) (placing the burden on the defendant), and United States v. Smith, 521 F.2d 374, 377 (10th Cir. 1975) (same), with United States v. Frank, 956 F.2d 872, 875 (9th Cir. 1992) (placing the burden on the prosecution), United States v. Velasquez, 885 F.2d 1076, 1089 (3d Cir. 1989) (same), and United States v. Hutson, 821 F.2d 1015, 1018 (5th Cir. 1987) (same).

114. See *Drope*, 420 U.S. at 164 ("[Defendant] filed a motion for a continuance . . . [so that he] might be examined and receive psychiatric treatment."); Yang v. United States, 114 F.4th 899, 907 (7th Cir. 2024) ("Congress has provided the district courts with the authority—in conjunction with and independent of the parties—to sua sponte raise the issue of competency . . . .").

115. *Medina*, 505 U.S. at 451.

116. Id. at 441 (stating that the trial judge instructed the jury that the defendant had to prove his incompetence "by a preponderance of the evidence" (internal quotation marks omitted) (quoting App. at 87)).

117. Cooper v. Oklahoma, 517 U.S. 348, 369 (1996) ("The *prohibition* against requiring the criminal defendant to demonstrate incompetence by clear and convincing evidence safeguards the fundamental right not to stand trial while incompetent.").

118. 509 U.S. 389, 392 (1993).

119. Id. at 402. In a later case, *Indiana v. Edwards*, the Supreme Court allowed a trial court to deny a defendant the right to represent himself at trial on competency grounds. 554 U.S. 164, 177–78 (2008). It did not, however, create a different federal constitutional

competency is a "modest" aim: "While psychiatrists and scholars may find it useful to classify the various kinds and degrees of competence, and while States are free to adopt competency standards that are more elaborate than the [*Dusky–Drope*] formulation, the Due Process Clause does not impose these additional requirements."[120] As a result, when a trial court evaluates a defendant for competency, the federal constitutional standard is the same whether the person is representing themselves or proceeding with an attorney, going to trial, or taking a plea.[121]

Defense advocates and scholars have frequently commented on and challenged the low bar for competency that state-appointed experts apply and courts enforce.[122] Scholars have argued in favor of raising the threshold for competency and have elaborated on the specific competencies that courts ought to assess.[123] Bonnie has argued that competence implies two elements: "[A] foundational concept of competence to assist counsel, and a contextualized concept of decisional competence."[124] Distinct from being able to collaborate with one's attorney, "Decisional competence refers to the additional abilities required for legally valid decisionmaking."[125] Bonnie also argues the test should vary according to the circumstances, something the Supreme Court specifically rejected.[126] Professor Christopher Slobogin argues for a single standard that involves two inquiries: first, "whether the defendant gives non-delusional reasons for the decision," and second, whether the defendant shows a "willingness

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standard for proceeding to trial pro se than in other situations. Id. at 178. The holding in *Godinez*, therefore, still stands. While courts are permitted to require a greater show of competency from defendants seeking to proceed to trial pro se, there is no federal constitutional standard requiring as much. Id.

120. *Godinez*, 509 U.S. at 402; see also United States v. Brown, 669 F.3d 10, 17 (1st Cir. 2012) ("The 'understanding' required is of the essentials—for example, the charges, basic procedure, possible defenses—but not of legal sophistication." (internal quotation marks omitted) (quoting Robidoux v. O'Brien, 643 F.3d 334, 339 (1st Cir. 2011))).

121. *Godinez*, 509 U.S. at 398 ("[W]e reject the notion that competence to plead guilty or to waive the right to counsel must be measured by a standard that is higher than (or even different from) the *Dusky* standard.").

122. See, e.g., Bonnie, A Theoretical Reformulation, supra note 4, at 297 ("The capacities required to assure the dignity of the process . . . seem to include the ability to understand the nature of wrongdoing and punishment and the purpose and effect of a criminal prosecution and conviction, together with the ability to relate this understanding to one's own situation as a defendant.").

123. See Jennifer L. Moore & Katherine Ramsland, Competence Assessment, Diverse Abilities, and a Pro Se Standard, 39 J. Psychiatry & L. 297, 309–10, 312–13 (2011) (arguing that *Indiana v. Edwards* was too vague about the "'basic tasks' needed to represent oneself" and the required levels of skill).

124. Richard J. Bonnie, The Competence of Criminal Defendants: Beyond *Dusky* and *Drope*, 47 U. Mia. L. Rev. 539, 548 (1993).

125. Id.

126. Id.

to exercise the autonomy one has, which can usually be demonstrated by a willingness to consider alternative scenarios."[127]

Across areas of law dealing with mental health, courts and examiners have incorporated what could be called a "product test."[128] They have done the same with the *Dusky–Drope* standard.[129] It requires fact finders to attribute the defendant's conduct to a mental disease or defect.[130] It essentially imposes a causation requirement.[131] Forensic experts, jurors, and judges are supposed to distinguish when conduct can be attributed to the disease and when it cannot. Courts and examiners must thus be convinced that any difficulties the defendant faces in meeting the *Dusky–Drope* standard are rooted in an identified mental or intellectual disability. As a result, much of the litigation this Essay discusses in Part III revolves around whether the defendants' difficulties are rooted in mental disability and which difficulties amount to a mental disability. Attorney Emily Stork has argued against the inclusion of "mental disease or defect" in the CST standard because "it invites unnecessary line-drawing and battles of the experts."[132]

The product test can be traced to the insanity standard enunciated in *Durham v. United States*.[133] The *Durham* standard allowed the jury to pronounce the defendant not criminally responsible "if his unlawful act was the product of mental disease or mental defect."[134] The test posits an artificial division in the human mind between the normal and abnormal parts.[135] If an action is consistent with the clusters of characteristics or symptoms that define the diagnosis, it lies outside of the accused's control and reflects their impairment.[136] In practice, courts have noted that jurors

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127. Slobogin, Mental Illness and Self-Representation, supra note 76, at 402.

128. See Bursten, supra note 26, at 5 (discussing the proliferation of the product test across areas of law touching upon mental health).

129. See infra Part III.

130. See Bursten, supra note 26, at 4 ("Many of the practical decisions that professionals have to make rest on whether a particular behavior is a *product of mental illness*.").

131. See Carter v. United States, 252 F.2d 608, 616 (D.C. Cir. 1957) ("There must be a relationship between the disease and the criminal act; and the relationship must be such as to justify a reasonable inference that the act would not have been committed if the person had not been suffering from the disease.").

132. Stork, supra note 22, at 957.

133. See Bursten, supra note 26, at 5 ("[*P*]*roduct of mental illness* and the concept it stands for is referred to as the *Durham* standard.").

134. Durham v. United States, 214 F.2d 862, 874–75 (D.C. Cir. 1954).

135. See Bursten, supra note 26, at 55 (differentiating between "the sick and the healthy parts" of someone that can influence behavior); Joshua Dressler & Stephen P. Garvey, Criminal Law: Cases and Materials 656 (9th ed. 2022) (underscoring that the success of an insanity defense lies in being able to establish that the defendant's criminal behavior is the product of their mental abnormality).

136. See Bursten, supra note 26, at 55 (discussing the difficulty of determining behaviors considered to be the product of mental illness and those that are not).

struggle to apply the test.[137] In both the insanity and competency contexts, courts have tended to allow experts to explain attribution.[138] As this Essay discusses, courts have tended to defer to forensic experts regarding all elements of competency tests.[139] But professional best practice insists that forensic examiners refrain from concluding on any ultimate issue, such as competency or insanity.[140] Similarly, Rule 704 of the Federal Rules of Evidence forbids experts in criminal cases from opining on the defendant's mental state as an element of either the offense charged or a possible defense, which includes competency.[141]

Although the Supreme Court has not specified how competency ought to be assessed, in practice, trial courts have enlisted forensic experts—psychologists, psychiatrists, and clinical social workers—to assist in their determinations.[142] These court-employed experts are tasked with conducting examinations and filing reports with the court.[143] But the law does not prescribe any parameters for that examination. In response to the *Dusky–Drope* standard, and its subsequent refinements in case law, researchers have developed screening instruments, questionnaires, and tests to assist forensic examiners.[144] Examiners can use any number of instruments to ascertain the accused's fitness to stand trial.[145] None are constitutionally mandated.[146]

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137. See, e.g., State v. Johnson, 399 A.2d 469, 474 (R.I. 1979) ("[T]he elusive, undefined concept of productivity . . . gave the jury inadequate guidance."(citing United States v. Freeman, 357 F.2d 606, 621 (2d Cir. 1966))).

138. See infra section III.C.

139. See infra notes 206–213 and accompanying text.

140. See Melton et al., supra note 42, at 40 ("Mental health professionals should be neither permitted nor cajoled to give opinions on the ultimate legal issue . . . .").

141. See Fed. R. Evid. 704(b) ("In a criminal case, an expert witness must not state an opinion about whether the defendant did or did not have a mental state or condition that constitutes an element of the crime charged or of a defense."); see also United States v. Eff, 524 F.3d 712, 716 (5th Cir. 2008) ("An expert is thus prohibited from testifying that a severe mental disease or defect does or does not prevent a defendant from appreciating the nature and quality or wrongfulness of his acts." (citing United States v. Dixon, 185 F.3d 393, 400 (5th Cir. 1999))). But see United States v. Levine, 80 F.3d 129, 134–35 (5th Cir. 1996) (finding that an expert can testify to the similarity of the facts in the present case and of a hypothetical manic person).

142. Mossman et al., supra note 106, at S8–S9 (highlighting cases in which forensic experts were called in to testify and provide clarity).

143. See id. at S14 (discussing a case in which the trial court had appointed a physician to conduct an examination and file a report).

144. Melton et al., supra note 42, at 198–209 (outlining various screening tools and tests that examiners use to ascertain competency).

145. See id. at 209 (noting that a review of current tools "reveals a variety of approaches").

146. Professor Deborah Denno suggests that, in the federal system, "some courts appear more willing to rely on so-called 'objective tests,' rather than an expert's testimony interpreting test results." Deborah W. Denno, How Prosecutors and Defense Attorneys Differ in Their Use of Neuroscience Evidence, 85 Fordham L. Rev. 453, 471 (2016) [hereinafter Denno, Prosecutors and Defense Attorneys].

B. *The Disability Justice Movement's Critiques of Competency*

As a standard that is ostensibly aimed at protecting neurodivergent defendants, the *Dusky–Drope* framework has few friends in the disability justice movement. This section discusses the CST framework's conceptual and practical flaws. Namely, the *Dusky–Drope* standard embraces a disability rights framework that relies on a biomedical model of disability, which mobilizes sanist conceptions about disability and metes out degrading treatment. In broad terms, there are two sets of axes that distinguish various current efforts to address ableist oppression: disability justice versus disability rights and the social model versus the biomedical model of disability. On the first axis, the disability rights movement is a single-issue agenda for social change that affords legal recognition to ability-based discrimination.[147] The passage of the Americans with Disabilities Act (ADA) in 1990[148] was one of the movement's crowning achievements. The ADA mandates private and public actors to make reasonable accommodations for individuals with disabilities.[149] Failure to offer those accommodations amounts to discrimination. The ADA also encodes a strong presumption against institutionalization.[150] It considers the isolation and segregation of individuals with disabilities to be "a serious and pervasive social problem."[151] Public health providers are instead ordered to administer services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[152]

Rights and legal process serve as central engines for social reform in the disability rights framework.[153] The hope is that if individuals with disabilities obtain the legal means to combat their exclusion, litigation will compel institutional reform.[154] But the ADA and its antidiscrimination

147. See Mia Mingus, Changing the Framework: Disability Justice, Leaving Evidence (Feb. 12, 2011), https://leavingevidence.wordpress.com/2011/02/12/changing-the-framework-disability-justice/ [https://perma.cc/X9XE-N628].

148. Americans with Disabilities Act of 1990, Pub. L. 101-336, 104 Stat. 327 (codified in scattered sections of 42 U.S.C. (2018)).

149. See Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 592 (1999) (noting that "[a]nother regulation requires public entities to 'make reasonable modifications' to avoid 'discrimination on the basis of disability'" (quoting 28 C.F.R. § 35.130(b)(7) (1998))).

150. See id. at 613 (Kennedy, J., concurring in the judgment) ("[U]nnecessary institutionalization may be the evidence or the result of the discrimination the ADA prohibits.").

151. 42 U.S.C. § 12101(a)(2).

152. 28 C.F.R. § 35.130(d) (2025).

153. See Marta Russell, What Disability Civil Rights Cannot Do, *in* Capitalism and Disability: Selected Writings by Marta Russell 62, 63 (Keith Rosenthal ed., 2019) ("[T]he [disability rights movement] has sought to alter the historical exclusion of disabled persons from the workforce through the establishment of individual legal rights and remedy . . . ."); see also Ruth Colker, The Reactive Model of Reasonable Accommodation, LPE Project: Blog (Oct. 11, 2022), https://lpeproject.org/blog/the-reactive-model-of-reasonable-accommodation/ [https://perma.cc/YFK2-S2HY] (noting what the disability rights movement cannot achieve, given its focus on the ADA and legal reform more generally).

154. See Russell, supra note 153, at 63 (noting that the ADA was "intended to end employer discrimination" by providing "disabled persons redress . . . in the courts").

framework are ill-equipped to deal with the stubborn material realities that shorten the lives and limit the educational achievements and incomes of individuals with disabilities.[155] In opposition, the disability justice movement cohered precisely to address the problems of the disability rights framework, which had "invisibilized the lives" of disabled individuals with intersectional identities.[156] The disability justice movement takes aim at the multiple systems of oppression that produce ableist and sanist supremacy.[157] It rejects formal legal equality as sufficient to guarantee the dignity and equality of individuals with disabilities.[158]

The CST standard embraces a disability rights framework. It grants a procedural accommodation in the hopes of levelling the playing field in criminal court. It expects to deliver some basic equality in criminal court between the state and the disabled defendant. In assuming mental disabilities are defects to be cured through restoration, the CST standard underestimates and overestimates the potential impacts of a mental disability.[159] What if disability under neoliberalism so diminishes life chances that it is impossible for any court to fairly judge an accused person who is disabled? What if court processes are fundamentally inaccessible to some neurodivergent defendants, in spite of restoration? Relatedly, the CST standard also ignores how criminalization itself can produce forms of disability.[160] Restoration is pointless if incarceration pending trial can cause disability. For these reasons, a disability justice perspective rejects the premise that rights in the criminal legal system can meaningfully address ableism, given the institution's persistent role in perpetuating it.[161]

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155. See Sins Invalid, supra note 83, at 15 (noting that the rights-based framework of the disability rights movement is not "appropriate for all situations"); see also Marta Russell & Ravi Malhotra, Introduction toCapitalism and Disability: Selected Writings by Marta Russell, supra note 153, at 1, 3 ("In the US . . . one third of disabled adults live in a household with an annual income of less than $15,000, while the 300 to 400 million living in developing countries have even less chance of employment and exist in abject poverty, usually with no social safety nets at all." (footnote omitted)).

156. Sins Invalid, supra note 83, at 15.

157. See id. at 18 ("Disability justice activists, organizers, and cultural workers understand that able-bodied supremacy has been formed in relation to other systems of domination and exploitation.").

158. See Colker, supra note 153 ("The primary problem [with the reasonable accommodation model] is its intense individual rights perspective.").

159. See Sins Invalid, supra note 83, at 52 (stating that the minds and bodies of people with disabilities "are not controllable and cannot always comply").

160. See Ben-Moshe, Decarcerating Disability, supra note 46, at 8 (discussing how the trauma, inhumane conditions, and lack of adequate medical care that often accompany incarceration can contribute to new or worsening disability); cf. id. at 10 (arguing that "demands for inclusion of people with disabilities in employment or education do not critique or change the system of exploitative racial capitalism or the settler ableist system of education but only expand it to fit more people").

161. See Adler-Bolton & Vierkant, supra note 67, at 14 (discussing Marta Russell's and Dean Spade's critiques of liberal, legalist reform strategies like the disability rights movement for "seek[ing] to expand rights within the framework of the courts, ignoring the fact that the resulting policies rarely shift the political economy of oppression"); see also

Disability justice activists have thus exposed the criminal legal system as one that disables individuals and entrenches ableist oppression.[162] The experience of jail, prisons, and prosecution triggers psychiatric distress and medical conditions,[163] and state agencies in the United States have historically used their punitive authority to eradicate, warehouse, and stigmatize neurodiversity and physical disability.[164] Thus, instead of focusing on CST proceedings or disability accommodations in criminal court, disability justice groups have placed the abolition of the prison industrial complex at the center of their demands.[165]

A second axis in this field of advocacy and analysis separates the social model from the biomedical model of disability. The biomedical model attributes psychiatric disability to biological and physiological processes—like chemical imbalances in the brain.[166] Because of its etiological claims, the biological model tends to account for the disadvantages associated with disability as natural and inevitable consequences of aberrations from the biophysiological norm.[167] At its worst, a biomedical vision of disability reduces disability to a sort of "personal tragedy which the individual must

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Ware et al., supra note 11, at 163 ("Because of the ways that prisons are constructed, imagined, and maintained, rampant ableism and racism affect the daily lives of many prisoners.").

162. See Ben-Moshe, Decarcerating Disability, supra note 46, at 8–9 ("[T]he prison environment itself is disabling so that even if an individual enters prison without a disability or mental health diagnosis, she is likely to get one . . . .").

163. See id. at 7–9 (explaining the disabling effects of the prison environment for both those who enter with preexisting disabilities and those who do not); Marta Russell & Jean Stewart, Disablement, Prison, and Historical Segregation**,** *in* Capitalism and Disability: Selected Writings by Marta Russell, supra note 153, at 86, 86–96 (exploring the connection between incarceration and disablement).

164. See Laura I. Appleman, Deviancy, Dependency, and Disability: The Forgotten History of Eugenics and Mass Incarceration, 68 Duke L.J. 417, 436–37 (2018) (arguing that the history of eugenics, also known as the "science of good breeding," which emerged in the Progressive Era as a means to "control those citizens with mental illness and physical and cognitive disabilities," is intertwined with the "history of the carceral state"(internal quotation marks omitted)); Jamelia N. Morgan, Rethinking Disorderly Conduct, 109 Calif. L. Rev. 1637, 1670–76 (2021) (demonstrating how disorderly conduct statutes have been used to police and punish individuals for their physical and mental disabilities).

165. In a campaign to oppose a police training program in Oakland, California, the disability justice organization Sins Invalid reasoned that "[i]ncreased militarization of the police leads directly to increased police violence, particularly against disabled people of color." Sins Invalid, supra note 83, at 52. Sins Invalid's opposition, however, is not simply predicated on the harms that policing poses to individuals who are disabled. Rather, because it adopts an intersectional approach that does not value one identity category over another but instead embodies a "cross-movement solidarity" approach, it posits that disability justice is not only concerned with ableist oppression but also with racial justice, an anti-capitalist future, and environmental justice. Id. at 23–24.

166. See Chloé Deambrogio, Judging Insanity, Punishing Difference: A History of Mental Illness in the Criminal Court 26–30 (2024) (discussing the various ways twentieth-century psychiatrists pointed to "human biology" to explain mental illnesses).

167. See Amundson, supra note 85, at 51 (critiquing the biomedical model's view that "the disadvantages of disabled people result from their own abnormality").

overcome."[168] Attributing psychiatric disability to biology can also reduce sympathy toward individuals with disabilities by stressing their perennial difference and by intimating their incorrigibility.[169] The biomedical model diminishes the human contributions to shaping the experience of disability.[170] Psychiatric disabilities fit awkwardly into the biomedical model because it is not possible to establish clear biophysical origins for all psychiatric diagnoses, a point to be revisited.[171]

By contrast, the social model of disability offers a different formulation.[172] As the Union of the Physically Impaired Against Segregation explained, "[D]isability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society."[173] The social model emphasizes the social forces that amplify differences in ability and convert those into political, social,

168. Russell & Malhotra, supra note 155, at 1; see also Mingus, supra note 147 ("Disability is framed as lacking, sad and undesirable: a shortcoming at best, a tragedy at worst.").

169. See Russell & Malhotra, supra note 155, at 4 (discussing how the biomedical model led to the segregation of "those who could not be cured"); see also Deambrogio, supra note 166, at 145–48 (discussing how the biological model worsened the "social stigma" surrounding individuals' conditions).

170. See Szasz, supra note 67, at 114 ("Mental illness . . . is then regarded as the *cause* of the human disharmony. It is implicit in this view that social intercourse between people is regarded as something *inherently harmonious*, its disturbance being due solely to the presence of 'mental illness' in many people.").

171. See Deambrogio, supra note 166, at 148 (decrying the "biological reductionism proposed by the new psychiatry movement"). The biomedical model of disability became dominant in mental health studies in the twenty-first century, alongside the ascendance of the *DSM* as the "universally and uncritically accepted . . . ultimate authority on psychopathology and diagnosis." Nancy C. Andreasen, *DSM* and the Death of Phenomenology in America: An Example of Unintended Consequences, 33 Schizophrenia Bull. 108, 111 (2007). Scholar Chloé Deambrogio argues that the biomedical model emerged to salvage psychiatry's reputation as a veritable medical discipline after it had been "relegated to a caregiving function" by other branches of medicine. Deambrogio, supra note 166, at 25. Biological explanations of insanity became popular because "[t]hey enhanced psychiatrists' professional status among the various branches of medicine, justified their claims for authority and expertise over mental disease, and supported their approach to criminal responsibility." Id. And although the *DSM* has formally integrated both "medical and psychosocial components of the clinical evaluation," scholars have alleged that, in practice, the *DSM* has sacrificed the psychosocial in favor of the biomedical. Id. at 146. The orthodox view of mental illness—the term favored by the *DSM*—is that it emerges from chemical imbalances, thus making medication critical to any treatment regime. Id. The *DSM* distilled symptoms to checklists to aid in diagnosis, but one result of this simplicity is that it "tended to privilege organic factors over sociopsychological ones." Id.; see also Andreasen, supra, at 110.

172. See Ben-Moshe, Decarcerating Disability, supra note 46, at 31 ("Disability studies offers the powerful idea of disability as empowering, enabling, productive, and political.").

173. Russell & Malhotra, supra note 155, at 1 (internal quotation marks omitted) (quoting Union of the Physically Impaired Against Segregation, Fundamental Principles of Disability 3 (1976)).

and economic disadvantages.[174] But both models of disability still embrace "the statistical construction of a biological 'normal,'" explains Kiera Lyons.[175] Professor Therí Alyce Pickens argues that even "[t]he social model privileges a particular kind of mental agility and cognitive processing to combat the stigma and material consequences that arise as a result of ableism. In turn, the model dismisses madness as a viable subject position . . . ."[176] That is, both the social and biomedical models endorse the distinction between the rational and irrational, the sane and mad, that express in a person's body, even if each offers distinct causal narratives.

The two sets of axes—justice versus rights, social versus biomedical—converge because the disability justice framework explicitly embraces a social model that attends to the production of disability.[177] The social model rejects biological determinism and accounts of disability that locate the source solely in the body of the person deemed disabled. Instead, a social model forces us to scrutinize the social forces that maim, debilitate, and traumatize groups and render their members more likely to be disabled.[178] It also seeks to dismantle the multiple "systems of domination and exploitation" that produce "able-bodied supremacy."[179]

Reflecting its biomedical orientation, the CST standard refers to neurodivergence as a mental disease or mental defect.[180] The standard invites examiners to test for deficits in functioning, rather than identify the person's potential for capacity.

Furthermore, in identifying cognitive difference as a defect, the standard is guilty of sanism.[181] Sanism refers to the beliefs, practices, and institutional arrangements that posit certain mental, cognitive, emotional, and psychological modalities as superior by virtue of being normal.[182]

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174. See Mike Oliver, The Social Model of Disability: Thirty Years On, 28 Disability & Soc'y 1024, 1024–26 (2013) (assessing the success and failures of the social model of disability).

175. Lyons, supra note 1, at 2005 (quoting Elizabeth F. Emens, Framing Disability, 2012 U. Ill. L. Rev. 1383, 1401).

176. Therí Alyce Pickens, Black Madness :: Mad Blackness 32 (2019).

177. See Russell & Malhotra, supra note 155, at 1–10 (describing the efforts of certain radical disability advocacy groups in the 1970s and 1980s that resisted the medical model's individualism and embraced the social model and its invitation to confront the production of impairments).

178. See generally Jasbir K. Puar, The Right to Maim: Debility, Capacity, Disability (2017) (describing the process of debility, whereby state violence and structural injustice produce bodily injury and social exclusion).

179. See Sins Invalid, supra note 83, at 18–19, 52–53 (calling for the abolition of, among other things, Immigration and Customs Enforcement and the prison industrial complex).

180. See Drope v. Missouri, 420 U.S. 162, 173 (1975) (describing a Missouri statute that refers to defendants with "mental disease or defect" (internal quotation marks omitted) (quoting Mo. Ann. Stat. § 552.020 (1969))).

181. See Perlin, Hidden Prejudice, supra note 29, at 43–47 (enumerating the "myths" of sanism).

182. Id.

Sanism relies on a socially constructed vision of normality and categorizes divergence as problematic.[183] In contrast, Sins Invalid, a disability justice group, affirms: "All bodies are unique and essential. All bodies have strengths and needs that must be met. We are powerful, not despite the complexities of our bodies, but because of them."[184]

A finding of incompetence deprives individuals with disabilities of the autonomy to make important decisions about their legal affairs, which amounts to discrimination.[185] The Convention on the Rights of Persons with Disabilities (CRPD), the relevant international human rights treaty, explicitly rejects legal distinctions made on the basis of disability, particularly ones that deprive individuals of decisionmaking power because of their neurodivergence.[186] The CRPD framework "encourage[s] legal systems to abandon the emphasis on identifying the point at which a person is unable to express their will and preferences and therefore unable to exercise legal capacity."[187] As an alternative, the CRPD stresses the importance of creating accommodations that can enable individuals to exercise their decisionmaking capacity.[188]

Current CST procedures assume that time and treatment can guarantee participation for individuals with mental disabilities. They imply that neurodivergence is only worthy of constitutional recognition if it can

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183. See id.; Amundson, supra note 85, at 48 ("The concept of normality, and not the concept of function, controls current thought about the disadvantages caused by biological atypicality.").

184. Sins Invalid, supra note 83, at 19.

185. See G.A. Res. 61/106, Convention on the Rights of Persons With Disabilities, art. 12 (Dec. 13, 2006) (requiring state parties to take measures to ensure people with disabilities enjoy "[e]qual recognition before the law"); Statement on Article 14 of the Convention on the Rights of Persons With Disabilities, UN Hum. Rts. Off. High Comm'r (Sep. 2014), https://www.ohchr.org/en/2014/10/statement-article-14-convention-rights-persons-disabilities [https://perma.cc/XNQ5-KUNP] ("The committee has established that declarations of unfitness to stand trial and the detention of persons based on that declaration is contrary to article 14 of the convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant.").

186. See G.A. Res. 61/106, supra note 185, art. 12(2) ("States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.").

187. Anna Arstein-Kerslake, Piers Gooding, Louis Andrews & Bernadette McSherry, Human Rights and Unfitness to Plead: The Demands of the Convention on the Rights of Persons With Disabilities, 17 Hum. Rts. L. Rev. 399, 406 (2017) (citing Piers Gooding & Charles O'Mahony, Laws on Unfitness to Stand Trial and the UN Convention on the Rights of Persons With Disabilities: Comparing Reform in England, Wales, Northern Ireland and Australia, 44 Int'l J.L. Crime & Just. 122, 129 (2016)).

188. See G.A. Res. 61/106, supra note 185, art. 12(3) ("States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."); Michael Bach & Lana Kerzner, A New Paradigm for Protecting Autonomy and the Right to Legal Capacity 58–72 (2010), https://www.lco-cdo.org/wp-content/uploads/2010/11/disabilities-commissioned-paper-bach-kerzner.pdf [https://perma.cc/EG9R-DNFP] (advancing a "new legal paradigm for maximizing autonomy" for individuals with disabilities as they navigate legal decisionmaking).

be treated. Restoration, ostensibly the therapeutic remedy for a person found unfit to stand trial, requires the person be cured before they can participate in court.[189] Medication is a key aspect of treatment during the restoration process, underscoring CST's biomedical orientation.[190] But some psychiatric disabilities are more responsive to medication than others, and some mental disabilities are not curable.[191] Beatrice Adler-Bolton and Artie Vierkant identify sanism in institutional policies that construct and reproduce distinctions between the incurably mad and curably mad.[192] Such categories can diminish compassion for those whose disabilities cannot be treated. These distinctions also can communicate the expectation that differently abled people must assimilate if they want to be included in society.

Once a person is found incompetent, they are, by default, involuntarily hospitalized or jailed awaiting institutionalization.[193] Institutionalization involves forced treatment, from therapy to a pharmaceutical regime.[194] Large, state-run mental health institutions have been

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189. See Fader-Towe & Kelly, supra note 92, at 1 (noting that "restoration services are designed to prepare people to participate in a courtroom process").

190. See Sell v. United States, 539 U.S. 166, 177–83 (2003) (holding that, in certain circumstances, the state may forcibly medicate a defendant found incompetent to stand trial to ensure their restoration); Fader-Towe & Kelly, supra note 92, at 6, 18, 22 (emphasizing the importance of a continued medication regiment to maintain a defendant's competency).

191. Psychiatric medications can help alleviate the symptoms of anxiety, depression, schizophrenia, and bipolar disorder. See Nat'l All. on Mental Illness, Medications Overview, https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Medications-Overview-FS.pdf [https://perma.cc/7GRY-TY4P] (last updated Mar. 2015). But intellectual disabilities are not curable. Intellectual Disability (Intellectual Developmental Disorder), Psych. Today, https://www.psychologytoday.com/us/conditions/intellectual-disability-intellectual-developmental-disorder [https://perma.cc/VXJ5-QQNW] (last updated Apr. 19, 2022).

192. See Adler-Bolton & Vierkant, supra note 67, at 61 ("[A] distinction between the mad and the not-mad is constructed and reproduced by medical and psychiatric expertise, which differentiates between those who can be returned to a state of perceived normalcy . . . and those considered to be irreparably impaired, different, or otherwise clinically unable to be made normal.").

193. Pol'y Rsch. Assocs., Quick Fixes for Effectively Dealing With Persons Found Incompetent to Stand Trial 2 (2020), https://www.prainc.com/wp-content/uploads/2020/09/ISTRebrand-508.pdf [https://perma.cc/Q2QW-SDUC] ("For individuals found incompetent to stand trial (IST), restoration in almost all instances is provided in psychiatric hospitals . . . ."); see also Jackson v. Indiana, 406 U.S. 715, 738 (1972) (imposing limits on the length of detention for restoration, not to exceed "the reasonable period of time necessary to determine whether there is a substantial probability that [the defendant] will attain that capacity in the foreseeable future"); Fader-Towe & Kelly, supra note 92, at 6 ("Instead of receiving needed behavioral health treatment while awaiting evaluation, restoration, or trial, many people are left in jail, where treatment for their mental illnesses may be disrupted and their risk of symptom recurrence is increased.").

194. See *Sell*, 539 U.S. at 181 (outlining the requirements before a court may authorize a state to involuntarily medicate a defendant under restoration, including that "any

notorious for their abuse and neglect of patients.[195] Indeed, repeated scandals in and exposés about state psychiatric hospitals prompted a critical reexamination of involuntary hospitalization and helped bring about deinstitutionalization—the shuttering of residential institutions and state hospitals that warehoused thousands of people for their neurodivergence.[196] In interpreting the ADA, the Supreme Court has held that "[u]njustified isolation . . . is properly regarded as discrimination based on disability."[197] Yet despite these proclamations, state institutionalization remains the default for individuals found incompetent to stand trial. The conditions in those facilities often remain degrading, and allegations of abuse and neglect are common.[198]

C. *CST in Practice*

Nationally, courts order between twenty-five thousand and fifty thousand CST evaluations each year.[199] They are the most common forensic assessments, with public defenders expressing concerns about their clients' competency—potentially triggering these evaluations—in 10% to 15% of cases.[200] Studies suggest that 20% to 30% of assessments result in a finding of incompetency.[201] In Wisconsin, the number of CST evaluations climbed 32.5% between 2010 and 2015.[202] In Washington, between 2001 and 2012, there was a 76.3% increase.[203] Colorado reported

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alternative, less intrusive treatments," such as therapy, "are unlikely to achieve substantially the same results").

195. See supra note 46 and accompanying text.

196. See supra note 46 and accompanying text.

197. Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 597 (1999).

198. See Gene Myers, Lawsuit Alleges Harrowing Conditions, Abuse in New Jersey Psychiatric Hospitals, NorthJersey.com, https://www.northjersey.com/story/news/new-jersey/2024/02/21/nj-psychiatric-hospitals-unsafe-conditions-abuse-lawsuit/72687863007/ [https://perma.cc/LLV3-93MY] (last updated Feb. 21, 2024) (reporting on a lawsuit in New Jersey that alleges that the conditions inside the state's facilities are "'more akin to psychiatric incarceration' than to a setting where patients can get proper care" and detailing sexual, physical, and emotional assaults that have caused permanent damage or death (quoting Complaint at 35, Disability Rts. N.J. v. Adelman, No. 3:24-cv-00949 (D.N.J. filed Feb. 20, 2024))).

199. See Katherine E. McCallum & W. Neil Gowensmith, Tipping the Scales of Justice: The Role of Forensic Evaluations in the Criminalization of Mental Illness, 25 CNS Spectrums 154, 155 (2020) ("Courts order an estimated 25,634–51,500 CST evaluations each year nationally, varying from fewer than 50 to approximately 5,000 per year in individual states.").

200. Melton et al., supra note 42, at 193.

201. Id.; see also Zapf et al., Have the Courts Abdicated?, supra note 34, at 28–29 ("The number of competence evaluations ordered each year in the United States has been estimated at 60,000 . . . . [A]pproximately 20% of those referred for competency evaluation [are deemed] incompetent to proceed with criminal proceedings." (citation omitted)).

202. Gowensmith, supra note 96, at 2 (describing the unprecedented increase in competency evaluations).

203. Id.

a 206% increase between 2005 and 2014.[204] Los Angeles County had a staggering 273% increase from 2010 to 2015.[205]

Lawyers and judges play a passive role when it comes to deciding who is fit to stand trial. Research consistently shows that it is forensic examiners, not judges, who make the ultimate decisions about competency.[206] Judges approve examiners' findings in all but a few cases. A 1991 meta-analysis found that "in the overwhelming majority of studies (26 of 30, or 86.7%), competency status was based entirely on decisions by a psychiatrist, a psychologist, or a team of forensic examiners."[207] In Alabama, a 2004 study found that courts agreed with examiners in 99.7% of cases.[208] Not only are contested hearings rare, but judges rarely scrutinize the information gathered or conclusions reached.[209] Once a report is filed with the court, the parties and judge simply confirm the findings.[210] Although forensic experts are instructed not to weigh in on the ultimate legal issue—whether someone is fit to stand trial—in practice the reports they file in CST proceedings form the entire basis for the court's fitness findings.[211] As a result, CST proceedings are neither adversarial nor adjudicative. Psychologist and scholar Patricia Zapf suggests that judges have abdicated their responsibility.[212] Effectively, the *Dusky–Drope* legal standard is enforced by examiners.[213]

In the absence of judicial or clinical oversight, research from the past forty years has revealed the poor quality of the reports filed with courts.[214] The *Dusky–Drope* inquiry is a predictive test, one that requires examiners to evaluate the degree to which a person will comprehend the proceedings against them and be able to participate. But evidence suggests that

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204. Id.

205. Id.

206. See Zapf et al., Have the Courts Abdicated?, supra note 34, at 39 ("The courts tend to ignore the rule that experts cannot give evidence on the ultimate issue in relation to competency evaluations." (citation omitted)); see also Christopher Slobogin, Psychiatric Evidence in Criminal Trials: To Junk or Not to Junk?, 40 Wm. & Mary L. Rev. 1, 20 (1998) [hereinafter Slobogin, Psychiatric Evidence] (noting "[m]ost forensic mental health professionals have never had their testimony challenged" on evidentiary grounds).

207. Nicholson & Kugler, supra note 76, at 357.

208. Zapf et al., Have the Courts Abdicated?, supra note 34, at 39 (showing the "higher [rate of] agreement" between courts' determinations of defendants' competence and mental health experts' determinations).

209. Id. at 39–40.

210. See id. at 36 (discussing courts' "strong reliance . . . on the report of the certified forensic examiner").

211. Id. at 41 ("[I]t may be that the report is the only piece of evidence upon which to make a determination of a defendant's competency.").

212. Id. at 41–42.

213. Melton et al., supra note 42, at 186 ("Despite the long recognition by both appellate courts and clinicians that the determination is a legal rather than clinical matter, studies have repeatedly shown that judges agree with clinicians' competence opinions in more than 90% of cases." (footnote omitted)).

214. See Zapf et al., Have the Courts Abdicated?, supra note 34, at 31–32.

examiners are not consistently testing the defendant's functioning. One study of 150 reports discovered that nearly all of the examiners omitted any discussion of the accused person's history.[215] Some examiners also failed to share their reasoning for their forensic opinion.[216] In another study, researchers discovered that reports were inconsistent as to which functional abilities they addressed and not a single report documented interactive characteristics—that is, how the defendant's functional deficits would interact with the particular demands of the trial.[217] Similarly, reports reveal that examiners fail to operationalize the competency standard: They do not connect the observed symptoms of psychopathology to legal skills needed for navigating trial.[218] Examiners also do not assess the accused's decisional competence.[219] In Alabama, "mental health examiners appear to put more weight on the defendant's knowledge and ability to participate in the proceedings than on the defendant's ability to appreciate and reason."[220] These superficial and inconsistent assessments may partly, but not entirely, be attributed to the poor quality of the testing instruments available to examiners. Many of the CST instruments are not standardized.[221] And while the first generation of tests often assessed the accused person's attitudes and knowledge rather than skills, researchers have published a second-generation instrument designed to help the expert gauge the accused's decisionmaking abilities.[222]

As trial courts have abdicated their responsibility to adjudicate, forensic examiners conduct their assessments guided by their loose

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215. See Richard Robinson & Marvin W. Acklin, Fitness in Paradise: Quality of Forensic Reports Submitted to the Hawaii Judiciary, 33 Int'l J.L. & Psychiatry 131, 135 (2010).

216. Id at 136 (finding that "66% of reports fail[ed] to document the ethically mandated notice of limits of confidentiality" and observing "a general lack of attention to quality elements" in those reports).

217. See Elisa Robbins, Judith Waters & Patricia Herbert, Competency to Stand Trial Evaluations: A Study of Actual Practice in Two States, 25 J. Am. Acad. Psychiatry & L. 469, 476–77 (1997) (reporting the numerous ways the reports differed from one another or failed to include information).

218. See Jennifer L. Skeem, Stephen L. Golding, Nancy B. Cohn & Gerald Berge, Logic and Reliability of Evaluations of Competence to Stand Trial, 22 Law & Hum. Behav. 519, 521 (1998) (discussing how the reports reflected a basic "operationalization" of the CST construct in which foundational psycho-legal abilities such as defendants' appreciation of their charges are addressed almost to the exclusion of contextually relevant decisionmaking abilities like defendants' appreciation of the benefits of plea bargaining (internal quotation marks omitted)).

219. Id. at 538–40.

220. Zapf et al., Have the Courts Abdicated?, supra note 34, at 40.

221. See Melton et al., supra note 42, at 152–58 (describing the various testing instruments examiners can use to determine competency). But see id. at 198 (noting that more recent instruments are "relatively standardized").

222. See id. at 203–09 (outlining the newer tests and noting their "greater attention to the discrete functional abilities articulated in *Dusky*").

interpretation of the *Dusky–Drope* standard,[223] which is itself already incomplete and problematic. Their reports reveal omissions in the information collected and thinly reasoned conclusions.[224] Because determining fitness to stand trial has been delegated to mental health specialists, understanding their practices is crucial to understanding how the standard is enforced.

II. PERSONALITY DISORDERS

To understand forensic experts' decisionmaking in criminal court, the following Part situates PDs in psychology and psychiatry's orthodox diagnostic typology.

A. *Classification and Presentation According to the* DSM

To diagnose a PD, examiners rely on the *DSM*'s criteria. The *DSM-5-TR* defines a PD as "an enduring pattern of inner experience and behavior that deviates markedly from the norms and expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[225] For a diagnosis, that enduring pattern must lead to "clinically significant distress or impairment in social, occupational, or other important areas of functioning," among other criteria.[226]

The previous finalized edition of the *DSM*—the fourth edition, text revision (*DSM-IV-TR*)—distinguished between Axis I and Axis II diagnoses; psychotic disorders fell under Axis I and PDs under Axis II.[227] The fourth edition made clear that this classification was not designed to create a hierarchy of disorders but rather to encourage diagnoses on several distinct dimensions.[228] Nonetheless, relative to psychotic disorders,

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223. See id. at 197, 203 (noting that test designers and examiners tailor their evaluations to *Dusky*).

224. See Zapf et al., Have the Courts Abdicated?, supra note 34, at 40–41 (providing results from an Alabama study that show "mental health examiners did not always address all of the [required] issues" in their assessments).

225. DSM-5-TR, supra note 15, at 733.

226. Id. at 735.

227. See Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 28 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR] (listing the various diagnoses that fall under each axis).

228. See Krueger, supra note 82, at 233 ("[T]he DSM–IV–TR is careful to note that the separation of mental disorders into CDs and PDs need not imply fundamental distinctions in terms of 'pathogenesis or range of appropriate treatment' . . . ." (quoting DSM-IV-TR, supra note 227, at 28)); see also Anthony C. Ruocco, Reevaluating the Distinction Between Axis I and Axis II Disorders: The Case of Borderline Personality Disorder, 61 J. Clinical Psych. 1509, 1517 (2005) ("There is an abundance of evidence refuting the rationale for the distinction between personality disorders and Axis I conditions in terms of phenomenology, cause, and course.").

PDs are perceived as more stable in their presentation over time, less severe, presenting earlier in life, and less treatable.[229]

PD categories have shifted over time and expanded. The *DSM*'s first iteration included a broad category called sociopathic personality disturbances, a label that has since been abandoned.[230] The fourth edition of the *DSM* identified a lack of research into PDs, which undermined the credibility of its classification, and reclassified the disorders to stimulate scholarly investigation.[231] Currently, the *DSM* categorizes PDs into three clusters: A, B, and C.[232]

Cluster B disorders present themselves most frequently in a treatment setting and in the criminal legal system. Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders.[233] According to the *DSM-5-TR*, these share common presentations: "Individuals with these disorders often appear dramatic, emotional, or erratic."[234] Antisocial personality disorder (ASPD) is recognized as "[a] pervasive pattern of disregard for and violations of the rights of others."[235] Borderline personality disorder (BPD) is defined as "[a] pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity."[236] Histrionic personality disorder is characterized by "[a] pervasive pattern of excessive emotionality and attention seeking."[237] Narcissistic personality disorder features "grandiosity[,] . . . need for admiration, and lack of empathy."[238] Symptoms of all Cluster B conditions can shape all three dimensions of human behavior relevant to legal decisionmaking: cognition, emotion, and impulse. Most evidently, these disorders can strain relationships, impede trust, and thwart collaboration, all of which are essential for attorney–client relationships.

As Lynn Williams, an individual diagnosed with BPD, explains:

> The best way I have heard borderline personality disorder described is having been born without an emotional skin—with no barrier to ward off real or perceived emotional assaults. What

229. See Krueger, supra note 82, at 234–41 (discussing the various ways PDs have been distinguished from psychotic disorders over time).

230. See Dean A. Haycock, Psychopathic, Sociopathic, or Antisocial Personality?, Psych. Today (July 2, 2019), https://www.psychologytoday.com/us/blog/tyrannical-minds/201907/psychopathic-sociopathic-or-antisocial-personality (on file with the *Columbia Law Review*) (discussing the evolution of the sociopathy diagnosis).

231. See Robert L. Trestman, DSM-5 and Personality Disorders: Where Did Axis II Go?, 42 J. Am. Acad. Psychiatry & L. 141, 141–42 (2014) (discussing the evolution of personality disorder diagnoses).

232. DSM-5-TR, supra note 15, at 734 (describing the differences between Cluster A, B, and C personality disorders).

233. Id.

234. Id.

235. Id. at 748.

236. Id. at 752.

237. Id. at 757.

238. Id. at 760.

> might have been a trivial slight to others was for me an emotional catastrophe . . . . This reaction was spontaneous and not something I chose.[239]

For people with BPD, that "thin skin" can trigger "feelings of suspicion and paranoia about the intentions of people around them."[240] Those interpersonal stresses can cause the person to dissociate and feel as though they were leaving their body.[241] John Gunderson, the foremost researcher of BPD, underscores that, although this form of neurodivergence can manifest as illogical thinking, many people with a BPD diagnosis are still able to maintain the appearance of normalcy.[242]

Professor Mala Chatterjee reminds us that the *DSM*'s checklists of symptoms only roughly approximate the internal experience of neurodivergence. Chatterjee, who has been diagnosed with BPD, explains that the criteria in the *DSM* are mere "shadows" that the disorder casts; they are only "outward reverberations rather than what seethes inside."[243] As for the common portrayal of "borderlines," as she puts it, who "behave in impulsive and destructive ways toward others," she explains that "these behaviors are not cruel, callous, or calculated. Rather, they are desperate and compulsive attempts at alleviating pain."[244] Diagnosis, Chatterjee underscores, should trigger the relief of recognition, but given societal views of BPD, it instead brings a feeling of shame often associated with difference.[245]

The *DSM* did not entirely displace other modes of categorizing different personality traits. In particular, the labels of "sociopathy" and "psychopathy," which became popular in the early to mid-twentieth century, have retained currency, independent of the *DSM*.[246] At times,

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239. Lynn Williams, A "Classic" Case of Borderline Personality Disorder, 49 Psychiatric Servs., 173, 173 (1998).

240. Understanding Borderline Personality Disorder: A Complete Guide, Mass Gen. Brigham McLean (Aug. 7, 2025), https://www.mcleanhospital.org/essential/bpd (on file with the *Columbia Law Review*).

241. Id. ("Dissociation feels like being spaced out, foggy, or as if you exist outside of your own body.").

242. See Diana Kwon, Borderline Personality Disorder May Be Rooted in Trauma, Sci. Am. (Jan. 1, 2022), https://www.scientificamerican.com/article/borderline-personality-disorder-may-be-rooted-in-trauma [https://perma.cc/CK5M-AVV5] ("Gunderson defined six key features [that] people [with a BPD diagnosis] shared . . . [including:] illogical or 'loose' thinking as evident in, for example, bizarre responses in unstructured psychological tests; and an ability to uphold an outward appearance of normalcy.").

243. Mala Chatterjee, Transcendent Luminescence, Ravaging Flames: On Alexander Kriss's "Borderline", L.A. Rev. Books (June 19, 2024), https://lareviewofbooks.org/article/transcendent-luminescence-ravaging-flames-on-alexander-krisss-borderline/ [https://perma.cc/XVJ5-C5UW].

244. Id.

245. Id.

246. See DSM-5-TR, supra note 15, at 885 (discussing a form of ASPD with psychopathic features); Haycock, supra note 230 (discussing the distinctions between sociopathic, psychopathic, and antisocial PDs).

sociopathy, psychopathy, and ASPD have been used interchangeably,[247] but they represent distinct constellations of behaviors and diagnostic approaches.[248] Hervey Cleckley, a forensic psychiatrist from the mid-twentieth century, derisively described a person with psychopathy as "a self-absorbed loner, an egocentric subject who, unable to feel genuine emotions of love and empathy, would carelessly crush other people's feelings to pursue [their] own needs."[249] Psychoanalysts, by contrast, embraced the diagnostic category but argued psychopathy stemmed from trauma, requiring sympathy from treatment providers.[250] Meanwhile, the *DSM-5-TR* no longer recognizes psychopathy as a stand-alone PD but instead categorizes it as a specification to ASPD.[251]

In *Sociopath: A Memoir*, Patric Gagne narrates her discomforting journey with her diagnoses of ASPD, sociopathy, and psychopathy. Gagne opens her text with a provocative confession: "I'm a liar. I'm a thief. I'm emotionally shallow. I'm mostly immune to remorse and guilt. I'm highly manipulative. I don't care what other people think. I'm not interested in morals. I'm not interested, period. Rules do not factor into my decision-making. I'm capable of almost anything."[252] But she also explains that, from a young age, her pattern of causing harm stemmed from irresistible urges:

> Had you asked me back then, I would have described this compulsion as a *pressure*, a sort of tension building in my head. It

247. See DSM-5-TR, supra note 15, at 748 ("The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy, sociopathy,* or *dyssocial personality disorder.*"); Partridge, supra note 82, at 55 (defining sociopathy as a common trait across psychopathic disorders that expresses itself as "anything deviated or pathological in social relations, whether of individuals with one another, or within or towards groups, and also in the relations of groups to one another"); see also id. at 75–81 (noting the absence of any consensus about how to distinguish between sociopathy, psychopathy, and specific disordered personality traits).

248. See Haycock, supra note 230 (noting distinctions between the different terms).

249. Deambrogio, supra note 166, at 119 (citing Hervey Cleckley, The Mask of Sanity: An Attempt to Reinterpret the So-Called Psychopathic Personality 241–42 (1st ed., The C.V. Mosby Co. 1941)); see also Robert D. Hare, David J. Cooke & Stephen D. Hart, Psychopathy and Sadistic Personality Disorder, *in* Oxford Textbook of Psychopathology 555, 555–57 (Theodore Millon, Paul H. Blaney & Roger D. Davis eds., 1999) (building on Cleckley's definition of psychopathy and defining it as "a specific form of personality disorder with a distinctive pattern of interpersonal, affective, and behavioral symptoms").

250. See Deambrogio, supra note 166, at 119–20 ("By aligning themselves with the changed cultural context and by respecting narcissists' emotional needs, psychoanalytic reformers could express sympathy and understanding for those who rejected family life, pursued activities and professions that served no social purpose, and expressed ideas and beliefs that challenged the established order." (citing Eli Zaretsky, Secrets of the Soul: A Social and Cultural History of Psychoanalysis 315 (2004))).

251. See DSM-5-TR, supra note 15, at 885–86 (describing a variance of ASPD termed psychopathy or "'primary' psychopathy").

252. Patric Gagne, Sociopath: A Memoir, at xiii (2024).

> was like mercury slowly rising in an old-fashioned thermometer. At first it was barely noticeable, just a blip on my otherwise peaceful cognitive radar. But over time it would get stronger. The quickest way to relieve the pressure was to do something undeniably wrong, something I knew would absolutely make anyone else feel one of the emotions I couldn't. So that's what I did.[253]

B. *Contested Status*

PDs are a matter of considerable controversy within the mental health community. All psychiatric disorders struggle with credibility because they comport poorly with the biomedical model of disease that predominates in psychology and psychiatry.[254] Many diagnoses listed in the *DSM* have neither a clear biological origin nor a guaranteed course of treatment.[255] Diagnostic testing instruments exist but have been criticized as being insufficiently technical and superficial.[256] The *DSM*, however, clarifies that etiology does not control diagnosis.[257] Instead, it embraces a "purely descriptive approach," captured by the series of checklists of "behavioral symptoms" that are grounded in clinical judgments, rather than neuroscientific testing or experimental results.[258] But these qualifications within

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253. Id. at xiv–xv.

254. This was not always the case. Early twentieth-century forensic psychiatrists described both insanity and criminality as the products of savage, uncivilized women and men. Deambrogio, supra note 166, at 30. Discourse shifted toward eugenics and racial inferiority, then into a puritan ethic of idleness. Id. at 31–33. At this time, Freudian psychoanalysis dominated in the United States, alongside eugenic and puritan discourses, but, gradually, scientific discourses about the brain and human behavior came into vogue and explained human behavior through base instincts and biology. Id. at 27, 32. By the 1960s, there was increasing concern amongst clinicians that the Freudian emphasis of psychodynamics had compromised diagnostic precision. Id. at 131–32. The *DSM-III*, published in 1980, marked a definitive departure and the rise of a new biomedical orthodoxy in behavioral health. Id. at 145. It supplanted other methods of studying and treating psychiatric distress. Id. at 132, 145. The *DSM* has since served as the ultimate and final authority on psychopathology and diagnosis, despite the text's own far more modest and schematic ambitions. Andreasen, supra note 171, at 111. It aimed to integrate both biological and psychosocial dimensions of clinical assessment but emphasized the former. Deambrogio, supra note 166, at 132, 146. While it aims to be comprehensive and serve as the standard, it crowds out other modes of treatment, nosology, and modes of conceiving of disease and disability. Andreasen, supra note 171, at 111.

255. See Deambrogio, supra note 166, at 35 (noting psychopathy is "without a clear organic origin").

256. See id. at 35–36 ("[W]hen dealing with mental health conditions without a clear organic origin . . . psychiatrists lacked . . . technical instruments.").

257. See DSM-5-TR, supra note 15, at 29–30 (noting that "a diagnosis does not carry any necessary implications regarding . . . etiology").

258. See Deambrogio, supra note 166, at 35 (noting that examiners often "rely on a purely descriptive approach, based on the observation of behavioral symptoms and physical characteristics" for mental health conditions); see also DSM-5-TR, supra note 15, at xxiii–xxiv (noting that "current diagnostic criteria" rely on "how mental disorders are expressed and can be recognized by trained clinicians").

the *DSM* have not settled the significance imputed to etiology and the biological origins of mental illness. PDs, along with other disorders,[259] have attracted heightened scrutiny because there is a widespread impression that they are less anchored in biology, less severe, and less responsive to treatment than psychotic disorders like schizophrenia.[260] But emerging research debunks these common impressions.[261]

How does one ascertain abnormal personality traits caused by a disorder? PDs tend to be consistent with the individual's sense of self.[262] Because these disorders affect a person's emotional, cognitive, and behavioral patterns—and thus their character—psychologists and philosophers have struggled to distinguish the person from the disorder.[263] Legal scholar Jill Peay remarks that when the "'personality disorder' is central to the individual's make-up, . . . the rational and the irrational, the

259. See Richard J. Bonnie, Compulsive Gambling and the Insanity Defense: *United States v. Torniero* and *United States v. Lewellyn*, 9 Am. Acad. Psychiatry & L. 5, 5–8 (1984) [hereinafter Bonnie, Compulsive Gambling] ("Two federal courts have recently held, as a matter of law, that psychiatric evidence purporting to show that the defendant suffered from 'pathological gambling disorder' cannot be introduced in support of an insanity claim."). Under federal law, since the Insanity Defense Reform Act of 1984 was enacted, the insanity defense has only been available to defendants who substantially lack rational capacity. 18 U.S.C. § 17 (2018). The Federal Sentencing Guidelines, however, permit downward departures for defendants if they can establish a significant impairment of their ability to control behavior that they otherwise know is wrongful. U.S. Sent'g Guidelines Manual § 5K2.13 (U.S. Sent'g Comm'n 2024); see also Transcript of Sentencing at 81–82, United States v. Caspersen, 275 F. Supp. 3d 502 (S.D.N.Y. 2017) (No. 16-cr-00414-JSR) (on file with the *Columbia Law Review*) (granting the defendant a downward departure due to his gambling addiction, among other things).

260. See Kamila Belohradova Minarikova, Jan Prasko, Michaela Holubova, Jakub Vanek, Krystof Kantor, Milos Slepecky, Klara Latalova & Marie Ociskova, Hallucinations and Other Psychotic Symptoms in Patients With Borderline Personality Disorder, 18 Neuropsychiatric Disease & Treatment 787, 788 (2022) (assessing the "evidence against the long-standing concept that psychotic signs in BPD are different and less severe than in psychotic disorders"); Katherine A. Fowler, William O'Donohue & Scott O. Lilienfeld, Introduction: Personality Disorders in Perspective, *in* Personality Disorders: Toward the *DSM-V*, at 1, 10–12 (William O'Donohue, Katherine A. Fowler & Scott O. Lilienfeld eds., 2007) (describing "myriad surrounding controversies" of PDs); John Gunderson, Sara Masland & Lois Choi-Kain, Good Psychiatric Management: A Review, 21 Current Op. Psych. 127, 127 (2018) (explaining how, prior to the 1990s, many psychologists believed that BPD was "untreatable"); Thomas A. Widiger, Alternatives to *DSM-IV*: Axis II, *in* Personality Disorders: Toward the *DSM-V*, supra, at 21, 23 (noting a common perception that there is not quality treatment for PDs).

261. See Marialuisa Cavelti, Katherine Thompson, Andrew M. Chanen & Michael Kaess, Psychotic Symptoms in Borderline Personality Disorder: Developmental Aspects, 37 Current Op. Psych. 26, 26–27 (2021) (explaining how individuals with BPD can exhibit many of the same symptoms as individuals with psychosis).

262. See Kevin Bennett, When You Can't See Your Own Illness, Psych. Today (Dec. 29, 2022), https://www.psychologytoday.com/us/blog/modern-minds/202203/when-you-cant-see-your-own-illness [https://perma.cc/SSX6-A48S] ("Most personality disorders are considered ego-syntonic because they do not conflict with your sense of identity.").

263. See Peay, supra note 25, at 240–41.

capacitous and the incapacitous, are almost impossible to disentangle."[264] Therefore, "there is no clear distinction, other than a moral one judged by others, between the true path and the disordered path."[265]

Furthermore, the traits associated with PDs are present in the general population. As a result, the *DSM-5-TR* advances a categorical approach to PDs, in which "personality disorders are qualitatively distinct clinical syndromes."[266] It also, however, credits the dimensional approach, which sees PDs as "impairments in personality *functioning* and pathological personality *traits*" on a "continuum with other mental disorders."[267]

How are PDs different from other psychiatric disorders? Among clinicians, there is a tendency to assume that PDs do not produce cognitive deficits, but empirical research does not confirm such assertions. Research suggests that both individuals with schizophrenia and individuals with PDs can display cognitive deficits.[268] Studies suggest that having BPD, for example, can undermine executive functioning.[269]

Research also points toward the significant overlap between psychotic disorders and PDs. The term "borderline" comes from a time when the diagnosis was used to describe people who were experiencing symptoms on the border between neurosis and psychosis.[270] The theory, at the time, was that the borderline disorder was "latent schizophrenia."[271] Eventually, the *DSM* moved to distinguish BPD from psychotic disorders. In its current iteration, the *DSM*'s definition recognizes that a person with BPD can experience some of the same symptoms seen in schizophrenia, but it distinguishes those symptoms as transient in BPD, noting the symptoms manifest as either "stress-related paranoid ideation or severe dissociative

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264. Id. at 241.

265. Id. at 240.

266. DSM-5-TR, supra note 15, at 734.

267. Id. at 734, 881 (emphasis added).

268. See Ian Barkataki, Veena Kumari, Mrigendra Das, Mary Hill, Robin Morris, Paul O'Connell, Pamela Taylor & Tonmoy Sharma, A Neuropsychological Investigation Into Violence and Mental Illness, 74 Schizophrenia Rsch. 1, 9 (2005) ("[B]oth violent and nonviolent schizophrenia groups had global deficits involving measures of general intellectual functioning . . . ."); Kinscherff, supra note 23, at 750 ("The functional impairments associated with personality disorders can be severe and similar to the functional impairments associated with mental disorders that would be permitted for consideration of nullification of criminal responsibility." (emphasis omitted)).

269. See Paola Bozzatello, Cecilia Blua, Claudio Brasso, Paola Rocca & Silvio Bellino, The Role of Cognitive Deficits in Borderline Personality Disorder With Early Traumas: A Mediation Analysis, J. Clinical Med., Feb. (I) 2023, at 1, 2 ("Among cognitive deficits, the impairment of executive functions and social cognition is considered a prominent feature of BPD patients . . . . In BPD patients, significant deficits were found in working memory processes, activities of planning and problem solving, set shifting, and decision making.").

270. See Introduction: Personality Disorders, *in* First Person Accounts of Mental Illness and Recovery 197, 198 (Craig Winston LeCroy & Jane Holschuh eds., 2012) ("From the late 1930s into the 1970s, the term *borderline* was used to describe people with symptoms on the borderline between neurosis and psychosis.").

271. Id.

symptoms."[272] The heart of the BPD diagnosis is emotional dysregulation, characterized by bursts of emotions that are hostile or depressive.[273]

PDs can share symptoms with psychotic disorders, and psychotic disorders can also manifest as divergent PDs.[274] Psychotic symptoms—hallucinations, delusions, and confused and disturbed thoughts—are best described as transdiagnostic because they can appear in schizotypal personality disorder, BPD, and schizophrenia.[275] The shared symptomology across PDs and psychotic spectrum disorders has led researchers and clinicians to call for a reevaluation of the current diagnostic approach.[276] Research demonstrates that PDs are best understood as the expressions of

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272. See DSM-5-TR, supra note 15, at 752–53, 757 ("Paranoid ideas or illusions may be present in both borderline personality disorder and schizotypal personality disorder, but these symptoms are more transient, interpersonally reactive, and responsive to external structuring in borderline personality disorder."); accord Kwon, supra note 242 ("For years 'borderline' remained a nebulous concept. It did not become an official diagnosis until the 1970s, when John Gunderson, a psychiatrist at McLean Hospital in Massachusetts, carefully examined and characterized a group of patients he noticed had been misdiagnosed with schizophrenia.").

273. See Introduction: Personality Disorders, supra note 270, at 198 ("Current theory on BPD holds that a central part of the disorder is emotional dysregulation, an inability to regulate intense emotions that become overwhelming.").

274. See Maria Gruber et al., Personality Functioning and Self-Disorders in Individuals at Ultra-High Risk for Psychosis, With First-Episode Psychosis and With Borderline Personality Disorder, Brit. J. Psychiatry Open, Sep. 2023, at 1, 6 ("Our results demonstrate that psychosis spectrum disorders are associated with impaired personality functioning."); Christian G. Huber, Lisa Hochstrasser, Klara Meister, Benno G. Schimmelmann & Martin Lambert, Evidence for an Agitated-Aggressive Syndrome in Early-Onset Psychosis Correlated With Antisocial Personality Disorder, Forensic History, and Substance Use Disorder, 175 Schizophrenia Rsch. 198, 202 (2016) ("These results indicate that a trait component of increased agitation and aggression may exist that is different for early-onset and adult-onset psychosis."); Aurelie Schandrin, Shona Francey, Lucia Nguyen, Dean Whitty, Patrick McGorry, Andrew M. Chanen & Brian O'Donoghue, Co-Occurring First-Episode Psychosis and Borderline Personality Pathology in an Early Intervention for Psychosis Cohort, 17 Early Intervention Psychiatry 588, 595 (2023) ("Borderline personality pathology is a common occurrence in psychotic disorders and is associated with more severe hallucinations and depression with higher risks of self-harm.").

275. See Sivasankaran Balaratnasingam & Aleksandar Janca, Normal Personality, Personality Disorder and Psychosis: Current Views and Future Perspectives, 28 Current Op. Psychiatry 30, 30 (2015) ("This overlap of symptoms [between psychotic disorders and personality disorders] present difficulties for practising clinicians in terms of diagnosis and in turn, treatment."); Joana Henriques-Calado, Rute Pires, Marco Paulino, João Gama Marques & Bruno Gonçalves, Psychotic Spectrum Features in Borderline and Bipolar Disorders Within the Scope of the *DSM-5* Section III Personality Traits: A Case Control Study, Borderline Personality Disorder & Emotion Dysregulation, Jan. 2023, at 1, 2 ("The innermost relationship of the borderline concept and psychosis has been historically intertwined and can be traced back to the twentieth century. Psychotic spectrum features in borderline personality disorder (PD) are a long-standing phenomenon . . . ." (footnote omitted)).

276. See Widiger, supra note 260, at 26–27 (discussing proposals to recategorize PDs as variants of other disorders).

psychotic disorders.[277] Furthermore, the robustly documented relationship between adverse childhood experience and the traits of PDs has led some to conclude that these conditions are expressions of trauma.[278]

What causes PDs? There remains "no consensus on underlying neuropathology or the optimum approach to diagnosis."[279] The disorders' "inadequate scientific base" has led to significant dissatisfaction with the current approach.[280] In psychology and psychiatry, unlike internal medicine, the symptoms and the disease are one and the same. The underlying cause for mental distress is not always discernible or treatable. Importantly, the *DSM-5-TR* is agnostic about etiology; diagnosis does not require establishing a cause.[281]

Psychologists John Gunderson and William Pollack note there is a "tendency to assume divergent etiologic primacy" for psychotic and personality disorders.[282] For example, clinicians and examiners have tended to reserve neuropsychological testing for disorders like psychosis and to favor psychological tests for conditions like PDs.[283] But "convergent research in neurocognitive sciences and behavioral genetics has increasingly rendered meaningless any distinction between those mental disorders with a 'biological' basis and those that are 'merely' a 'psychological' disorder."[284] There is increasing evidence from neurocognitive science "demonstrating the neural substrates of personality disorders."[285] Twin

277. See Kinscherff, supra note 23, at 749 ("[T]he personality disorders are developmental *endpoints*, most typically built upon a series of preceding heritable traits and individual adverse life circumstances combining in ways to fashion underlying neural architectures that often would have precedent Axis I diagnoses before being 'clustered' to yield a personality disorder on Axis II." (footnote omitted)).

278. See Nan Zhao, Dianhong Shi, Juan Huang, Qiuying Chen & Qiang Wang, Comparing the Self-Reported Personality Disorder Traits and Childhood Traumatic Experiences Between Patients With Schizophrenia vs. Major Depressive Disorder, Frontiers Psychiatry, Oct. 2021, at 1, 2 ("Importantly, the relationship between PD traits and [childhood traumatic experience] is extremely close, and they can both affect subsequent psychiatric disorders.").

279. Trestman, supra note 231, at 142.

280. See Fowler et al., supra note 260, at 22–26 (outlining the various issues involved in the current process of diagnosing PDs).

281. See DSM-5-TR, supra note 15, at 30 ("Nonclinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder.").

282. John G. Gunderson & William S. Pollack, Conceptual Risks of the Axis I-II Division, *in* Biological Response Styles: Clinical Implications 82, 86 (Howard Klar & Larry J. Siever eds., 1985); see also Krueger, supra note 82, at 245 ("Historically speaking, there has been a tendency for clinicians to regard [Clinical Disorders] as more genetic in etiology . . . whereas PDs were regarded as more environmental in etiology . . . .").

283. See Gunderson & Pollack, supra note 282, at 85–86.

284. Kinscherff, supra note 23, at 748.

285. Id.; see also Veena Kumari, Mrigen Das, Sheilagh Hodgins, Elizabeth Zachariah, Ian Barkataki, Michael Howlett & Tonmoy Sharma, Association Between Violent Behaviour and Impaired Prepulse Inhibition of the Startle Response in Antisocial Personality Disorder

studies[286] show that personality pathology is inheritable.[287] In fact, one study suggests that the heritability of PDs "approximates or exceeds" the heritability of some psychotic disorders.[288] Studies have also established physiological differences in individuals who meet the criteria for psychopathy.[289]

Do PDs respond to treatment? Because PDs appear in adolescence and become a durable part of a person's makeup, there is a common perception that they are untreatable.[290] PDs have been "defined in such a way as to be ingrained aspects of a person's behavior, affect, and cognition that are fundamentally problematic for the person and/or society, as well as for the essential ingredients of intervention, such as the ability to establish a good working relationship."[291] Yet, notwithstanding this dominant historical conceptualization, there is evidence that effective treat-

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and Schizophrenia, 158 Behav. Brain Rsch. 159, 160 (2005) ("There is also evidence for an association between certain neurotransmitter systems, which are known to influence [prepulse inhibition of the startle response], and violence. . . . A large number of studies have reported impaired [prepulse inhibition of the startle response] in schizophrenia." (footnote omitted)).

286. Twin studies examine twins to "distinguish[] between the effects of tendencies received due to genes at birth and those imposed by the different environments they were exposed to during their lives after birth." Monalisha Sahu & Josyula G Prasuna, Twin Studies: A Unique Epidemiological Tool, 41 Indian J. Cmty. Med. 177, 177 (2016).

287. Krueger, supra note 82, at 246 ("The twin method has been applied to the study of personality pathology, and the results show clearly that personality pathology, like other forms of psychopathology, is significantly heritable." (citations omitted)).

288. See Kinscherff, supra note 23, at 748.

289. These physiological differences manifest in the brain:

> [I]t was possible to find that psychopaths have reduced gray matter in their frontal lobes, increased striatal volume, abnormal asymmetry in the hippocampus, a larger corpus callosum, a lack of structural integrity in the uncinate fasciculus, abnormal activity in the anterior cingulate cortex (ACC), and deformations within the amygdala. . . . [A]ll of these neurological studies have added an immense amount of knowledge to what it means biologically to be a psychopath.

Jack Pemment, Psychopathy Versus Sociopathy: Why the Distinction Has Become Crucial, 18 Aggression & Violent Behav. 458, 459 (2013) (footnote omitted) (citations omitted). But it would be a mistake to say ASPDs are the same as psychopathy. Though often conflated, neuroimaging suggests these are distinct conditions. See Lynch & Perlin, supra note 76, at 455 ("Emerging research using neuroimaging is demonstrating that the brain of a psychopath responds differently to punishment than the brains of other non-psychopathic criminal offenders." (footnote omitted)).

290. See Fleenor v. Farley, 47 F. Supp. 2d 1021, 1066 (S.D. Ind. 1998) (noting the testimony from a defense-hired psychologist who testified that the defendant's personality disorder would be "quite resistant to treatment" (internal quotation marks omitted) (quoting Dr. Paul Campbell)), aff'd sub nom., Fleenor v. Anderson, 171 F.3d 1096 (7th Cir. 1999); Gunderson et al., supra note 260, at 127 (noting the "growing consensus" that BPD is untreatable).

291. Krueger, supra note 82, at 239.

ment for some PDs, including BPD, exists.[292] Dialectical behavior therapy can reduce the likelihood of more intrusive emergency interventions.[293] Pharmacologic interventions, like medications, have been successful in addressing the psychopathological processes shared by PDs and other clinical disorders.[294]

Do the diagnostic categories predictably match distinct psychological profiles? Because there are several criteria that can establish any given personality disorder, two people with the same diagnosis may present very differently. In clinical practice, the same person can be assigned different diagnoses. Such "excessive diagnostic co-occurrence" suggests the criteria distinguishing each unique disorder are not accurate.[295] Clinicians frequently diagnose by impression rather than abide by the *DSM*'s criteria.[296] The instability of diagnostic categories has led scholars to call for a different nosological framework.[297]

Who opposes this category of disorders? Capital defense attorneys have long been skeptical of PDs.[298] There is a perception that in death

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292. See Falk Leichsenring & Eric Leibing, The Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders: A Meta-Analysis, 160 Am. J. Psychiatry 1223, 1223 (2003) (stating that "psychotherapy . . . is an effective treatment for personality disorders"); J. Christopher Perry, Elisabeth Banon & Floriana Ianni, Effectiveness of Psychotherapy for Personality Disorders, 156 Am. J. Psychiatry 1312, 1318 (1999) (discussing various studies analyzing the effects of treatments on PDs); Adrian Raine, Schizotypal Personality: Neurodevelopmental and Psychosocial Trajectories, 2 Ann. Rev. Clinical Psych. 291, 312 (2006) ("In contrast, multiple intervention studies indicate that neuroleptic medication is an effective treatment for schizotypy.").

293. See Marsha M. Linehan, Hubert E. Armstrong, Alejandra Suarez, Douglas Allmon & Heidi L. Heard, Cognitive-Behavioral Treatment of Chronically Parasuicidal Borderline Patients, 48 Archives Gen. Psychiatry 1060, 1063 (1991) ("[D]ays of inpatient psychiatric hospitalization were fewer for subjects who received DBT than for control subjects."); Paul J. Markovitz, Recent Trends in the Pharmacotherapy of Personality Disorders, 18 J. Personality Disorders 90, 90–101 (2004); see also Anthony Bateman & Peter Fonagy, Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial, 156 Am. J. Psychiatry 1563, 1568 (1999) ("Patients treated with partial hospitalization for 18 months showed significant improvement on both symptomatic and clinical measures.").

294. See Krueger, supra note 82, at 239 ("Nevertheless, psychotherapy can be effective in PDs, as can pharmacotherapy." (citations omitted)).

295. Fowler et al., supra note 260, at 10–12, 22–24; Mark D. Cunningham & Thomas J. Reidy, Antisocial Personality Disorder and Psychopathy: Diagnostic Dilemmas in Classifying Patterns of Antisocial Behavior in Sentencing Evaluations, 16 Behav. Scis. & L. 333, 334–36 (1998) (discussing ASPD's diagnostic weaknesses in the *DSM-IV*).

296. Trestman, supra note 231, at 142.

297. See, e.g., Fowler et al., supra note 260, at 6 ("The predictive utility and perhaps even the existence of personality itself have been called into question." (emphasis omitted)); see also Widiger, supra note 260, at 26 ("One proposal for DSM-V is to abandon the concept of a personality disorder. Proposals have been made to redefine personality disorders as early onset, chronic variants of existing Axis I disorders." (citations omitted)).

298. See, e.g., Kathleen Wayland & Sean D. O'Brien, Deconstructing Antisocial Personality Disorder and Psychopathy: A Guidelines-Based Approach to Prejudicial Psychiatric Labels, 42 Hofstra L. Rev. 519, 525 (2013) ("Testimony labeling a capital

penalty cases, a PD diagnosis tends to foreclose opportunities for mitigation and aggravate outcomes.[299] The capital defense community has criticized the use of these disorders as convenient shortcuts taken by unsympathetic examiners.[300] Furthermore, practitioners have suggested that PDs are not discrete disorders but symptoms of deeper, but unexamined, trauma.[301] Capital defense litigation strategy thus involves challenging examiners who reach that diagnosis and hiring experts who identify different symptomology.[302] Neoconservative critics writing in the 1990s, after the passage of the ADA, saw PDs as "the psychiatric profession's success in medicalizing emotional problems."[303] This kind of criticism looked for neat equivalences between physical diseases and mental disorders and, failing to find them, expressed skepticism about the *DSM*'s incorporation of PDs.[304]

More broadly, there is a resilient cultural skepticism toward PDs because they are associated with criminal offending. The empirical connection between PDs and contact with the criminal legal system may mean that "personality disorders have to some degree lost their identity as

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defendant antisocial or psychopathic has one overriding purpose: to obtain and carry out a sentence of death.").

299. See id. ("Judicial decisions discussing ASPD and psychopathy almost uniformly reflect reliance on the dehumanizing stereotype."); see also Lynch & Perlin, supra note 76, at 471–74 (examining the prejudicial impact of a psychopathy diagnosis on defendants of color). But see Deborah W. Denno, The Myth of the Double-Edged Sword: An Empirical Study of Neuroscience Evidence in Criminal Cases, 56 B.C. L. Rev. 493, 503 (2015) [hereinafter Denno, The Myth of the Double-Edged Sword] (finding "neuroscience evidence is usually offered to mitigate punishments in the way that traditional criminal law has always allowed, especially in the penalty phases of death penalty trials," which "controverts the popular image of neuroscience evidence" as something that either "get[s] defendants off the hook" or "unfairly brand[s] them").

300. See Wayland & O'Brien, supra note 298, at 522–31 (criticizing forensic evaluators' misuses of PD diagnoses in capital cases).

301. See, e.g., id. at 540 ("[E]xcessive focus on antisocial behavior without attention to contextual factors such as trauma history, thought or mood disorders, and neuropsychological dysfunction, may lead to failure to identify relevant diagnostic considerations."); Kathleen Wayland, The Importance of Recognizing Trauma Throughout Capital Mitigation Investigations and Presentations, 36 Hofstra L. Rev. 923, 947 (2008) ("A major problem leading to frequent misdiagnoses of ASPD in the capital setting is that mental health evaluators routinely ignore guidelines of the DSM [III] which suggest the importance of understanding behavior in context in order to properly identify symptoms.").

302. See, e.g., Russell v. State, 849 So.2d 95, 141 (Miss. 2003) (en banc) (relaying that the defense expert's testimony rejected the state's experts' conclusions, calling them "flawed" and noting that an antisocial PD diagnosis can be the product of "racial bias"); State v. Jenkins, 931 N.W.2d 851, 867 (Neb. 2019) (noting the disagreement between state and defense experts in a death penalty case).

303. G.E. Zuriff, Medicalizing Character, 123 Pub. Int. 94, 97 (1996).

304. See id. at 95–98 (noting that the *DSM*'s attempt to include PDs is "disturbing" and contradicts the *DSM*'s own logic).

mental illnesses, and instead are often seen as common population characteristics."[305]

C. *Transinstitutional Hostility*

Across spheres of life, individuals with PDs are regularly denied recognition as disabled.[306] They face hostility as they seek care or accommodation. The signs of these diagnoses tend to prompt negative reactions, in part because they are not unique to disability but commonly disvalued traits.[307]

In employment discrimination suits, courts have denied redress to plaintiffs with PDs.[308] Scholar Adi Goldiner has surveyed cases involving employees with PDs defending themselves against termination for misconduct by attributing their behavior to their disability.[309] Goldiner reveals that "[c]ourts typically hold that employees who engaged in impairment-related misconduct are not disabled, not otherwise qualified for the job, or that the adverse action against such employees was not because of their disability."[310]

In healthcare settings, people with BPD diagnoses report experiencing hostility. For example, while self-mutilation, suicidal behavior, and other behaviors that require attention from health service providers are established features of BPD's clinical profile,[311] people diagnosed with BPD have revealed that their healthcare providers accuse them of engaging in attention-seeking behavior.[312] In an effort to dispel providers' hostility, Lynn Williams wrote: "The first misconception most people have about borderline personality disorder is that its dramatic manifestations

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305. Sally C. Johnson & Eric B. Elbogen, Personality Disorders at the Interface of Psychiatry and the Law: Legal Use and Clinical Classification, 15 Dialogues Clinical Neuroscience 203, 208 (2013).

306. See Young et al., supra note 39, at 714 ("For disability cases, BPD was often introduced by the Social Security Administration (SSA) Commissioner or administrative law judge (ALJ) to rebut the Cluster B litigant's claim of disability."); id. at 718 ("In general, Cluster B personality disorders were treated negatively in case law and were solely used to support the termination of parental rights.").

307. See Coppola, supra note 76, at 27 ("There is consequently a tendency—in criminal law as well as in common understanding—to qualify patients suffering from pathological socioaffective deficits as iconic wrongdoers, as 'evil' individuals who constantly and willingly reject and break the rules of societal coexistence.").

308. See Adi Goldiner, Moral Accommodations: Tolerating Impairment-Related Misconduct Under the Americans With Disabilities Act, 54 Colum. Hum. Rts. L. Rev. 171, 175 (2022) (describing how courts almost exclusively rule against plaintiffs with PDs in employment discrimination cases).

309. See id.

310. Id. at 202.

311. See, e.g., Williams, supra note 239, at 173–74 ("[W]hen I was acutely ill, no other options besides my suicidal behavior existed.").

312. See id. (offering a first-hand account of the experience of BPD and correcting misconceptions).

such as reckless or suicidal behavior are merely deliberate, manipulative attempts to get attention. That is not true. The distress is real."[313] Williams is not alone in noting the suspicion toward BPD and other Cluster B disorders.[314] Researchers have documented how the personality traits associated with PDs can prompt negative and prejudicial responses.[315] Those who are responsible for caring for individuals with BPD report more negative experiences with professional medical care providers than those caring for individuals with psychosis.[316]

The American Law Institute's Model Penal Code specifically excluded ASPD from the definition of mental disease or defect, excluding any "abnormality manifested only by repeated criminal or otherwise anti-social conduct."[317] Federal law denies the insanity defense to defendants whose only diagnosis is a PD.[318] Case law suggests courts often treat ASPD as an aggravating factor at sentencing.[319]

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313. Id. at 173.

314. See, e.g., Goldiner, supra note 308, at 177 ("[P]eople with BPD face negative social stigma and disadvantage on the basis of their diagnosis and related symptoms.").

315. Id.

316. Sue M. Cotton et al., A Comparison of Experiences of Care and Expressed Emotion Among Caregivers of Young People With First-Episode Psychosis or Borderline Personality Disorder Features, 56 Australian & N.Z. J. Psychiatry 1142, 1147 (2022) (describing "caregivers of young people with BPD" as reporting "problems with services," including problems with mental health professionals not taking them seriously).

317. Model Penal Code § 4.01(2) (Am. L. Inst., Proposed Official Draft 1962); see also Young et al., supra note 39, at 717 ("Overall, Cluster B litigants who argued the insanity defense were unsuccessful on their appeals . . . ."). Under section 4.01(1), a "person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law." Model Penal Code § 4.01(1) (brackets in original).

318. See, e.g., United States v. Salava, 978 F.2d 320, 323 (7th Cir. 1992) ("The government relies on the legislative history of 18 U.S.C. § 17, which states: 'The concept of severity was added to emphasize that non-psychotic behavior disorders or neuroses such as an "inadequate personality," "immature personality," or a pattern of "antisocial tendencies" do not constitute the defense.'" (quoting S. Rep. No. 98-225, at 229 (1984))). But see United States v. Henley, 8 F. Supp. 2d 503, 505 (E.D.N.C. 1998) ("This is not to say, however, that personality disorders can never rise to the level of a mental disease or defect under [18 U.S.C.] § 4246. Federal case law on the subject has been ambiguous at best.").

319. See, e.g., Evans v. Sec'y, Dep't of Corrs., 703 F.3d 1316, 1327–28, 1332–33 (11th Cir. 2013) (en banc) (upholding the rejection of a defendant's ineffective assistance of counsel claim, which was based on the defense's failure to pursue a "mental health theory of mitigation," because such evidence—especially that of the defendant's PD—could be aggravating rather than mitigating); Suggs v. McNeil, 609 F.3d 1218, 1231 (11th Cir. 2010) (noting that evidence of the defendant's "antisocial personality disorder" would be "potentially aggravating"). But see Brumfield v. Cain, 576 U.S. 305, 319–21 (2015) (finding that, contra the prosecution's arguments, an ASPD diagnosis did not preclude relief under *Atkins v. Virginia*, a prior case that had disallowed capital punishment for individuals with intellectual disabilities); Young et al., supra note 39, at 715–16 (noting that *Brumfield* cut against the trend of using ASPD as an aggravating factor at sentencing). Deborah Denno cautions against giving this trend too much credence because it underestimates jurors' and

PDs' uncertain position in mental health and the common institutional hostility toward individuals who carry this diagnosis shape such individuals' treatment in criminal court.

III. A HIERARCHY OF DIAGNOSES

In this Part, a systematic review of state and federal cases from the last decade reveals a hierarchy of diagnoses embedded in the CST standard. Examiners are most likely to find a person incompetent to stand trial if their symptoms are consistent with psychosis.[320] Examiners and the courts that defer to their judgments consistently approach defendants with PDs with skepticism. Court actors doubt the veracity of their symptoms and that PDs can create veritable disabilities in criminal court.

Studies from the last thirty years confirm a strong association between incompetency and psychosis.[321] A diagnosis of psychosis is assigned when the individual has experienced hallucinations, delusions, disorganized speech, and abnormal psychomotor behavior.[322] The crux of the diagnosis

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judges' capacity to appreciate nuanced arguments about culpability. See Denno, Prosecutors and Defense Attorneys, supra note 146, at 453, 467–68 (explaining that the "double-edged sword" myth erroneously assumes that "reasonable jurists" cannot appreciate when mental illness is an aggravating versus mitigating circumstance).

320. See Melton et al., supra note 42, at 194–96 (describing the characteristics of incompetent defendants); Nicholson & Kugler, supra note 76, at 363 ("[T]he strongest correlates of incompetency are (a) poor performance on psychological tests specifically designed to assess defendants' legally relevant functional abilities, (b) a psychotic diagnosis, and (c) psychiatric symptoms indicative of severe psychopathology."); Janet I. Warren, Preeti Chauhan, Lauren Kois, Ashley Dibble & Jeff Knighton, Factors Influencing 2,260 Opinions of Defendants' Restorability to Adjudicative Competency, 19 Psych. Pub. Pol'y & L. 498, 500 (2013) (noting that psychosis is a common factor that can drive determinations about both competency and insanity).

321. A meta-analysis of thirty studies examined the differences between individuals deemed competent and those deemed incompetent and found that "the correlation between psychosis and incompetency was among the highest obtained in the review." Nicholson & Kugler, supra note 76, at 359. In addition, the same study discovered a strong association between "psychiatric symptoms indicative of severe psychopathology" and incompetency. Id. at 363; see also Pirelli et al., supra note 76, at 6 (discussing Nicholson and Kugler's findings from this study). Individuals found unfit are also more likely to have been hospitalized for their psychiatric needs, suggesting the severity of their symptoms prior to the instant arrest. See Steadman, supra note 76, at 31 (finding that 81% of incompetent defendants had a history of psychiatric hospitalization); Pirelli et al., supra note 76, at 15 ("Most incompetent defendants were diagnosed with a Psychotic Disorder (66.5%) and had a previous psychiatric hospitalization (53.4%) . . . ."); Ronald Roesch, Determining Competency to Stand Trial: An Examination of Evaluation Procedures in an Institutional Setting, 47 J. Consulting & Clinical Psych. 542, 545 (1979) (finding that incompetent defendants had been hospitalized for an average of almost three years); Alex M. Siegel & Amiram Elwork, Treating Incompetence to Stand Trial, 14 Law & Hum. Behav. 57, 59 (1990) ("Thirty eight (93%) of the subjects had been previously hospitalized at a state or city psychiatric facility.").

322. See DSM-5-TR, supra note 15, at 101–03 (enumerating the key features of psychotic disorders).

is the experience of losing touch with reality.[323] With a tenuous grasp of reality, the person may also experience a diminished capacity to express themselves. As one person described: "It felt like I was outside my body and someone else was inside my body. That's the only way I can explain it."[324] Psychiatrist Larry Davidson contends that the experience of psychosis can prevent authentic decisionmaking:

> Being unable to retain a sense of oneself as the source of the direction of one's own awareness may thus deprive the person with schizophrenia of the most fundamental sense of ownership of his or her own experiences. Without this basic self-awareness, people may then lose their secondary sense of themselves as agents active in and affected by the world. The impact of voices and cognitive disruptions in this way reverberates throughout the person's experiences of self[,] leading to the constitution of a sense of personal identity built more on feelings of being controlled by and vulnerable to external influences than of being the agent of one's own thoughts, perceptions, and feelings as well as actions.[325]

The strong connection between incompetency and psychotic disorders may suggest this cluster of disabilities creates the very impairments the CST standard is intended to detect. Alternatively, and as suggested below, the observed association between psychosis and incompetency might imply that forensic examiners equate the CST standard with a particular diagnosis without meticulously assessing the accused person's capacities.[326]

A. *Skepticism Toward Personality Disorders*

A review of state and federal cases[327] reveals a recurring skepticism toward PDs in CST proceedings. Not only symptomology but also diagnostic categories guide forensic examiners and courts reaching competency decisions. Their conclusions articulate and reproduce a hierarchy of disorders, with PDs occupying the lowest rung. These categories of

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323. See Larry Davidson, Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia 139 (2003) ("What appears to be unique about psychosis is the alien, ambiguous, and intangible nature of the onslaught that people experience.").

324. Id. (internal quotation marks omitted) (quoting a study participant).

325. Id. at 141.

326. See Siegel & Elwork, supra note 321, at 58 ("[S]ince courts often simply defer to the expertise of mental health professionals, high rates of agreement between the two cannot be assumed to indicate effective treatment." (citation omitted) (citing Steadman, supra note 76, at 56)).

327. The survey draws from a search of state cases after 2000, using Lexis to search the following query: "personality disorder" /10 (competen! OR incompeten!). For federal cases, the survey used the same search terms and focused on cases between January 1, 2013, and December 31, 2023. Memorandum from Zohra Ahmed to Columbia L. Rev. (July 30, 2025) (on file with the *Columbia Law Review*). Emily Stork's note surveys federal cases before 2013. Stork, supra note 22, at 929.

psychiatric conditions attract disdain and blame rather than empathy and accommodation.

In several cases,[328] courts have found either an explicit or an implicit association between competency and PDs.[329] In addition, many cases follow a similar pattern. Defense counsel or their experts aver that their client's neurodivergence makes it difficult for them to confide in their representative, candidly discuss inculpatory evidence, or reconsider a self-defeating trial strategy.[330] The defense may even concede that the accused person is able to understand the proceedings and the roles of the judge and jury, meeting the first part of the *Dusky–Drope* test.[331] In response, prosecutors allege that the proper diagnosis is a PD, which can result in a categorical denial of the defense's incompetency claim.[332] Or, the state's

328. A few caveats about the data collected. First, because competency issues are so rarely litigated at the trial level, these decisions represent a minority of CST determinations. Nonetheless, their holdings likely inform courts', litigants', and examiners' practices in cases in which the issue of competency is never litigated. Second, this analysis is limited to court decisions. The depth of reasoning varies across cases, and experts' testimonies are only partially excerpted or paraphrased. Third, the nature of clinical knowledge precludes clear causal arguments because there are no controls. That is, while this Essay identifies cases in which the examiners offer some evidence of impairment relevant to competency, we cannot claim that, but for their PD diagnoses, defendants would be found incompetent. This Essay also cannot account for variation in symptoms and the quality of the examiners' reasoning. The survey identifies, at a minimum, cases in which the record establishes some evidence of incompetency, the defendant has a PD diagnosis, and the court declines to find them unfit. Sometimes the court is explicit in ruling that the PD precludes a finding of incompetency. Other times, there is insinuation. Despite such limitations, these qualitative results can help identify lines of inquiry for quantification and correlation.

329. See, e.g., United States v. Rosenheimer, 807 F.2d 107, 112 (7th Cir. 1986) (per curiam) (affirming a finding of competency because "the defendant did not suffer from any mental disease or defect, but rather from a narcissistic personality disorder which is separate and distinct"); United States v. Mitchell, 706 F. Supp. 2d 1148, 1220 (D. Utah 2010) ("[E]xperts agree that Mitchell's personality disorders would not be a basis for a finding of incompetency." (citing Competency Hearing Transcript at 632, 816, 1879)); see also United States v. Van Hoesen, No. 06-CR-394 (GLS-DRH), 2008 WL 4283419, at *2 (N.D.N.Y. Sep. 16, 2008) (holding that a PD is not normally a disease that renders a defendant incompetent), aff'd, 450 F. App'x 57 (2d Cir. 2011). But see United States v. DeShazer, 554 F.3d 1281, 1287 (10th Cir. 2009) ("Whether or not Mr. DeShazer could be diagnosed with an Axis I or Axis II illness is irrelevant . . . ."); United States v. Miller, No. 2:10-cr-136-DBH, 2011 WL 1898251, at *2–6 (D. Me. May 18, 2011) (finding the defendant competent but noting that the Axis II PD did not preclude a finding of incompetency); United States v. Salley, No. 01 CR 0750, 2004 WL 170322, at *1, *5 (N.D. Ill. Jan. 16, 2004) (explaining that narcissistic personality disorder did not preclude incompetency, but finding the defendant competent).

330. See, e.g., People v. Berg, No. B236694, 2013 WL 492553, at *3 (Cal. Ct. App. Feb. 11, 2013) (noting defense counsel's incompetency argument would focus on the defendant's inability to "consult with his attorney with a reasonable degree of rational understanding").

331. See id. ("At the beginning of the competency hearing, counsel for appellant said she would not be contending that appellant was unable to understand the proceedings and the roles of the judge and jury.").

332. See infra section III.B.

experts explain that as a matter of psychology, these disorders are qualitatively different.[333] In both situations, prosecutors tend to prevail.[334] In the process, courts tend to downplay evidence of socioaffective distress and contentious attorney–client relationships.[335] As a consequence, courts have minimized the second part of the *Dusky–Drope* standard, which focuses on the defendant's capacity to assist their attorney.

For example, in *People v. Berg*, counsel for the defense at a competency hearing in California clarified that their arguments would focus solely on whether Ronald Berg, the accused, possessed the "ability to consult with his attorney with a reasonable degree of rational understanding, and was able to assist in his defense."[336] The defense's expert focused on Berg's "longstanding problems with social interactions, e.g. the capacity to read social cues and respond appropriately."[337] Berg struggled to focus and to absorb and filter relevant information.[338] One mental health specialist attributed those difficulties to a mood disorder that fluctuated between depression and hypomania and to a developmental disability.[339] When stressed, Berg showed signs of paranoia, which the defense expert expected to flare at trial.[340] In his forensic interview, Berg revealed deep fears of being attacked by jail guards and even being executed.[341] The defense argued he would be unable to exercise his right to testify because of these overwhelming and irrational fears, but the prosecutor's expert argued that Berg was "logical, coherent, and rational," countering the defense's claims.[342] Berg showed no delusions or other psychotic symptoms, according to the state's expert.[343] Tellingly, however, the defense did not argue that Berg was either delusional or psychotic, so the prosecution's

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333. See infra sections III.C–.D.

334. See, e.g., United States v. Heard, 762 F.3d 538, 542 (6th Cir. 2014) (denying the defendant relief on competency grounds because his only diagnosis was a PD); State v. Cooke, No. 0506005981, 2022 WL 17817903, at *17, *29 (Del. Super. Ct. Dec. 15, 2022) (finding no merit to the defendant's claim that he was incompetent in a case in which expert testimony established an ASPD diagnosis), aff'd, 338 A.3d 418 (Del. 2025); State v. Jenkins, 931 N.W.2d 851, 865 (Neb. 2019) (affirming the trial court's ruling on competency that relied on an expert's conclusion that the defendant was properly diagnosed with ASPD); State v. Hundley, 166 N.E.3d 1066, 1087 (Ohio 2020) (affirming the defendant's competency because he only established a diagnosis for a PD). But see People v. Asberry, No. F070000, 2017 WL 2686544, at *31 (Cal. Ct. App. June 22, 2017) (reversing a conviction because the trial court erred in finding the defendant competent).

335. See, e.g., *Berg*, 2013 WL 492553, at *6–7 (affirming the trial court's decision to follow the testimony of a single expert who deemed the defendant competent).

336. Id. at *3.

337. Id.

338. Id.

339. Id. at *2–3.

340. See id. at *3 ("The paranoid symptoms arose when appellant became extremely stressed and unable to understand what was going on around him.").

341. Id.

342. Id. at *4.

343. Id.

focus on these symptoms revealed its preconceptions about which diagnoses trigger incompetency.[344] The prosecution's expert testified that Berg failed to demonstrate "'glaring' symptoms of mental illness."[345] In the end, the court endorsed the prosecution's theory: Berg showed traits of a PD with features of depression and anxiety.[346] The prosecution's expert informed the court that "a personality disorder is not a major mental illness . . . [since it] continu[es] throughout a lifetime[] and there is very little mental health professionals can do for individuals suffering from a personality disorder other than long-term psychotherapy."[347] The expert contrasted Berg's personality disorder with schizophrenia and its tangential thinking.[348] The court rejected the defense's arguments about Berg's developmental disabilities, credited the state's expert for his experience, and found Berg competent to stand trial.[349]

Berg illustrates some common features of the cases discussed in this Essay: Courts and examiners expect defendants to exhibit obviously severe impairments to reach a finding of incompetency. Litigation focuses on the diagnosis as well as observed symptoms. PDs are not compatible with incompetency, whether by law or by fact. *Berg* and the cases that follow are appellate decisions reviewing trial level determinations of competency. Because competency is a question of fact, appellate review is generally deferential to the trial court's credibility determinations.[350] Some cases are post-conviction review cases, in which the defense has raised an ineffective assistance of counsel claim based on trial counsel's failure to raise competency. In those cases, the defense's expert may be testifying to the defendant's competency retrospectively. In some jurisdictions, like California, Texas, and Washington, competency is a question for a jury.[351] Trial courts, as the triers of fact in competency determinations, have the

344. Id.

345. Id. (quoting Dr. Kory Knapke).

346. See id. at *6 ("Dr. Knapke's diagnosis of appellant was found the most accurate by the trial court: long-standing traits of a [PD] with mild depression and anxious features.").

347. Id. at *5 (internal quotation marks omitted) (quoting Dr. Knapke).

348. Id. at *7. The defense challenged the testimony offered by the examiner, Dr. Knapke, which included the following: "I don't believe that [Berg] was so tangential, like a schizophrenic would be where he's off on a tangent and never coming back to the original question." Id. (internal quotation marks omitted) (quoting Dr. Knapke). Similarly, the defense cited Dr. Knapke's testimony that "a defendant need not have a 'Harvard law degree' to be found competent because only a basic understanding of courtroom proceedings is required." Id. (quoting Dr. Knapke).

349. Id. at *6.

350. See United States v. Villegas, 899 F.2d 1324, 1341 (2d Cir. 1990) (holding that the determination of a defendant's competence to stand trial under 18 U.S.C. § 4241 is a question of fact).

351. Cal. Penal Code § 1369 (2025); Tex. Code Crim. Proc. Ann. § 46B.0755 (West 2025); Wash. Rev. Code § 10.77.645 (2025).

authority to consider lay and expert testimony and may accept or reject any evidence.[352]

B. *Categorical Bans*

Federal district courts and the Seventh Circuit have ruled that PDs do not count as diseases or defects for competency purposes.[353] The Sixth

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352. That the trier of fact has ultimate authority to sift through the evidence and determine the importance to accord to different pieces of evidence is a well-established norm of trial level practice. See United States v. Bailey, 444 U.S. 394, 414 (1980) ("The Anglo-Saxon tradition of criminal justice, embodied in the United States Constitution and in federal statutes, makes jurors the judges of the credibility of testimony offered by witnesses."); 1A Kevin F. O'Malley, Jay E. Grenig, William C. Lee & Nadine Jean Wichern, Federal Jury Practice and Instructions § 15:01, Westlaw (7th ed. 2025) ("You, as jurors, are the sole and exclusive judges of the credibility of each of the witnesses called to testify in this case and only you determine the importance or the weight, if any, that their testimony deserves.").

353. See, e.g., United States v. Clements, 522 F.3d 790, 796 (7th Cir. 2008) ("The mere fact that a criminal defendant has a personality disorder does not prevent the defendant from appreciating the proceedings or assisting in his defense." (internal quotation marks omitted) (quoting United States v. Savage, 505 F.3d 754, 759 (7th Cir. 2007))); *Savage*, 505 F.3d at 758 ("Savage on appeal contends that the district court should have ordered *sua sponte* a competency hearing. . . . Savage argues that the district court had 'reasonable cause' to doubt his competence. During Savage's case, Dr. Rubin testified that Savage suffered from post-traumatic stress disorder and dependent personality disorder."); United States v. Teague, 956 F.2d 1427, 1432 (7th Cir. 1992) (affirming the conviction on the ground that the defendant did not have any diagnoses "that would prevent a defendant from understanding the proceedings against him and interfere with his ability to confer with his attorney on his own behalf"); United States v. Rosenheimer, 807 F.2d 107, 112 (7th Cir. 1986) (per curiam) (affirming the district court's finding of competency and sanity because "the defendant did not suffer from any mental disease or defect, but rather from a narcissistic personality disorder which is separate and distinct from suffering from a mental disease or defect"); United States v. Mitchell, 706 F. Supp. 2d 1148, 1220 (D. Utah 2010) ("[E]xperts agree that Mitchell's personality disorders would not be a basis for a finding of incompetency. Mitchell's personality disorders do not detach him from reality or affect his rational ability to understand the world around him." (citation omitted) (citing Competency Hearing Transcript at 632, 816, 1879)); see also United States v. Prescott, 920 F.2d 139, 146 (2d Cir. 1990) (describing that the sentencing judge found that the defendant "was not suffering from a mental disease or defect that would qualify him for . . . provisional sentencing" and declining to find clear error upon review); Stork, supra note 22, at 957 (arguing against the inclusion of "mental disease or defect" in the CST standard because "it invites unnecessary line-drawing and battles of the experts").

Federal courts have excluded PDs or considered whether PDs are mental diseases or defects for a range of purposes. See, e.g., 18 U.S.C. § 4241 (2018) (discussing incompetency); id. § 4243 (discussing "[h]ospitalization of a person found not guilty only by reason of insanity"); id. § 4244 (discussing "[h]ospitalization of a convicted person suffering from mental disease or defect"); id. § 4246 (discussing "[h]ospitalization of a person due for release but suffering from mental disease or defect"); United States. v. Henley, 8 F. Supp. 2d 503, 505 (E.D.N.C. 1998) ("This is not to say, however, that personality disorders can never rise to the level of a mental disease or defect under [18 U.S.C.] § 4246. Federal case law on the subject has been ambiguous at best.").

Other conditions have been categorically excluded for competency purposes, like amnesia. See, e.g., United States v. No Runner, 590 F.3d 962, 965 & n.2 (9th Cir. 2009)

Circuit has also noted, "[O]ur caselaw repeatedly emphasizes that even a severe personality disorder is not alone sufficient to make one legally incompetent to stand trial."[354]

In the Seventh Circuit, the seminal case *United States v. Rosenheimer* affirmed the district court's competency finding on the grounds that "the defendant did not suffer from any mental disease or defect, but rather from a narcissistic personality disorder which is separate and distinct from suffering from a mental disease or defect."[355] The district court considered James Rosenheimer's competency and sanity together, following a combined hearing.[356] The experts debated whether Rosenheimer experienced delusions consistent with a psychotic disorder or was prone to exaggerations consistent with a PD.[357] The district court issued a joint ruling focusing on the statutory element common to both insanity and competency: whether the accused had a mental disease or defect.[358] But the district court dedicated most of its opinion to the issue of the accused's sanity. Once it decided Rosenheimer was not insane because of his PD, it then quickly dispensed with his incompetency claim.[359] The Seventh Circuit affirmed.[360] The discussion in *Rosenheimer* reveals how the substantive defense of insanity shapes competency, a procedural protection. In *Rosenheimer*, the former subsumed the latter. *Rosenheimer* set a precedent in the Seventh Circuit that PDs do not meet the legal standard for a mental disease or defect under the federal competency standard.[361]

("[Other] courts have uniformly held that amnesia regarding the alleged crime does not constitute incompetence per se but may establish a basis for a finding of incompetence in a particular case.").

354. United States v. Prigmore, 15 F.4th 768, 777 (6th Cir. 2021) (citing United States v. Heard, 762 F.3d 538, 542 (6th Cir. 2014)).

355. 807 F.2d at 112.

356. See id. at 109 ("On November 13, 1985, an evidentiary hearing was held to determine the defendant's competency to stand trial and his sanity at the time the acts were committed.").

357. Id. at 109–10.

358. See id. at 110–11 ("Under this definition, the defendant is first required to present 'some evidence' of a mental disease or defect." (quoting United States v. Sennett, 505 F.2d 774, 775–76 (7th Cir. 1974))).

359. See id. at 112 ("[T]he court found that the defendant . . . suffer[ed] from . . . a narcissistic personality disorder which is separate and distinct from suffering from a mental disease or defect.").

360. Id.

361. See id. at 111 (concluding that PDs are not the same as mental diseases or defects); see also United States v. Clements, 522 F.3d 790, 796 (7th Cir. 2008) ("The district court's decision not to order a competency hearing during trial was correct."); United States v. Savage, 505 F.3d 754, 758–59 (7th Cir. 2007) (rejecting the defendant's argument that he was not competent because he "suffered from post-traumatic stress disorder and dependent personality disorder"); United States v. Riggin, 732 F. Supp. 958, 964 (S.D. Ind. 1990) ("[A]ll of the qualified experts who have examined Mr. Riggin have carefully analyzed this obsession and have found it to be nothing more than a personality disorder as opposed to a mental illness or defect.").

As a result of these clear rejections, the issue of competency can hinge on the presence of a PD.[362] In *United States v. Diehl Armstrong*, a district court in the Third Circuit distilled the extensive litigation about the accused's mental status in the following way:

> [T]he parties dispute whether the Defendant suffers from bipolar disorder or, alternatively, a personality disorder alone. This is a significant issue because there is uncontradicted evidence in this record that, while bipolar disorder is considered a serious "mental disease or defect" for purposes of establishing an individual's mental incompetence, a personality disorder is not.[363]

The court did not fully explain the basis of that exclusion.

Both examiners observed that the defendant, Marjorie Diehl-Armstrong, struggled to collaborate with her attorney. One examiner observed that her speech was "pressured and voluminous," and as a result it was "difficult to get her to stop talking and to focus on questions posed to her."[364] These symptoms were consistent with hypomania, a feature of bipolar disorder.[365] That same examiner also found that she "exhibited paranoid ideation, which was sometimes focused on her attorney."[366] At the competency hearing, this expert relayed his bipolar disorder diagnosis, explaining that "while the Defendant is competent in terms of rationally understanding the nature of her charges[,] . . . her mental illness renders her psychotic to the point that she is incapable of rationally working with her attorney to assist in the defense of her criminal charges."[367] The prosecution's expert challenged the bipolar disorder diagnosis.[368] The state's witness averred that Diehl-Armstrong's "personality disorder may cause her to be incorrectly seen as not competent to stand trial."[369] He attributed Diehl-Armstrong's tumultuous relationships and erratic mood

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362. In other cases, courts have emphasized that the diagnosis is not dispositive and have instead emphasized symptomology. Yet, in those cases, courts have nonetheless denied incompetency claims to defendants with PDs. See, e.g., United States v. DeShazer, 554 F.3d 1281, 1287 (10th Cir. 2009) ("Whether or not [the defendant] could be diagnosed with an Axis I or Axis II illness is irrelevant, and there is no indication the district court relied on such a diagnosis."); United States v. Salley, No. 01 CR 0750, 2004 WL 170322, at *1 (N.D. Ill. Jan. 16, 2004) (asserting that whether the defendant has an Axis I or Axis II diagnosis is not dispositive for competency).

363. No. 1:07cr26, 2008 WL 2963056, at *26 (W.D. Pa. July 29, 2008) (citing Transcript of May 21 Competency Hearing at 30–31, 71, 272, 285–86; Transcript of May 22 Competency Hearing at 88–89).

364. Id. at *15.

365. Id. at *21 ("[The examiners] documented their own personal observations of the Defendant's manic and/or hypomanic episodes." (citing Transcript of May 21 Competency Hearing at 131–33)).

366. Id. at *15 (citing Report of Dr. Robert L. Sadoff at 4).

367. Id. at *20 (citing Transcript of May 21 Competency Hearing at 122, 124–25, 128, 143–46, 156, 202–05, 208, 210–11, 221).

368. Id. at *18–19.

369. Id. at *17 (quoting Exhibit Two at 13).

to BPD.[370] He argued that her grandiosity, "sense of entitlement," and arrogance were characteristics associated with narcissistic personality disorder.[371] Furthermore, he stated that because the defendant continued to struggle to collaborate with her attorney even after being prescribed medication, and, given that personality disorders "are not easily treatable," her real issue was that she had PDs.[372] To support the PD diagnoses, the state's specialist claimed that Diehl-Armstrong was "unscrupulous," "manipulative," and "demanding" and "intrusively advocated for her own needs and desires."[373] Ultimately, the court embraced the plurality of experts who confirmed Diehl-Armstrong's bipolar disorder diagnosis and found her incompetent because, when under stress, her mood disorder frustrated her ability to collaborate with her attorney.[374] The district court's findings reveal the central importance of diagnosis. Even if both experts observed the same interpersonal difficulties, namely collaboration and trusting others, the formal diagnosis mattered to the court. Unlike the Seventh Circuit, the Third Circuit has not excluded PDs from incompetency claims.

The Sixth Circuit's decision in *United States v. Heard* also echoed this hierarchy of diagnoses. In *Heard*, the court considered whether the district court abused its discretion when it accepted the defendant's stipulation to his competency and allowed him to represent himself.[375] The Sixth Circuit affirmed the judgment below by distinguishing between the kinds of disorders that can establish incompetence. The court explained that to argue that a PD can impede competency "seriously misunderstands the nature of" PDs because "[p]ersonality disorders are not psychoses."[376] The court credited an expert who explained that a PD "'is not a condition which interferes significantly with Mr. Heard's routine functioning, substantially impairs his reasoning or reality testing, or prevents him from comprehending or controlling his actions.' Quite the contrary: people with personality disorders are present in all walks of life."[377] The court continued:

> [A]ntisocials fill the nation's prisons: indeed the first criterion of an antisocial personality is a "failure to conform to social norms with respect to [sic] behaviors as indicated by repeatedly performing acts that are grounds for arrest[.]" Thus, to equate

370. Id. at *16.

371. Id. (quoting Exhibit Two at 10–11).

372. Id. at *17 (quoting Exhibit Two at 13).

373. Id. at *18 (quoting Exhibit Two at 14).

374. Id. at *37.

375. United States v. Heard, 762 F.3d 538, 541 (6th Cir. 2014) ("We review for an abuse of discretion the district court's determination not to conduct a competency hearing." (citing United States v. Ross, 703 F.3d 856, 867 (6th Cir. 2012))).

376. Id. at 542.

377. Id. (citation omitted) (quoting Report of Dr. Judith Campbell at 8).

> personality disorders with legal incompetence is simply to misunderstand what those terms mean.[378]

The court seemed keen to preserve the mental disease or defect category for an exceptional group of defendants. Precisely because the traits associated with PDs are so common, they do not trigger accommodations in the Sixth Circuit.

As in federal courts, certain state courts have also excluded PDs as a matter of law. The Missouri Court of Appeals denied relief to a defendant challenging the twin rulings finding him competent and denying a diminished capacity defense.[379] For both, the Missouri court relied on the forensic examiner's conclusions about the defendant, who had a "'borderline personality disorder with antisocial personality traits' rather than a qualifying mental disease or defect."[380] Here, as in other cases, the court did not disentangle the defendant's procedural claim of incompetency from the substantive claim of diminished capacity.[381] The defendant's diminished capacity defense appears to have overshadowed his due process claim at both the trial and appellate level. Once the court had established he did not have a qualifying disability under Missouri's statute for the purpose of diminished capacity, it briefly addressed his competency claim. Because a personality disorder was the defendant's only diagnosis, the appellate court found there was no prejudice when the trial court denied him a diminished capacity jury instruction and his incompetency claim.[382]

Lower courts in other jurisdictions have reached similar conclusions. The Delaware Superior Court, a trial court, found a defendant competent to stand trial even after considering conflicting testimony from experts and conceding that he likely had ASPD.[383] A post-conviction medical evaluation concluded that the defendant was likely incompetent at trial due to brain damage and a delusion disorder.[384] Another expert disputed

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378. Id. (second alteration in original) (citation omitted) (quoting Theodore Millon, Seth Grossman, Carrie Millon, Sarah Meagher & Rowena Ramnath, Personality Disorders in Modern Life 152 (2d ed. 2004)) (misquotation).

379. State v. Walther, 581 S.W.3d 702, 709 (Mo. Ct. App. 2019) ("Viewing the evidence in the light most favorable to Appellant establishes, at best, Appellant suffered from a personality disorder and not from a statutorily cognizable mental disease or defect.").

380. Id. at 706 (quoting Dr. Bridget Graham).

381. Id. ("The trial court denied this motion for the same reason it granted the State's motion to preclude Appellant's diminished-capacity defense.").

382. Id. at 709–10 (denying the defendant a jury instruction for a diminished capacity defense because he failed to establish a requisite mental disability under the statute).

383. State v. Cooke, No. 0506005981, 2022 WL 17817903, at *25 (Del. Super. Ct. Dec. 15, 2022), aff'd, 338 A.3d 418 (Del. 2025). The court's analysis did not hinge on the diagnosis alone, but it also catalogued facts to dispute the defendant's claim that he struggled to assist his attorneys. Id. at *17–18.

384. Id. at *22 ("[T]he persecutory delusions and his impairments in reading social cues and rationally weighing and deliberating options likely would have rendered him

the findings of brain damage and a prior diagnosis for schizoid/schizotypal personality disorder; instead, he used the evidence to support an ASPD diagnosis.[385] The court agreed that the defendant's "misbehavior can best be explained by the diagnosis of ASPD," precluding as a matter of law a finding of incompetency.[386] It noted that "from a legal standpoint, the competency threshold is quite low," assessing average rather than reasonable capacities.[387]

C. *A Different and Voluntary Disorder*

In addition to the courts' exclusions, experts articulate their own legal and psychological grounds for rejecting incompetency claims by defendants with PDs. "[A]ntisocial personality disorder is not the type of disorder that would cause one to be incompetent to stand trial or to lack appreciation for the criminality of his acts," explained one expert in a case that eventually went up to the Arkansas Supreme Court.[388] Similarly, in federal courts, a forensic psychologist frequently hired by the prosecution, Dr. Shawn Channell, explained that "Antisocial Personality Disorder is not generally determined to be a mental disease or defect sufficient to establish incompetence to stand trial."[389]

Examiners have justified their conclusions by arguing that PDs are categorically different from other disorders. These psychologists and psychiatrists assert that individuals maintain the ability to control the expressions of their disordered personality traits.[390] Testimony from one court-appointed psychiatrist led a court to state that unlike psychotic disorders, "personality disorders do not detach [the defendant] from reality or affect [their] rational ability to understand the world around [them]. They are merely maladaptive personality traits that lead to poor decisions. These are not competency limiting because they are voluntary decisions."[391]

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incompetent to stand trial, waive counsel and represent himself at the time of the trial . . . ." (quoting Report of Dr. Busham S. Agharkar)).

385. Id. at *23–24.

386. Id. at *25.

387. Id. (quoting State v. Shields, 593 A.2d 986, 1012–13 (Del. Super. Ct. 1990)).

388. Ward v. State, 455 S.W.3d 303, 306 (Ark. 2015).

389. United States v. Gillispie, No. 1:16-cr-77, 2017 WL 2779698, at *3 (E.D. Tenn. June 27, 2017) (citing the testimony of Dr. Shawn Channell at 47–49). The same examiner also provided similar testimony in two other cases. See United States v. Prigmore, 15 F.4th 768, 772 (6th Cir. 2021) ("Dr. Shawn Channell, a forensic psychologist with the Bureau of Prisons, evaluated Prigmore and concluded that he was competent to stand trial."); United States v. Mashali, 298 F. Supp. 3d 274, 276 (D. Mass. 2018) ("Dr. Channell concluded in January 2018 that defendant is competent." (citing Report of Dr. Channell at 25)).

390. See, e.g., United States v. Heard, 762 F.3d 538, 541–42 (6th Cir. 2014) ("Heard's 'diagnosis is not a condition which interferes significantly with [his] routine functioning, substantially impairs his reasoning or reality testing, or prevents him from comprehending or controlling his actions.'" (quoting Report of Dr. Judith Campbell at 8)).

391. United States v. Mitchell, 706 F. Supp. 2d 1148, 1220 (D. Utah 2010).

Similarly, before the Ohio Supreme Court, a defendant, Lance Hundley, asserted he had been incompetent at his sentencing and thus could not have validly waived counsel. Hundley argued that he was "likely under the duress of a personality disorder" when he asked to represent himself in his sentencing hearing.[392] The Ohio Supreme Court rejected his claim, crediting a psychiatrist who had assessed the defendant before his trial.[393] The psychiatrist explained that "Hundley's antisocial-personality disorder did not affect his competency or decisionmaking abilities."[394] In her testimony, she claimed that "people with personality disorders still have a conscious choice over how they interact."[395] The trial court and Supreme Court of Ohio endorsed this finding, explaining that Hundley could not establish that "a severe mental disorder or illness" affected his decision to waive counsel.[396] Notably, the Ohio statute does not even require the accused to establish a severe disorder or illness.[397]

D. *A Tendency for Procedural Misconduct*

Having made this distinction between PDs and psychotic disorders, and volitional and nonvolitional conditions, many examiners and courts assert that any difficulties defendants with PDs face in navigating their criminal cases are their own fault. These court actors characterize defendants with PDs as intentionally subverting courtroom processes, thereby engaging in procedural misconduct.[398] When a defendant struggles to collaborate with their attorney or withdraws from the process, many court actors interpret this conduct as deliberately obstructionist.[399] Experts and courts have alleged that defendants with PDs will go so far as to feign mental illness and incompetency.[400] Even if a defendant's conduct

392. State v. Hundley, 166 N.E.3d 1066, 1087 (Ohio 2020) (internal quotation marks omitted) (quoting Appellant's Merit Brief at 20, *Hundley*, 166 N.E.3d 1066 (No. 2018-0901), 2019 WL 2904315).

393. Id.

394. Id.

395. Id. (internal quotation marks omitted) (quoting Dr. Delaney Smith).

396. Id.; see also State v. Halder, No. 87974, 2007 WL 3286904, at *3–4, *6 (Ohio Ct. App. Nov. 8, 2007) (affirming the lower court's finding of competency and relying on a forensic expert's conclusions that the defendant did not "suffer[] from a major mental disorder" but only "a severe personality disorder").

397. See Ohio Rev. Code Ann. § 2945.37(G) (2023) (stating that if the court ascertains "that, because of the defendant's present mental condition, the defendant is incapable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense, the court shall find the defendant incompetent to stand trial").

398. See, e.g., State v. Dahl, 783 N.W.2d 41, 46–49 (N.D. 2010) (describing the accused person's vandalism of his jail cell as an attempt to manipulate the judicial system rather than irrational behavior stemming from mental illness).

399. See infra section III.D.2.

400. See, e.g., United States v. Greer, 158 F.3d 228, 237–41 (5th Cir. 1998) (upholding the district court's finding that the defendant, who suffered from personality disorders, feigned incompetency in an attempt to obstruct justice).

is consistent with the symptoms of disorders, examiners and courts are inclined to find that this undermining conduct is not the product of a mental disability. The following two sections underscore the importance courts and experts accord to malingering and to defendants' motivations to disrupt the criminal process.

1. *Malingering*. — Malingering is a common concern in any forensic assessment and is frequently grounds for denying defendants' competency claims.[401] Psychiatrist Ben Bursten explains that "[m]alingering commonly is conceptualized as the voluntary production of symptoms."[402] And it is a real concern for mental health experts in that it can unravel the entire forensic enterprise. Because it is not possible to observe mental processes, experts rely on the patient or defendant to report their own symptoms and experiences.[403] While the fields of psychiatry and psychology have devised ways to check for malingering, none are perfect.[404] Ultimately, in any case involving evidence about a person's mental health, experts and courts face a tradeoff between false positives and false negatives.[405] But something unique occurs in CST proceedings involving defendants who are labelled with PDs: Courts and examiners allege that their diagnoses predispose them to malingering.[406] That is, they claim that defendants will feign a disability to evade legal accountability. One trial court in Florida drew an explicit connection between PDs and misconduct when, relying on the doctors' findings, it stated the defendant had "malingering antisocial personality disorder" and found him competent to stand trial.[407] The *DSM* does not provide for such a diagnosis.[408] Instead, the examiner appears to

401. See Deborah W. Denno, Neuroscience and the Personalization of Criminal Law, 86 U. Chi. L. Rev. 359, 387 (2019) ("[N]ineteen cases noted the possibility of a malingering defendant: strikingly, courts held in more than half of those cases (eleven) that defendants were malingering or feigning an illness.").

402. Bursten, supra note 26, at 84 (citing J.A. Boydston, Malingering, *in* Comprehensive Textbook of Psychology/III (Harold I. Kaplan, Alfred M. Freedman & Benjamin J. Sadock eds., 3d ed. 1980)).

403. See Arthur A. Stone & Jaylan S. Turkkan, Preface to The Science of Self-Report: Implications for Research and Practice, at ix, ix (Arthur A. Stone, Jaylan S. Turkkan, Christine A. Bachrach, Jared B. Jobe, Howard S. Kurtzman & Virgina S. Cain eds., 2000) ("Peoples' reports about what they are feeling, what they are doing, what they recall happening in the past—that is, self-reported data—are essential to the health care profession and underlie many of our research endeavors.").

404. See Bursten, supra note 26, at 86–89 (discussing the various ways that one can check for malingering and clarifying that these methods are "not necessarily definitive").

405. See id. at 84 (stating that "whether the patient meets the criteria" for malingering "depends on [their] inner experiences").

406. See, e.g., Nolasco v. State, 275 So. 3d 795, 797 (Fla. Dist. Ct. App. 2019) (per curiam) (finding the defendant competent and noting that substantial evidence existed to support the trial court's determination of competence, including that the accused was diagnosed with malingering ASPD).

407. Id. (quoting the trial court's May 2, 2018, ruling).

408. DSM-5-TR, supra note 15, at 748–52 (including no references to "malingering antisocial personality disorder").

have improvised, fusing diagnostic and legal categories.[409] A PD diagnosis enables courts and examiners to set aside the defendant's claims of impairments and to recast the assertion of disability as a ploy.

Some prosecutors have used the diagnosis of a PD to argue in favor of competency.[410] For example, in a competency hearing in California, the prosecutor solicited evidence of the accused person's prior bad acts.[411] Before a jury, the defendant's father described when the defendant assaulted him, and the defendant's brother recounted the defendant threatening him with a weapon.[412] Defense counsel objected, arguing that the evidence was designed to be inflammatory in front of a jury charged with the narrow task of determining competency, rather than guilt.[413] But the appellate court did not disturb the trial court's decision to admit this evidence at the competency hearing. The court explained that the harm the accused, George Banda, perpetrated against his family members confirmed the forensic experts' ASPD diagnosis.[414] "The evidence of Banda's prior bad acts . . . was relevant to bolster [the state's expert's] determination that Banda had antisocial personality disorder, but was competent to stand trial. The prosecutor further used the diagnosis of antisocial personality disorder to argue that Banda was lying or pretending to be incompetent."[415] The competency hearing thus operated as a minitrial that ventured into the defendant's criminal history, not to establish liability but ability. The admissibility of prior bad acts at a competency hearing reveals that the issues of liability and disability are sometimes blurred, depending on the asserted diagnosis. This case demonstrates how PDs can be used to make the case for a defendant's ability rather than disability.

In response to prosecutors' claims about PDs, defense experts have exposed prosecutors' common strategy of using PD diagnoses to discredit defendants' claims of disability and incompetency.[416] For example, in a

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409. Compare United States v. Porter, 907 F.3d 374, 381, 385 (5th Cir. 2018) (affirming a district court's holding that a defendant was malingering—or falsifying his symptoms—and thus was competent to stand trial), with DSM-5-TR, supra note 15, at 748–52 (discussing the medical diagnostic criteria for "Antisocial Personality Disorder").

410. See, e.g., People v. Banda, No. F066389, 2015 WL 6734767, at *16 (Cal. Ct. App. Nov. 3, 2015) ("The prosecutor further used the diagnosis of antisocial personality disorder to argue that Banda was lying or pretending to be incompetent.").

411. Id. at *16 & n.12.

412. Id. at *8, *16.

413. Id. at *16. In California and Texas, the legislatures have empowered juries to determine competency. See Cal. Penal Code § 1369(c)(4) (2025) ("[A] determination of the defendant's competency to stand trial shall be decided by a jury."); Tex. Code Crim. Proc. Ann. § 46B.0755(d) (West 2025) (stating that when there is disagreement about a defendant's competence to stand trial, "a jury shall make the competency determination").

414. *Banda*, 2015 WL 6734767, at *16.

415. Id.

416. Deborah Denno's work notes a similar tactic prosecutors use at the penalty stage in capital cases. See Denno, The Myth of the Double-Edged Sword, supra note 299, at 533

contested CST proceeding, the California Court of Appeals reversed the trial court's finding of competency for insufficient evidence.[417] A state expert who found the accused fit to stand trial explained that "people with antisocial personality disorder are manipulative, . . . are better at malingering, and more likely to malinger, than people without antisocial personality disorder."[418] In response, a defense expert challenged the state expert's methods and motivations, explaining that forensic experts frequently infer malingering when someone with an ASPD diagnosis is being assessed for competency in a criminal proceeding.[419] Malingering, in his retelling, is an accusation by clinicians to undermine evidence of impaired functioning when the person accused also has been assigned a PD.[420] Ultimately, the appellate court discredited the finding of malingering and credited other experts who concluded that the defendant was not competent because of an intellectual disability.[421]

More commonly, however, courts have credited experts' commentary on malingering. In *Sands v. Commonwealth*, the Kentucky Court of Appeals consulted with an examiner at the Kentucky Correctional Psychiatric Center, who found the defendant, Robert Sands, was malingering and had a PD.[422] The court explained that Sands "was a malingerer with tendencies to be uncooperative by choice."[423] In consulting with the court, the state facility explained that it could not treat PDs.[424] The court thus affirmed the lower court's ruling that Sands was competent.[425]

(explaining that the court in *Fleenor v. Farley* held that "it was not 'unreasonable or unfair' for the prosecution to attempt to rebut expert testimony that [the defendant's] antisocial personality disorder could be controlled, especially because the defense set forth mental health and other mitigating evidence at the penalty phase" (quoting 47 F. Supp. 2d 1021, 1072 (S.D. Ind. 1998), aff'd sub nom., Fleenor v. Anderson, 171 F.3d 1096 (7th Cir. 1999))).

417. People v. Asberry, No. F070000, 2017 WL 2686544, at *31 (Cal. Ct. App. June 22, 2017).

418. Id. at *11. The appellate court ultimately rejected the expert's conclusion as unfounded because she did not establish all the criteria for ASPD. Id. at *26–27.

419. Id. at *12.

420. See id. (noting that "malingering is frequently attributed to criminal defendants" simply because they are a defendant in a criminal proceeding and have a PD).

421. Id. at *18, *31.

422. 358 S.W.3d 9, 11 (Ky. Ct. App. 2011) ("Dr. Russell Williams from [the Kentucky Correctional Psychiatric Center] . . . diagnosed Sands as being a 'blatant' malingerer and as having a personality disorder with narcissistic, dependent, and borderline traits.").

423. Id. at 13 (emphasis omitted); see also State v. Miraglia, No. A-0407-09T2, 2013 WL 1092106, at *11 (N.J. Super. Ct. App. Div. Mar. 18, 2013) (summarizing the opinion of one expert who diagnosed the defendant with "a personality disorder" with "narcissistic and borderline features" and concluded he could cooperate with his attorneys "[i]f he chose to" (alteration in original) (internal quotation marks omitted) (quoting Report of Dr. Timothy J. Michals)).

424. *Sands*, 358 S.W.3d at 12 (noting that the Kentucky Correctional Psychiatric Center was "unable to treat personality disorders").

425. Id. at 15.

In *State v. Jenkins*, the Nebraska Supreme Court affirmed the trial court's findings that the defendant, Nikko Jenkins, was competent after lengthy proceedings that produced multiple examinations and conflicting expert reports.[426] The trial court embraced findings that the defendant presented the symptoms of ASPD.[427] One psychiatrist opined that "there was a 'very slim' likelihood of Jenkins's having any other psychotic illness, and that Jenkins was mostly malingering."[428] The forensic report endorsed by the trial court suggested the defendant was pursuing secondary gain in manipulating his symptoms—specifically, that he was self-harming to get out of solitary confinement.[429] Other experts, however, cast doubt on the finding that Jenkins was malingering and provided a different diagnosis—psychosis—based on Jenkins's history of hearing voices since childhood.[430] Dr. Bruce D. Gutnik testified Jenkins could not survive the stress of trial without a mental breakdown, although Gutnik opined that Jenkins's competence could be restored.[431] But a state expert challenged these findings, arguing that Jenkins's presentation was not typical for schizophrenia, thereby suggesting he was fabricating his distress.[432] Multiple examiners suggested that the defendant was exaggerating his symptoms.[433] Yet they did not stop there and concluded Jenkins was manipulative. They also suggested that he had a PD, attributing his conduct to a psychiatric condition.[434] *Jenkins* reveals the paradoxical position PDs occupy: They are psychiatric conditions that confer capacity and competency.

2. *Breakdown in Attorney–Client Relations.* — The denial of incompetency claims is most troubling when examiners and judges appear to disregard persuasive evidence of a breakdown in the attorney–client relationship. When the person accused has a diagnosis for a PD, courts and examiners have interpreted that person's difficulties in collaborating with their attorney as a reflection of their desire to obstruct, rather than the product of their neurodivergence. These court actors have empha-

426. See 931 N.W.2d 851, 889 (Neb. 2019) ("We cannot say that the district court abused its discretion in finding Jenkins to be competent to waive counsel, to enter no contest pleas, to proceed to sentencing, and to be sentenced to death.").

427. Id. at 863.

428. Id. at 865 (quoting Dr. Y. Scott Moore).

429. Id. at 875.

430. Id. at 865 ("According to [Dr.] Gutnik, hallucinations and delusions are the two primary signs of psychosis and a review of Jenkins' records showed a history of hallucinations dating back to age 8. Thus, Gutnik testified that if Jenkins was malingering, he had been doing so since he was 8."). But see United States v. Gabrion, 719 F.3d 511, 533 (6th Cir. 2013) (en banc) ("To malinger is to manipulate; and persons with Histrionic or Antisocial personalities tend to be highly manipulative.").

431. *Jenkins*, 931 N.W.2d at 871.

432. See id. ("Moore thought that all the symptoms Jenkins reported were fabricated.").

433. Id. at 871–72 ("[M]any of Jenkins' symptoms appeared contrived."); id. ("Jenkins appeared to be attempting to use mental health symptoms for secondary gain.").

434. Id. at 872 ("Hartmann felt that Jenkins had a personality disorder which accounted for his symptoms.").

sized that the defendant was unwilling rather than unable to collaborate. As a Delaware intermediate appellate court concluded, a defendant diagnosed with ASPD was still "able to consult with his attorneys even if he made their jobs difficult."[435]

In *Silverburg v. Commonwealth*, a case on post-conviction review, the defense's expert concluded that Joseph Silverburg, the defendant, experienced a "paranoid mistrust of attorneys" that prevented him "from developing a trusting relationship with counsel."[436] The forensic psychologist noted that Silverburg's mistrust was so severe that he fired several attorneys, lodged disciplinary complaints against them, and filed pro se motions.[437] But these facts did not suffice to establish a due process deprivation. Defense counsel appears to have failed to specifically aver how Silverburg's paranoid mistrust would erode his ability to assist in his defense.[438] The court leaned on Silverburg's sophisticated understanding of the trial process, without probing whether he could draw on that knowledge to strategize in his own case.[439]

In *State v. Tribble*, the Vermont Supreme Court affirmed the trial court's finding that the accused, Dennis Tribble, was competent, despite a defense expert testifying that he was not "able to work with his attorney through the whole process of trial."[440] Psychiatrist Dr. Albert Drukteinis explained that Tribble's "delusional disorder . . . made it impossible for him to cooperate with his lawyers" and further insisted that the accused was not intending to be "obstructionistic."[441] The court, however, sided with the state's expert, who found Tribble was competent and diagnosed him with "paranoid personality disorder."[442] The state's expert stated that Tribble's PD "made it difficult for him to cooperate with his attorneys, but that this challenge was 'not one in [his] view that can't be achieved.'"[443]

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435. State v. Cooke, No. 0506005981, 2022 WL 17817903, at *20 (Del. Super. Ct. Dec. 15, 2022), aff'd, 338 A.3d 418 (Del. 2025).

436. No. 2005-CA-001751-MR, 2007 WL 2994604, at *1 (Ky. Ct. App. Oct. 12, 2007) (internal quotation marks omitted) (quoting a motion for funds for an expert evaluation of the defendant). The examiner's report is not available on the electronic databases, so it is not possible to say with certainty the precise diagnosis the examiner ascribed. Nonetheless, the descriptions suggest that the examiner may have diagnosed Silverberg with paranoid personality disorder. See id. ("Dr. Martha Wetter conducted a psychological evaluation of Silverburg on April 2, 2004, in which she opined that Silverburg has a paranoid mistrust of attorneys.").

437. See id. at *2.

438. Id. ("[H]e has provided little specific explanation of how this behavior harmed his defense.").

439. See id. ("Silverburg displayed a clear and often sophisticated understanding of the trial process.").

440. 892 A.2d 232, 236 (Vt. 2005) (internal quotation marks omitted) (quoting Dr. Albert Drukteinis).

441. Id. (internal quotation marks omitted) (quoting Dr. Drukteinis).

442. Id. at 236–37.

443. Id. at 236 (quoting Dr. Robert Linder).

The court suggested that Tribble's impairment and difficulties in collaborating were not enough for incompetency; although the "defendant had difficulty collaborating with his court-appointed attorneys, the [trial] court found that defendant nonetheless had shown that he could change his position and tactics."[444] In differentiating between a person's lack of ability and lack of will, the Vermont Supreme Court ruled out psychiatric disabilities that act on a person's willpower as evidence of incompetency. That is, the court seemed to exclude conditions that undermine someone's instincts to make choices to their advantage, like collaborating with their attorney.

In a capital case, the Ohio Court of Appeals, the state's intermediary appellate body, affirmed a trial court's finding of competency when the defendant, Biswanath Halder, showed signs of "a severe personality disorder that [made] him unwilling to assist his attorney with his defense."[445] The trial court considered the opinion of three experts.[446]

One expert found Halder competent, although she conceded that Halder's attorneys reported serious concerns about his memory loss.[447] The other two experts found Halder incompetent and diagnosed him with delusional disorder and personality disorders.[448] Relying on one of the defense expert's testimonies, the court noted that "Halder was convinced that his attorneys were conspiring against him."[449] His persecutory beliefs "[made] it almost impossible for him to have any meaningful collaborative relationship with his attorneys."[450] One expert, however, reported that Halder could discuss the events leading up to his arrest, an assertion that

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444. Id. at 237.

445. State v. Halder, No. 87974, 2007 WL 3286904, at *8 (Ohio Ct. App. Nov. 8, 2007).

446. See id. at *6 ("Three doctors submitted reports and testified at the competency hearing. Drs. Eisenberg and Fabian found that Halder was not competent to stand trial, while Dr. Bergman found that Halder was competent to stand trial.").

447. Id. at *4.

448. See id. at *3. ("Dr. Fabian testified that he believed that Halder suffered from both delusional and personality disorders."); id. ("Dr. Eisenberg . . . diagnosed Halder with a personality disorder with narcissistic, paranoid, and obsessive qualities.").

449. Id. One expert, Dr. James Eisenberg, although hired by the defense, is responsible for offering racist testimony, suggesting that certain racial groups are more prone to PDs than others. See Court Overturns Ohio Death Sentence After Defense Expert Testifies that One Quarter of Urban Black Men Should Be Locked Up or Thrown Away, Death Penalty Info. Ctr. (Sep. 1, 2022), https://deathpenaltyinfo.org/court-overturns-ohio-death-sentence-after-defense-expert-testifies-that-one-quarter-of-urban-black-men-should-be-locked-up-or-thrown-away [https://perma.cc/JT4P-5ETR] (last updated Mar. 14, 2025) ("Eisenberg . . . offered the jury what the court desribed as a 'racialized' desription of [antisocial personality disorder], falsely stating that while the disorder afflicated 'one to three percent of the general population,' it was present in '15 to 25 percent, maybe even 30 percent' of 'urban African American males.'" (quoting the testimony of Dr. Eisenberg at the trial of Malik Allah-U-Akbar)).

450. *Halder*, 2007 WL 3286904, at *3.

undermined the defense's claim that Halder could not properly consult with his attorneys.[451]

The trial court sided with the expert who found Halder competent.[452] The court did not consider the possibility that the defendant's feelings of mistrust could credibly vary from person to person.[453] The trial court ruled that Halder had "a severe personality disorder[] but showed no evidence of a major mental disorder."[454] The Ohio Court of Appeals concluded that the trial court's decision was supported by competent, credible evidence.[455]

Similarly, one expert credited by the California Court of Appeals stated that PDs can cause impairments that are circumstantial and variable.[456] In *People v. Tooker*, the court endorsed a court-appointed psychiatrist's testimony regarding his relationship with the defendant, Charles Tooker: "Once Mr. Tooker 'felt good' about me he exhibited no 'mental disease or defect' . . . that would substantially interfere with his ability to [proceed with the trial]."[457] The court concluded that because Tooker's symptoms varied, he had the power to control them.[458] It did not consider the fact that the variation was itself a product of a disability.[459] The court did not probe the expert's determination that Tooker had control over his symptoms.[460] The court found that Tooker "might choose not to cooperate if he did not like counsel, but he was cognitively able to do so."[461] He was deemed fit to stand trial, although he clearly struggled to confer with his attorney.[462] In reaching its conclusion, the court deferred to the expert's interpretation of the *Dusky–Drope* standard:

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451. See id. at *6–8 ("In addition, Dr. Fabian acknowledged that Halder also provided detailed answers to questions he posed.").

452. Id. at *4 (explaining that the trial court found Halder competent to stand trial after hearing Dr. Barbara Bergman's testimony that Halder was "capable of assisting his attorneys").

453. See id. (including no discussion that Halder's feelings could legitimately vary depending on the person and situation).

454. Id. at *6.

455. Id.

456. See People v. Tooker, No. A154181, 2019 WL 6726523, at *5 (Cal. Ct. App. Dec. 9, 2019) (noting that an expert "offered an additional diagnosis of antisocial personality disorder, which did not change his 'fundamental conclusions that if [Tooker] so chooses, [he] is entirely competent to go forward with a trial'" (alterations in original) (quoting Supplemental Report of Dr. Martin Blinder)).

457. Id. (first alteration in original) (quoting Dr. Blinder).

458. Id.

459. See id. (including no discussion on whether a PD could be the cause of such variation).

460. See id. (including no critical evaluation of Dr. Blinder's testimony and conclusions).

461. Id. at *7 (emphasis omitted).

462. Id. at *5 (noting that the court was "not persuaded" by Tooker's claims of incompetency, despite Tooker's lawyer eventually withdrawing from the case due to a "disintegrating" relationship with Tooker).

"'[C]ompetence' is less a relationship issue than an objective clinical measure of the degree to which an individual is cognitively able to . . . collaborate with counsel."[463]

By embracing the examiner's reframed legal standard, the California Court of Appeals diminished the relational component of the *Dusky–Drope* standard. It also rejected the court-appointed psychologist's report on the grounds that it was superficial.[464] The expert whose findings the court rejected had diagnosed Tooker with paranoid personality disorder and noted that while the defendant could grasp the proceedings cognitively, he "was not 'able to cooperate in a rational manner with counsel' due to his 'pervasive distrust and suspiciousness of others.'"[465] The expert stressed that Tooker "would not be able to prepare and conduct his own defense in a rational manner with or without counsel. This is something Mr. Tooker admits himself, he does not know how to defend himself."[466]

The Washington Superior Court favorably cited the opinion of an expert tasked with examining a defendant who was diagnosed with an unspecified personality disorder:

> While Mr. Brown may be a difficult client to represent, there is no data that shows his presentation is due to symptoms of a mental illness; but rather appear to represent maladaptive behaviors and attempts to avoid moving forward with his legal case. Therefore, it is my professional opinion that Mr. Brown has the capacity to understand the nature of the proceedings and assist in his own defense should he choose to do so.[467]

The examiner did not explain how they knew that Brown's attitude was a maladaptive choice, rather than the product of illness.[468] The examiner may have ultimately been correct, but the decision about choice was neither contested by the defense nor adjudicated by the court.[469] The expert further reasoned that while Brown's statements were unusual, they were not consistent with cognitive deficits because Brown would have had

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463. Id. (internal quotation marks omitted) (quoting Dr. Blinder).

464. See id. at *6 ("The other report by Ph.D. Kim is uncomfortably superficial, has no real substantive analysis in terms of what mental disorders the defendant would be suffering from that would afflict him here, [and] essentially is unpersuasive in its conclusion . . . ." (internal quotation marks omitted) (quoting the trial court's opinion)).

465. Id. at *5 (quoting Dr. Mary Ann Yaeil Kim).

466. Id. (internal quotation marks omitted) (quoting Dr. Kim).

467. State v. Brown, No. 11-1-121743-3 KNT, 2012 Wash. Super. LEXIS 284, at *12 (Wash. Super. Ct. Oct. 31, 2012) (emphasis omitted) (quoting Dr. Jolene Simpson); see also United States v. Wessel, 2 F.4th 1043, 1049–50 (7th Cir. 2021) (affirming the trial court's reliance on an expert who noted that the "[defendant's] maladaptive personality traits may prevent him from working with his attorney in a manner that is most effective" but "his decision to do so is considered volitional and not related to any mental illness" (internal quotation marks omitted) (quoting Dr. Allison Schenk's April 19, 2018, competency report)).

468. *Brown*, 2012 Wash. Super. LEXIS 284, at *11–12.

469. Id.

to present as more confused than he was.[470] Instead, the examiner maintained that Brown presented normally.[471]

E. *The Construction of Disability in CST Proceedings*

CST proceedings admit only a narrow band of disabilities.[472] Criminal court actors construct disability as a passive, unvarying, and cognitive phenomenon that is untouched by individual agency or larger social forces.

In criminal cases, the disabled defendant is passive. Psychotic disorders, which can distort perceptions of reality, consistently earn examiners' endorsement as authentic impairments that act on the defendant.[473] Meanwhile, examiners believe that defendants retain the capacity to mediate the symptoms of their PDs.[474] Perhaps because mistrust and deceit are universal experiences, examiners conclude that when defendants describe their symptoms or appear to sabotage their relationships with their attorneys, they do so willfully. And yet, examiners emphasize that deceit, manipulation, and lack of empathy are also common symptoms of PDs.[475] In framing the signs and symptoms of PDs as the product of volition while also embracing the diagnostic frame of a mental disorder, they find themselves in a paradox. Why even classify these personality traits as signs of illness?

Once examiners posit that the accused has the capacity to control their PD symptoms, they worry that defendants may manipulate the process to their advantage.[476] That suspicion of manipulation is a hallmark of sanism.[477] As Professor Doron Dorfman notes, "Disability's fluid nature,

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470. See id. at *10 ("[Defendant's] pattern of incorrect responses to questions assessing for cognitive deficits, if genuine, would be indicative of a severely demented and confused individual, which again were not evident in his general conduct."(quoting Report of Dr. Daisuke Nakashima)).

471. See id. at *9–11 ("[Defendant] possess[es] the normal range of mental capabilities without being compromised by any symptoms of a major psychiatric illness." (quoting Report of Dr. Nakashima)).

472. See Stork, supra note 22, at 931 (discussing the circuit split over whether Axis II personality disorders count as mental diseases under the statutory test for incompetency).

473. See Loren E. Mallory & Michelle R. Guyton, Competency to Stand Trial and Criminal Responsibility in Forensic Neuropsychology Practice, *in* APA Handbook of Forensic Neuropsychology 341, 346 (Shane S. Bush, George J. Demakis & Martin L. Rohling ed., 2017) ("[T]he presence of psychotic symptoms is one of the strongest predictors of incompetence." (citing Pirelli et al., supra note 76)).

474. See Johnson & Elbogen, supra note 305, at 209 ("The characteristic dysfunction of personality disorders often appears to be under volitional control.").

475. See Peay, supra note 25, at 234 (noting psychopaths' "capacity to be . . . manipulative" and the potential "absence" of empathy).

476. See supra section III.D.1.

477. See Doron Dorfman, Fear of the Disability Con: Perceptions of Fraud and Special Rights Discourse, 53 Law & Soc'y Rev. 1051, 1054–62 (2019) ("[T]he suspicion of fakery has been engrained in the legal treatment of disability and how disability rights are often viewed as 'special rights.'"); see also Katherine A. Macfarlane, Disability Without Documentation,

which takes on visible and invisible forms, is the basis for the perpetual connection made between disability and fakery."[478] Dorfman suggests this skepticism persistently obstructs efforts for legal recogni-tion.[479] The sanist suspicion reinforces criminal court's institutional skepticism toward defendants, who are perceived by court actors to be dishonest.[480] As a result, CST proceedings articulate an exclusive prototype for disability in criminal courts: It is an impermanent state. Criminal court's vision of disability rests on a binary distinction between illness and choice. Any conduct that appears volitional is denied recognition. Disability is reduced to an externally verifiable condition that overwhelms the true self.[481]

The parameters set by examiners also limit disability to those overwhelming conditions that interfere with cognition, like difficulty tracking and exchanging information, or challenges in approaching a problem in a goal-directed, logical, and reality-based way.[482] Psychotic disorders with delusions as their key feature are the most frequent grounds for incompetency. The courts remain primarily concerned with a defendant's understanding of proceedings, not their actual ability to participate.[483] Although courts and experts recognize that PDs may impede a defendant from assisting their attorney—a capacity explicitly mentioned in *Dusky v. United States*[484]—this is of secondary concern.[485] By excluding PDs, courts do not consider a group of psychiatric disabilities that can shape attorney–client relationships.

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90 Fordham L. Rev. 59, 70 (2021) (discussing how the documentation procedures for disability claims reveal a prevalent fear of fraud).

478. Dorfman, supra note 477, at 1056.

479. Id. at 1051.

480. See Nicole Gonzalez Van Cleve, Crook County: Racism and Injustice in America's Largest Criminal Court 69–70 (2016) (discussing how prosecutors and court staff characterize criminal defendants as either "monsters" or "mopes").

481. See Perlin, Hidden Prejudice, supra note 29, at 45 (explaining that one tenet of sanism is the belief that "[m]ental illness can easily be identified by lay persons" simply through observation and common sense).

482. See State v. Dahl, 783 N.W.2d 41, 45 (N.D. 2010) ("The doctors testified Dahl remembered the facts of his case, had moments of clarity, had a good understanding of the legal proceedings, knew where he was and understood the harm caused by his actions."); supra note 335 and accompanying text (discussing *Berg*).

483. See, e.g., Commonwealth v. Puksar, 951 A.2d 267, 285–89 (Pa. 2008) ("[A]ppellant's experts never opined that appellant lacked the capacity to understand the proceedings and what he was waiving. In fact, the defense experts opined to the contrary—that appellant clearly understood the nature of the proceedings, but had given up on the system."). The post-conviction review court also relied on the attorneys' contemporaneous observations confirming competency. Id. at 285.

484. See 362 U.S. 402, 402 (1960) (per curiam) (noting that part of the test for incompetency is whether the defendant can assist their attorney).

485. See State v. Gutierrez, No. 11-C-06119-8 KNT, 2011 Wash. Super. LEXIS 296, at *18–19 (Wash. Super. Ct. Oct. 5, 2011) ("As a result of his personality functioning, [the defendant] may be a difficult client to work with; however[,] he has the capacity to provide relevant information and to communicate rationally with his defense counsel, if he so chooses.").

Effectively, courts and examiners are affording greater importance to the first prong of the *Dusky–Drope* standard than to the second. That is, attorney–client collaboration appears to be less important than whether the accused understands the nature and object of the proceedings against them.[486] When there is evidence of mistrust between the accused and their lawyer or a breakdown in their relationship, courts are reluctant to attribute it to neurodivergence.[487] Courts can disregard this prong by relying on the Supreme Court's own gradual divestment in the right to counsel. Over the course of the twentieth century, the Supreme Court has retreated from maintaining the right to counsel it enunciated.[488] It has gone so far as to declare that defendants have no right to a "meaningful" relationship with their attorney.[489] That disinvestment has material consequences: It produces the conditions for chronic mistrust between people accused of crimes and their attorneys.

A criminal court's reluctance to impute attorney mistrust to psychological distress is thus not per se unreasonable. That is, there are structural conditions that produce mistrust, and that mistrust can be rational, rather than psychologically idiosyncratic.[490] Ethnographies of criminalization illuminate how a predatory carceral state and neoliberal divestment can cause those most likely to be policed, prosecuted, and incarcerated to withdraw and feel estranged from the trial process. Sociologist Matthew Clair has revealed that defendants' class positions can shape their attitudes toward their attorneys and the criminal process.[491] Working-class defendants are more likely to mistrust the process unfolding

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486. See Drope v. Missouri, 420 U.S. 162, 171–72 (1975) ("It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him . . . may not be subjected to a trial."); Perlin, Hidden Prejudice, supra note 29, at 60 ("Pretextuality, in combination with the impact of sanism on expert testimony and judicial decisions, often helps create a system that . . . regularly subverts statutory and case law standards; and . . . raises insurmountable barriers that ensure the allegedly 'therapeutically correct' social outcome and avoidance of the worst-case-disaster-fantasy, the false negative." (footnote omitted)).

487. See supra section III.D.1.

488. See Zohra Ahmed, The Right to Counsel in a Neoliberal Age, 69 UCLA L. Rev. 442, 446–48 (2022) (discussing the "evolution of the right to counsel" and shift from equality to autonomy as the "central value").

489. Morris v. Slappy, 461 U.S. 1, 14 (1983).

490. Sociologist Matthew Clair's careful ethnographic work documents factors contributing to this mistrust and shows how this mistrust is often expressed through conduct that defies the norms of criminal court. Matthew Clair, Privilege and Punishment: How Race and Class Matter in Criminal Court 3, 20, 28 (2020). This mistrust can express itself as defendants rejecting their attorneys' advice, even if it is to their strategic disadvantage. Id. at 1–3. Clair's findings corroborate similar research on the experiences of people from disadvantaged backgrounds forced to navigate criminal court. See Jonathan D. Casper, Did You Have a Lawyer When You Went to Court? No, I Had a Public Defender., 1 Yale Rev. L. & Soc. Action 4, 4–7 (1971) (exploring how seventy-two interviewees charged with felonies navigated the criminal system).

491. See Clair, supra note 490, at 7 ("The attorney-client relationship *reproduces* race and class inequalities.").

before them, precisely because of their more intimate experience of state repression and abandonment.[492] Clair's findings corroborate decades of sociological research on the experiences of people from disadvantaged backgrounds forced to navigate criminal court that shows that their alienation from the process worsens their case outcomes and reproduces their precarious class position.[493] Similarly, legal scholar and sociologist Monica Bell developed the concept of legal estrangement to move away from psychologizing those on the receiving end of state supervision.[494] Legal estrangement "implicate[s] a particular set of structural conditions that produced that subjective feeling."[495]

This body of literature exposes the structural conditions of mistrust. One function of the PD exclusion is that it does not require examiners to disentangle mistrust rooted in state abandonment from mistrust rooted in psychological distress. The line court actors draw excludes disabilities that express themselves in relationships, especially those involving state institutions. Thus, courts firmly shut the door to claims of disability anchored in a social model. In other words, court actors reject a view of disability that is produced through a complex set of interactions between social conditions and human bodies. Instead, they erect a firm boundary to exclude claims of difference that express most apparently in institutional settings. One consequence of this exclusion is that CST proceedings may deny recognition to the debilitating force of state repression. Mistrust is construed in these proceedings as an affective choice, never as the sign of a disability, whether it is produced by structural conditions or emerges spontaneously from a psychological condition. Disabilities that reflect the debilitating force of criminalization are categorically excluded.

IV. MORAL JUDGMENTS

This Part explores the function that the PD exclusion plays in criminal court. Chiefly, the exclusion preserves criminal law's commitment to imputing responsibility.[496] Indeed, a preoccupation with personal respon-

492. Id.

493. See, e.g., Victor M. Rios, Punished**:** Policing the Lives of Black and Latino Boys 8 (2011) ("Delinquent inner-city youths . . . spoke directly to the impact of punitive policies and practices prevalent in welfare and criminal justice institutions."); Paul E. Willis, Learning to Labour: How Working Class Kids Get Working Class Jobs 176–79 (Routledge 2016) (1978) ("[S]ince social reproduction of the class society in general continues despite the intervention of the liberal state and its institutions, it may be suggested that some of the real functions of institutions work counter to their stated aims."); see also Casper, supra note 490, at 4–7 (interviewing seventy-two subjects charged with felonies to explore how individuals navigate and perceive the criminal legal system).

494. See Monica C. Bell, Police Reform and the Dismantling of Legal Estrangement, 126 Yale L.J. 2054, 2066–67 (2017) (reframing the breakdown in police–civilian relationships as one rooted in legal estrangement rather than a crisis of legitimacy).

495. Id. at 2085.

496. For further discussion of the role of responsibility in criminal proceedings, see generally H.L.A. Hart, Punishment and Responsibility: Essays in the Philosophy of Law (2d

sibility undergirds examiners' and courts' conclusions that defendants with PDs are competent to stand trial.[497] Such an abiding preoccupation is arguably inappropriate because the *Dusky–Drope* standard directs trial courts to focus on the accused's participation, rather than their responsibility.[498]

A. *Assigning Responsibility*

State examiners often make one key allegation about defendants with PDs: They are in control, unlike defendants who are diagnosed with psychosis.[499] But when examiners claim that defendants are responsible for modulating the expressions of their PDs, they make normative rather than clinical judgments about responsibility. This section illuminates the logical leaps and assumptions examiners make to reach their conclusions.

In CST proceedings, examiners confront individuals who engage in ordinary, if maligned, conduct. They are tasked with assessing defendants' ability according to the legal standard.[500] Examiners' decisions suggest they put significant emphasis on one part of the analysis: whether impairments in cognition, affective response, and impulse control are the product of a mental illness or defect.[501] It is not unreasonable for them to interpret symptoms as they present—that is, to interpret conduct that appears manipulative, deceitful, and obstructionist as those very behaviors. Examiners conclude that because individuals with PDs act in ways that could be intentional and even calculating, they are being their true selves,

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ed. 2008) (centering questions concerning the legal criteria for attributing responsibility in the study of criminal offenses); James Edwards, Theories of Criminal Law, Stan. Encyc. of Phil. (Aug. 6, 2018), https://plato.stanford.edu/entries/criminal-law/#CrimResp [https://perma.cc/QE64-EDV3] (surveying the dominant theories of criminal respon-sibility along with the required elements and defenses implicated in proving responsibility).

497. See, e.g., United States v. Heth, 338 F. App'x 489, 496 (6th Cir. 2009) ("[B]oth psychologists concluded that [the defendant's] difficult nature was caused by a personality disorder, which both agreed was under his control and did not qualify as a mental disease or defect."); People v. Tooker, No. A154181, 2019 WL 6726523, at *7 (Cal. Ct. App. Dec. 9, 2019) ("In other words, Dr. Blinder opined that Tooker might *choose* not to cooperate if he did not like counsel, but he was cognitively able to do so.").

498. See supra section I.A.

499. See, e.g., *Tooker*, 2019 WL 6726523, at *6 ("As Tooker recognizes, one of the experts concluded that he could assist counsel in his own defense, which would normally constitute sufficient evidence of competency in this respect.").

500. See United States v. Brown, 669 F.3d 10, 17 (1st Cir. 2012) ("To challenge the district court's finding of competency, Edward 'must present facts sufficient to positively, unequivocally and clearly generate a real, substantial and legitimate doubt as to [his] mental competence.'" (alteration in original) (quoting United States v. Collins, 949 F.2d 921, 927 (7th Cir. 1991))).

501. See *Tooker*, 2019 WL 6726523, at *5 ("Once Mr. Tooker 'felt good' about me he exhibited no 'mental disease or defect' . . . that would substantially interfere with his ability to do any of these things . . . ." (alterations in original) (internal quotation marks omitted) (quoting Dr. Blinder)).

rather than expressing their psychiatric disability.[502] But in doing so, experts, judges, and attorneys sidestep genuine moral questions. They do not consider whether apparently intentional conduct could reflect internal distress and neurocognitive difference. Courts and examiners seem to assume that such conduct cannot be the product of disability.[503] But these are precisely the foundational questions about responsibility that PDs pose.[504]

It is not possible to empirically ascertain whether a particular trait is within a person's control.[505] As discussed, there is no consensus on the etiology of PDs.[506] There are some indications that PDs have neurological origins, just like other psychiatric disorders, suggesting that an individual with a PD does not have complete control over their behavior.[507] But as scholar Federica Coppola stresses, "Brain mechanisms do not alone account for an individual's (lack of) culpability."[508] And yet, PDs can cause impairments as severe as those resulting from other psychiatric conditions,

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502. See State v. Brown, No. 11-1-121743-3 KNT, 2012 Wash. Super. LEXIS 284, at *12 (Wash. Super. Ct. Oct. 31, 2012) (stating that the challenges associated with the client's presentation were not related to "symptoms of a mental illness" but rather an attempt by the client to halt the legal proceedings against him); see also Perlin, Hidden Prejudice, supra note 29, at 16 (describing how certain jurists throughout time have based determinations about mental disabilities on whether a "defendant bears a 'normal appearance'" (quoting Michael L. Perlin, The Supreme Court, the Mentally Disabled Criminal Defendant and Symbolic Values: Random Decisions, Hidden Rationales, or "Doctrinal Abyss?", 29 Ariz. L. Rev. 1, 83 n.811 (1987))).

503. See supra Part III.

504. PDs, psychopathy, and ASPD were each once known as moral imbecility or moral insanity. See Partridge, supra note 82, at 65–67; Lucy Ozarin, Moral Insanity: A Brief History, Psychiatric News, May 18, 2001, at 21, 21 ("The 1968 revision [of the *DSM*] uses 'antisocial personality,' and *DSM-III* and *-IV* retain this rubric.").

505. See, e.g., United States v. Lyons, 731 F.2d 243, 248 (5th Cir. 1984) (en banc). In *Lyons*, the Fifth Circuit refused to extend the federal insanity defense to circumstances in which the defendant lacked the capacity to conform their conduct to the requirements of the law. Id. The court cited two reasons for its decision: First, it relied on a new consensus in which "a majority of psychiatrists now believe that they do not possess sufficient accurate scientific bases for measuring a person's capacity for self-control or for calibrating the impairment of that capacity." Id. (citing Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196 (1983)). And second: a concern of malingering, explaining that "the risks of fabrication and 'moral mistakes' in administering the insanity defense are greatest 'when the experts and the jury are asked to speculate whether the defendant had the capacity to "control" himself or whether he could have "resisted" the criminal impulse.'" Id. at 249 (quoting Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196 (1983)).

506. See supra note 82 and accompanying text.

507. See Robert O. Friedel, Christian Schmahl & Marijn Distel, The Neurobiological Basis of Borderline Personality Disorder, *in* Neurobiology of Personality Disorders 279, 280 (Christian Schmahl, K. Luan Phan, Robert O. Friedel & Larry J. Siever eds., 2018) (noting "that BPD has a strong neurobiological basis and that it is important to understand the biological underpinnings of the disorder").

508. Coppola, supra note 76, at 3.

including in ways relevant to establishing legal responsibility.[509] As a result, bioethicists Dominic Sisti and Arthur Caplan argue against attributing responsibility to individuals with BPD: "BPD is an impairment in a person's ability to control their first-order desires. Persons suffering from BPD, by definition, also lack a stable deeper self and a strong set of volitions."[510] Nonetheless, those very individuals also "possess desires, and sufficient volition to give some insight and empathic capability, [so] there should be a prima facie assumption they are responsible for their actions."[511] In other words, the issue of control is contested within the fields of psychology and psychiatry. Jonas Robitscher, lawyer and psychiatrist, explains:

> A psychiatrist for example can give details of previous mental troubles, trace the course of a developing illness, demonstrate ego deficiencies—all of which may indicate a defendant might have found an impulse more irresistible than might a man with a stronger ego. But the point at which an impulse crosses the borderline from resistibility to irresistibility is not a determination for a psychiatrist; it can only be made in the abstract by a meta-physician and in the concrete by a judge and jury.[512]

In the absence of empirical certainty and in the context of disciplinary debates, the CST examiner is typically tasked with reaching findings about competency and ascertaining attribution: That is, are the difficulties the accused person is experiencing in their case attributable to their bad choices or to a psychiatric disorder? Even the way prosecutors, their experts, and courts frame the question assumes that choices cannot be shaped by disability.[513] To answer this loaded question, the examiner moves from a descriptive account to a normative account, from what is attributable to disability to what ought to be attributed to disability. Put more simply, the examiner is deciding what the law of competency ought to accommodate and what it ought to ignore.[514] The examiners deliver a moral judgment because they are implicitly applying a code of conduct

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509. Kinscherff, supra note 23, at 750–51 (noting that neither clinical nor scientific grounds can support categorical bans on insanity defenses for individuals with PDs because the "functional impairments associated with personality disorders can be severe and similar to . . . mental disorders that would be permitted for consideration of nullification of criminal responsibility" (emphasis omitted)).

510. Dominic A. Sisti & Arthur L. Caplan, Accommodation Without Exculpation? The Ethical and Legal Paradoxes of Borderline Personality Disorder, 40 J. Psychiatry & L. 75, 78 (2012).

511. Id.

512. Robitscher, supra note 26, at 170.

513. See supra section III.D; see also supra note 467 and accompanying text.

514. See Stephen J. Morse, Culpability and Control, 142 U. Pa. L. Rev. 1587, 1657–58 (1994) [hereinafter Morse, Culpability and Control] ("[P]sychology does not know, whether and to what degree people are *unable* to refrain from acting. . . . [W]e do not know how mental disorder affects self-control in general, apart from its more clear role in affecting perception and belief, which are variables central to rationality.").

that identifies those behaviors that justify accountability.[515] But the cloak of clinical expertise shrouds what are ultimately moral pronouncements.

Critics of psychology and bioethics have noted the essential moral character of diagnosing disease and disability.[516] The moral interventions occur in two ways. First, the fields of psychology and psychiatry make moral judgments when they define diagnostic categories in the *DSM* and pronounce when a cluster of characteristics "deviate[] markedly from the norms and expectations of the individual's culture."[517] Human diversity occurs naturally, but psychologists and psychiatrists determine which forms of difference ought to be recognized as medical abnormalities.[518] Not all differences are deemed disabilities or diseases. Some are deemed innocuous, while others are met with disdain rather than support. Diagnostic categories are thus not only scientific categories but also value-laden judgments about who deserves autonomy, dignity, and care and who can be rightfully denied those rights.[519]

Second, forensic examiners and other practitioners interpret the *DSM* in CST proceedings and make judgments about responsibility.[520] In CST proceedings, some examiners and courts advance a specific moral claim about individuals with PDs: that even individuals who lack normative

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515. See The Definition of Morality, Stan. Encyc. Phil. (Apr. 17, 2002), https://plato.stanford.edu/entries/morality-definition/ [https://perma.cc/XRQ4-XRVD] (last updated Jan. 28, 2025) ("[T]he term 'morality' can be used . . . descriptively to refer to certain codes of conduct endorsed by a society or a group (such as a religion), or accepted by an individual for [their] own behavior . . . .").

516. See, e.g., Foucault, Jan. 15 Lecture, supra note 31, at 39–41 (narrating the historical evolution of the relationship between psychiatry and law from an antagonistic one to a complimentary one, culminating in a consolidated medico-judicial power in which "both justice and psychiatry are adulterated" in the expert opinion commissioned to describe abnormal individuals).

517. See DSM-5-TR, supra note 15, at 733.

518. Amundson, supra note 85, at 51 (arguing that while philosophers and medical practitioners have attributed disabled people's disadvantages to their own abnormality, this may reflect professionals' "preference for 'ways of doing things that are preferred by the dominant classes and to which we have therefore become accustomed'" (quoting Anita Silvers, A Fatal Attraction to Normalizing: Treating Disabilities as Deviations From "Species-Typical" Functioning, *in* Enhancing Human Traits: Ethical and Social Implications 95, 108 (Erik Parens ed., 1998))).

519. Perlin states:

> "Morality" issues affect the incompetency to stand trial process in several critical ways. First, the process is subject to significant political bias. Second, the power imbalance issues that taint the entire forensic process are especially potent. Third, . . . the inadequacy of pre-trial evaluations, cursory testimony, the misuse and misapplication of substantive standards, and the non-implementation of Supreme Court constitutional directives receive little judicial or scholarly attention . . . .

Perlin, Pretexts and Mental Disability Law, supra note 101, at 653.

520. See supra Part III.

capacity are responsible for their conduct in criminal proceedings.[521] A person who lacks normative capacity struggles to recognize that other people have justifiable claims over their conduct.[522] And, indeed, one of the common traits across several PD diagnoses is a lack of empathy, "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another."[523] The *DSM* states that "[i]ndividuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others."[524]

Policymakers have wrestled with whether normative incapacity undermines claims for moral capacity and responsibility. For the most part, jurisdictions embrace a rule that attributes criminal responsibility for apparently volitional conduct.[525] In the absence of delusion or coercion, a person is responsible for their criminal conduct, even if they lack normative capacity.[526] The insanity doctrine does not accommodate defendants who experience socioaffective distress, like defendants who experience PDs.[527] The law has "limited regard of emotional faculties within the evaluation of the capacity for moral rationality."[528] As noted earlier, jurisdictions have imposed a categorical ban on claims of insanity that rely exclusively on a PD diagnosis.[529]

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521. See supra sections III.C–.D; see also Note, Bias Baked In: How Antisocial Personality Disorder Diagnoses Trigger Legal Failures, 138 Harv. L. Rev. 1101, 1118 (2025) ("Judgments about the culpability and moral worth of a person diagnosed with ASPD can prematurely end investigations into mitigating circumstances and foreclose empathy.").

522. Gary Watson, The Trouble With Psychopaths, *in* Reasons and Recognition: Essays on the Philosophy of T.M. Scanlon 307, 307–08 (R. Jay Wallace, Rahul Kumar & Samuel Freeman eds., 2011) ("[P]sychopathy . . . precisely involves an incapacity to recognize the interests of others as making any valid claims on them.").

523. Empathy, Merriam-Webster, https://www.merriam-webster.com/dictionary/empathy [https://perma.cc/5AUH-8SHP] (last visited Feb. 10, 2025); supra note 39 and accompanying text.

524. DSM-5-TR, supra note 15, at 749.

525. See, e.g., United States v. Lyons, 731 F.2d 243, 249 (5th Cir. 1984) (en banc) ("[T]he risks of fabrication and 'moral mistakes' in administering the insanity defense are greatest 'when the experts and the jury are asked to speculate whether the defendant had the capacity to "control" himself or whether he could have "resisted" the criminal impulse.'" (quoting Richard J. Bonnie, The Moral Basis of the Insanity Defense, 69 A.B.A. J. 194, 196 (1983))).

526. See Watson, supra note 522, at 307 ("Those who (without psychosis or coercion) deliberately and callously harm, defraud, and manipulate others, as psychopaths frequently do, seem appropriately subject to blame and to applicable penal sanction.").

527. See Model Penal Code § 4.01(2) (Am. L. Inst., Proposed Official Draft 1962) (excluding "an abnormality manifested only by repeated criminal or otherwise anti-social conduct").

528. Coppola, supra note 76, at 26.

529. See Richard J. Bonnie, Should a Personality Disorder Qualify as a Mental Disease in Insanity Adjudication?, 38 J.L. Med. & Ethics 760, 761 (2010) (noting that "[i]n a few jurisdictions . . . the insanity statutes specifically exclude all personality disorders from the definition of mental disease"); Johnson & Elbogen, supra note 305, at 207–08 (surveying

From another perspective, philosophers have theorized about individuals who lack normative incapacity. Philosopher Gary Watson has argued that normative incapacity prohibits accountability.[530] Watson argues that although a person can cause harm, they are not necessarily accountable.[531] He identifies a group of people who "are disabled from standing in the reciprocal relations or . . . from engaging in the mutual recognition that lie at the core of moral life."[532] A person's normative incapacity may cause them to harm others and invite reproach. But their normative incapacity also means they lack moral agency.[533] While it might feel intuitively correct to blame someone who "willingly or callously" harms others "without coercion or psychosis," Watson suggests the person cannot be held morally accountable if they cannot recognize that others have standing to make legitimate claims on their behavior.[534] In other words, under Watson's account, a person cannot be held responsible if they do not have the capacity—emotionally, cognitively, and volitionally—to grasp the basis for interpersonal accountability and act accordingly.[535]

In CST proceedings, examiners navigate similar terrain. Examiners confront individuals who appear to manipulate CST proceedings and refuse to speak with their attorneys.[536] These defendants tend to cause irritation, even if they do not draw outright condemnation.[537] The examiners must decide whether apparently subversive activity ought to

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federal and state cases and statutes that have excluded certain PDs, including ASPD, as a basis for diminished capacity defenses). But New Jersey has recognized diminished capacity defenses when the defendant presented evidence of a PD. See State v. Galloway, 628 A.2d 735, 740 (N.J. 1993) ("[T]he statutory defense of diminished capacity contemplates a broad range of mental conditions that can be a basis for the defense . . . .").

530. Watson, supra note 522, at 307–08 (exposing the moral dilemma in holding individuals who lack normative capacity accountable for their actions). Watson set forth four propositions that have served as an anchor in philosophical literature and capture this key dilemma. The grounds are as follow: (1) "[N]ormative incapacity undermines moral agency," (2) "moral[] responsibility requires moral agency," (3) "being properly open to moral blame and penal sanctions entails the possession of moral agency," and (4) "to willingly and callously harm or manipulate others, without coercion or psychosis, is to make oneself a proper object of moral blame and punishment." Id. Upon first glance, these four claims may seem uncontroversially true. But in considering the special case of individuals who are unable to cultivate empathy, a tension emerges. Id. Watson suggests that there is a group of people who meet proposition four by causing harm without apparent external excuse but who also lack normative capacity, thus undermining proposition one. Id. "[W]hat appears to explain a good bit of the conduct for which we naturally want to blame these individuals is the very incapacity that disqualifies them as moral agents." Id.

531. See id.

532. Id.

533. Id.

534. Id.

535. Id.

536. See supra section III.D.

537. See supra sections III.D.1–.2; see also supra notes 445–455 and accompanying text (discussing *Halder*, a case in which the court found the defendant competent despite his inability and unwillingness to assist his defense counsel).

trigger a procedural type of legal responsibility. That is, they decide not on the ultimate substantive question of whether the person should be blamed and punished but on whether they should be compelled to undergo the process for blame and punishment. State examiners hold defendants with PDs accountable for their procedural misconduct as if they were morally capable actors, but they fail to consider whether the defendant has the capacity to appreciate the legitimacy of the proceedings brought against them.[538] But what if, instead, the defendants in the cases profiled in this Essay struggled to collaborate and potentially exaggerated their symptoms not just because they made bad choices but because they experience such profound mistrust rooted in psychological distress? While a person who shows symptoms of a cluster B personality disorder may be more likely to engage in behavior that causes interpersonal harm, they may also fail to grasp the very basis for interpersonal accountability.[539] More precisely, they may be unable to recognize the criminal proceedings as justifiable or their legal representatives as faithful. Their socioaffective difference may frustrate cooperation, which the law of criminal procedure otherwise expects.[540] While the examiners do not seem to embrace this possibility, the cases surveyed suggest an alternative interpretation that would credit PDs as genuine psychiatric disabilities, just as genuine as psychosis, and recognize the importance of interpersonal collaboration for trial competency.[541]

The controversy PDs pose is mostly buried.[542] Furthermore, court testimony does not reveal a principled basis for attributing procedural misconduct to defendants with PDs.[543] At worst, it seems that examiners' moral judgments are grounded in the negative reactions that the manifestations of PDs evoke. Or perhaps they are suggesting that legal competence does not require normative competence. In other words, they may be suggesting that defendants with PDs need not have a robust capacity to appreciate the legitimacy of criminal processes, their attorneys, and the examiners. But we are left guessing. Examiners do not explain how they set the threshold for responsibility that underlies their legal determinations. While we cannot expect examiners to offer philosophical proof, we can expect them to offer insight into how they reconcile the dilemma that PDs pose: a category of disorders in which the person is predisposed to display morally disvalued traits that confer the impression of agency.

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538. See supra sections III.C–.D.

539. See Watson, supra note 522, at 308 (noting psychopaths often experience "callous interpersonal relations" and "refus[e] to take responsibility for the troubles caused to others").

540. See supra section III.D.2; see also Drope v. Missouri, 420 U.S. 162, 172 (1975).

541. See supra sections III.D.1–.2.

542. See supra Part III.

543. See supra section III.D.

B. *The Disability–Criminality Binary*

In CST proceedings, the essential moral character of psychology and psychiatry becomes apparent. Examiners define mental disability for competency purposes narrowly. Conduct that is consistent with criminal liability cannot support a defense of competency.[544] In this way, competency decisions mirror substantive criminal outcomes. CST, a procedural safeguard, absorbs criminal court's substantive agenda.

As this Essay has shown, the steps for determining whether someone is responsible for their conduct in both the competency and insanity context are the same.[545] PDs pose the same controversy across these two areas of law. The uniformity is remarkable because the two bodies of law advance distinct purposes. Procedural accommodations for disability advance the Sixth Amendment's guarantee of a fair trial and effective representation.[546] Insanity is not a constitutional doctrine but is a widely embraced defense in the United States that advances the goals of positive retribution.[547] When courts adjudicate competency, they take the same approach to differentiating between disability and deviance that is used in the insanity context and thus potentially ignore the unique values animating the CST standard: It is a protection aimed at recalibrating the imbalance between the defense and the prosecution and between able-minded and disabled defendants.[548] Furthermore, the exclusion of PDs in the insanity doctrine is more firmly established in law.[549] The insanity doctrine has received more thorough scholarly attention than competency.[550] Judges first dispense with insanity before addressing

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544. See Michel Foucault, Lecture of 22 January 1975, *in* Abnormal: Lectures at the Collège de France 1974–1975, supra note 31, at 55, 64 (stating that, despite the possibility that disability "upsets the natural order, . . . it has a place in civil or canon law," unlike "monstrosity," which is an "irregularity that calls law into question and disables it").

545. See supra notes 358–361 and accompanying text (discussing a federal case in which discussion of the insanity defense subsumed discussion of incompetency claims); supra notes 379–382 (discussing a state case in which a diminished capacity defense subsumed discussion of incompetency claims).

546. See Drope v. Missouri, 420 U.S. 162, 171–72 (1975) ("[W]e held that the failure to observe procedures adequate to protect a defendant's right not to be tried or convicted while incompetent to stand trial deprives him of his due process right to a fair trial.").

547. See Kahler v. Kansas, 140 S. Ct. 1021, 1037 (2020) (declining to hold that the Constitution required Kansas to adopt an insanity defense when the defendant could not appreciate his acts as immoral); id. at 1030 ("Kahler is right that for hundreds of years jurists and judges have recognized insanity (however defined) as relieving responsibility for a crime.").

548. See Bonnie, A Theoretical Reformulation, supra note 4, at 295 ("To proceed against a defendant who lacks the capacity to recognize and communicate relevant information to his or her attorney and to the court would be unfair to the defendant and would undermine society's independent interest in the *reliability* of its criminal process.").

549. The Model Penal Code's exclusion of ASPD is one example of this firm tendency. See Model Penal Code § 4.01(2) (Am. L. Inst. Proposed Official Draft 1962).

550. See supra note 76 and accompanying text.

competency.[551] These trends reveal the force of the insanity doctrine as it permeates competency decisions. Ultimately, concerns about moral and legal responsibility shape a procedural protection.

To put it in other terms, CST proceedings are not merely procedural but substantive. When it comes to PDs, CST proceedings, in their most dramatic form, become miniature trials about the accused's moral and criminal responsibility.[552] Procedural and substantive criminal law are not always so easy to disentangle. But criminal procedure derives its legitimacy from erecting firewalls around substantive criminal law. In theory, the rules of process are the same regardless of guilt or innocence to ensure accurate case outcomes.[553] But courts have frequently allowed substantive concerns to overshadow procedural ones.[554] In other words, courts have been willing to undermine defendants' criminal process rights precisely because defendants are factually culpable, legally guilty, or—in some eyes—worthy of contempt.

In the CST context, substance and process converge, but in a unique way: A rule of procedure, modeled after a rule of substance, has also absorbed its normative content. It is not simply that the background context of guilt and innocence shapes the rule. The procedural rule, CST, replicates the substantive one regarding legal responsibility. That is, even if examiners are not opining on defendants' ultimate criminal responsibility, they reach a finding of moral responsibility that mimics a finding of guilt.

The shadow of substantive concerns helps explain examiners' narrow framing of disability in CST proceedings, discussed in Part II. Competency

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551. See supra notes 358–361 and accompanying text (discussing *Rosenheimer*, a case in which discussion of the insanity defense subsumed discussion of incompetency claims).

552. See supra notes 410–415 and accompanying text (discussing *Banda*, a case in which the defendant's competency proceeding veered into questions about prior criminal history and culpability).

553. See Martinez, supra note 33, at 1019 ("We presume innocence in criminal trials not because we think most defendants are in fact innocent, but because of concerns about limiting government power and a preference for avoiding erroneous convictions even at the cost of erroneous acquittals.").

554. Courts have narrowed Fourth and Fifth Amendment protections for criminal defendants in the face of gory and disturbing facts about their crimes. See, e.g., Brewer v. Williams, 430 U.S. 387, 393–94 (1977) (stating that the defendant waived his right to an attorney when he provided critical information to police officers during the investigation of the abduction and murder of a ten-year-old girl). The sustained backlash to *Mapp v. Ohio* and the exclusionary rule is grounded in a view that guilty defendants deserve fewer protections than the innocent. See, e.g., Stone v. Powell, 428 U.S. 465, 490 (1976) ("The disparity in particular cases between the error committed by the police officer and the windfall afforded a guilty defendant by application of the rule is contrary to the idea of proportionality that is essential to the concept of justice."); Louis Michael Seidman, Factual Guilt and the Burger Court: An Examination of Continuity and Change in Criminal Procedure, 80 Colum. L. Rev. 436, 449 (1980) ("When a guilty [defendant] is released because of a fourth amendment violation, the result is not only truth-denying; it denies the truth in order to mold police conduct in a way that itself impedes our ability to secure the truth.").

assessments complement other moves in criminal law to exclude forms of disability that would absolve antisocial behaviors of responsibility. In both insanity and competency contexts, there are categories of disabilities that carceral actors do not recognize as such[555]—perhaps because doing so would undermine the foundational institutional logic that misconduct is prima facie evidence of volition. Apparently, volitional conduct is sufficient for responsibility. As such, in criminal court, disability operates as an exclusive category that is reserved for those whose neurodivergence does not invite blame and whose conduct does not appear voluntary.[556] Disability is a residual category for those ways of being that do not disrupt a robust conception of criminal responsibility.

The knowledge examiners produce is anchored in distinct institutional motivations—namely the administration of criminal law. Disability emerges as a relational concept, defined by the "oriented act of perception, intimately tied to [the] evaluation that guides interaction."[557] In an employment context, as Professor Jasmine Harris points out, disability tends to be construed as the "markers of corporeal deviation" that single out people whose bodies "disrupt a constructed ideal of an optimal 'docile body' and its celebrated set of functional capacities that position the ideal market actor."[558] Criminal court defines disability in contradistinction to criminality and its close cousin: moral culpability.[559] The person who is disabled and incompetent is one who does not attract blame.

The treatment of PDs in CST proceedings exposes the limits of even the modest agenda of disability rights in the carceral state. The demands and underlying logic of criminalization place ideological limits on criminal courts' accommodations. CST proceedings may always fail to accomplish their professed function of equalizing the playing field.

V. IMPLICATIONS FOR REFORM

This Part teases out the practical implications of these findings for court reform. First, when it advances their clients' interests, defense attorneys can litigate the *Dusky–Drope* standard to enforce the second prong that relates to the attorney–client relationship, and they can push examiners and courts to make more transparent and principled decisions

555. See supra section III.B.

556. See Slobogin, Psychiatric Evidence, supra note 206, at 25–26 (reporting on the exclusion of novel psychiatric testimony that "pushes the doctrinal envelope" because it would "open the floodgates to traditionally disfavored volitional impairment claims"); see also Bonnie, Compulsive Gambling, supra note 259, at 7 (stating that "the link between a compulsion to gamble and the offense of theft is too tenuous to permit a jury to find that the defendant, as a result of his compulsive gambling disorder, lacked substantial capacity to conform his behavior to the requirements of the laws").

557. Titchkosky, supra note 10, at 5.

558. Jasmine E. Harris, The Aesthetics of Disability, 119 Colum. L. Rev. 895, 952 (2019).

559. See supra section IV.A.

about PDs. Second, the exclusion of defendants with PDs reveals some of the inherent limitations of disability inclusion in criminal court. Third, the underappreciated moral and substantive valence of examiners' decisions should temper our enthusiasm for therapeutic interventions in criminal court that rely on behavioral health expertise, as these may always exclude an important group of neurodivergent defendants.

A. *Courtroom Correctives*

Examiners and courts make two critical errors in their CST assessments and findings. One is a category error. Courts have deferred entirely to examiners to make normative decisions about responsibility in addition to clinical assessments about capacities.[560] But responsibility, even in a procedural context, is a question of law, policy, and institutional prerogatives. Whether to treat defendants with PDs as responsible or incompetent is a legal question to be litigated and adjudicated. The other type of error is an interpretive error. Courts have ignored the second, relational element of the *Dusky–Drope* standard and have failed to engage with the competency standard's core purpose.[561]

To rectify the category error, examiners and courts should surface several embedded legal issues that emerge in CST proceedings involving PDs. These distinct issues deserve more rigorous engagement by litigants and explicit treatment by courts.

First, courts must decide as a matter of policy if PDs can form the basis of incompetency. If not, what are the principled grounds for excluding these diagnoses and behaviors? If malingering and misconduct are the primary motivations for excluding PDs, then courts must be willing to conclude that, as a matter of law, individuals with these diagnoses are responsible for their conduct. It must be a legal, rather than an empirical, conclusion because courts cannot accurately claim that a person's emotional fragility and deep-seated mistrust rooted in psychopathology does not undermine the capacities the competency standard measures. Courts should be forced to justify their decisions on legal grounds—that is, by actually holding that the competency standard does not recognize certain categories of impairments. And defense attorneys will need to remind courts that the *Dusky–Drope* standard contemplates a range of disabilities that shape interpersonal relations.

Second, if courts do not categorically exclude PDs, under what circumstances can PDs sustain a finding of incompetency, if not in the case before the court? As a litigation position, defense attorneys should urge courts to separate facts from law, even if ontologically those are unstable categories. Courts should be explicit when they determine whether the

560. See supra Part III.

561. See supra note 103 and accompanying text.

defendant can control their symptoms and explain why their competency finding hinges on the defendant's apparent control.

Control, and whether conduct stems from a disorder or from the person, cannot be definitely ascertained empirically.[562] Furthermore, the capacity for self-control might militate in favor of incompetency because it suggests the defendant may be amenable to treatment.[563] As a matter of psychology, the exercise of control over a disorder is not necessarily incompatible with a psychiatric disability.[564] Similarly, that a person's symptoms vary does not necessarily show control; it may instead underscore the fluid nature of disability.[565] Judges should reach these determinations by drawing on law, policy, and clinical expertise.

To rectify the interpretive error, as courts address this issue, defense attorneys should press upon the distinct policy motivations for the competency safeguard. Seeking consistency with the insanity doctrine's exclusions is not a satisfactory explanation because the competency doctrine serves different purposes. The singular focus on responsibility may be more appropriate for the insanity doctrine. But that concern is diminished if fashioning a procedural protection. One could imagine an examiner willing to recognize PDs at the competency stage and not the insanity stage, when the key consideration is the fairness and accuracy of the process rather than culpability. Furthermore, to find that the attorney–client element of the competency standard is secondary in importance creates new law. Neither *Dusky*, *Drope*, nor subsequent Supreme Court cases permit courts to prioritize one part over the other.[566]

These arguments are only possible when defense attorneys document and present the specific behaviors that meet the *Dusky–Drope* standard. If the accused's only diagnosis is a PD, the attorney should establish how conduct consistent with that label can impede trust, communication, and

562. Morse, Culpability and Control, supra note 514, at 1657 ("[T]he studies do not address, and folk psychology does not know, whether and to what degree people are *unable* to refrain from acting. Neither in psychology, philosophy, nor folk psychology is there a reasonably uncontroversial understanding of these matters." (footnote omitted)).

563. The capacity for control is one of the reasons why dialectical behavior therapy (DBT) has proven to be an effective treatment for BPD. DBT asks patients to "balance two seemingly opposing forces: acceptance and change," and in turn to embrace their reality as such while also appreciating their capacity to transform their current conditions. See Dialectical Behavior Therapy to Treat Borderline Personality Disorder, Mass Gen. Brigham McLean, https://www.mcleanhospital.org/treatment/bpd-dbt (on file with the *Columbia Law Review*) (last visited Aug. 20, 2025); see also Jennifer M. May, Toni M. Richardi & Kelly S. Barth, Dialectical Behavior Therapy as Treatment for Borderline Personality Disorder, 6 Mental Health Clinician 62, 63–66 (2016) (discussing the effectivity of DBT for individuals with BPD).

564. The *DSM*'s recognition of ASPD suggests that even intentional conduct characterized by "[a] pervasive pattern of disregard for and violation of the rights of others" can establish a psychiatric condition. See DSM-5-TR, supra note 15, at 748.

565. See supra note 10 and accompanying text; supra notes 453–459 and accompanying text.

566. See supra section I.A (discussing the multiple prongs of the *Dusky–Drope* test).

collaboration. Ideally, the defense should address the impairments as they shape all dimensions of legal decisionmaking: cognition, affect, and impulse control. To anticipate arguments that diminish such evidence because it stems from a PD rather than a psychotic disorder, defense counsel can draw on emerging research that debunks the categorical distinctions between PDs and psychotic disorders.[567] PDs are also responsive to treatment and have neurological underpinnings.[568] Furthermore, the symptoms observed may indicate other unaddressed psychiatric conditions.[569] Finally, defense counsel should underscore that courts retain the ultimate authority to determine whether the defendant's procedural difficulties are a product of a psychiatric disability. Determining which, if any, conduct is a product of a disability is a question of responsibility that implicates ethical, not merely clinical, considerations. Currently, the examiners' conclusions conflate the clinical and moral dimensions of their decisions,[570] preventing clearheaded analysis. Defense attorneys should surface the veritable dilemma.

While rules of evidence empower experts to address each of the elements of the *Dusky–Drope* analysis,[571] experts are no more qualified to determine control and volition than a judge. The fact that an expert has concluded that the defendant has a disorder should weigh in favor of incompetency, not against it. Defense counsel should argue that although there is always a risk of malingering, eliminating the risk of fabrication would also eliminate accommodations.[572]

Defense attorneys should carefully consider when to advance such arguments. There may be occasions when a finding of incompetency, a pause in the proceedings, and mandatory treatment could be the lesser of two evils.[573] The risks of institutionalization, however, should not be underestimated.

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567. See, e.g., Kinscherff, supra note 23, at 748 (suggesting mental disorders are better understood as dimensional rather than categorical diagnostic constructs); supra notes 269–294 and accompanying text.

568. See supra notes 282–292 and accompanying text.

569. See Wayland & O'Brien, supra note 298, at 540 (discussing that the diagnosis process for ASPD relies on an "over-inclusion of symptoms," which can lead to inaccuracy and a failure to recognize other diagnoses or conditions).

570. See supra section IV.A.

571. See Fed. R. Evid. 702–704.

572. See Bursten, supra note 26, at 93 (arguing that "exclud[ing] all circumstances where lying is possible would deprive society of the compassion it requires as part of the emotional glue that holds it together").

573. For a critique of the lesser-evil calculus in social reform, see Eyal Weizman, The Least of All Possible Evils: Humanitarian Violence From Arendt to Gaza 6 (2011). Scholar Eyal Weizman stated,

> The principle of the lesser evil is often presented as a dilemma between two or more bad choices in situations where available options are, or seem to be, limited. . . . Both aspects of the principle are understood as taking place within a closed system in which those posing

Advancing this kind of strategic litigation requires funds.[574] Defense attorneys and public defender offices would benefit from more resources to rigorously contest examiners' and courts' findings that PDs are not cognizable disabilities. Defense attorneys need funds to hire forensic experts, time to work with them to prepare for hearings, time to build trust with their clients, and time to educate themselves about developments in mental health. Additional funding could also help prevent unnecessary competency litigation and the risk of prolonged civil commitment because it would grant public defender offices the resources to devise ways to support their neurodivergent clients.

B. *Beyond Competency*

Advocates asking courts to recognize their clients as incompetent may face an epistemic barrier. Examiners produce a view of disability skewed by institutional demands.[575] Unless those institutional constraints shift, advocates' pleas will go unanswered. To ask examiners and courts to accept PDs as grounds for incompetency troubles substantive criminal law's default commitment to ascribing blame. Exemptions from competency could bleed into exemptions from criminal responsibility. This context cautions against efforts to compel courts and examiners to

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> the dilemma, the options available for choice, the factors to be calculated and the very parameters of calculation are unchallenged. Each calculation is undertaken anew, as if the previous accumulation of events has not taken place, and the future implications are out of bounds.

Id.

574. Increasing funding for public defenders and indigent defense providers is not a new demand, but a plea as old as the right to counsel itself. See Sara Mayeux, Free Justice: A History of the Public Defender in Twentieth-Century America 144–45 (2020) (discussing the indigent defense crisis, including crushing caseloads in Boston, once a leader in public representation); Sara Mayeux, What *Gideon* Did, 116 Colum. L. Rev. 15, 54–55 (2016) (discussing the absence of federal support for public defense in the 1960s through the 1970s). For an assessment of the crisis today, see Bryan Furst, Brennan Ctr. for Just., A Fair Fight: Achieving Indigent Defense Resource Parity (2019), https://www.brennancenter.org/media/4438/download/Report_A%20Fair%20Fight.pdf?inline=1 [https://perma.cc/36TP-CQK8] (finding unsustainable workloads, disparities between public defenders' and prosecutors' salaries, insufficient support staff, and disparate federal funding as compared to law enforcement and recommending, inter alia, increased state and federal funding for indigent defense systems); see also Miriam S. Gohara, James S. Hardy & Damon Todd Hewitt, The Disparate Impact of an Under-Funded, Patchwork Indigent Defense System on Mississippi's African Americans: The Civil Rights Case for Establishing a Statewide, Fully Funded Public Defender System, 49 How. L.J. 81, 82–84 (2005) (noting the "lack of adequate defense" for accused individuals in Mississippi given the state's failure to fund counsel). See generally Evaluations, Sixth Amend. Ctr., https://6ac.org/what-we-do/evaluations/ [https://perma.cc/WE7Y-85TN] (last visited Feb. 21, 2025) (evaluating the state of compliance with the Sixth Amendment right to counsel nationally).

575. See supra Part III; see also Perlin, Hidden Prejudice, supra note 29, at 62 (arguing that the legal system selectively accepts social science evidence).

recognize how the symptoms of PDs can undermine *Dusky–Drope* capacities.[576] Such efforts may be bound for failure.

Even if it were possible to expand criminal court's conception of disability, more findings of incompetence is not a desirable outcome. Institutionalization has proven harmful for many and thus cannot be considered an accommodation.[577] Given these limitations and the finite energy for reform, the solutions might not lie in redefining the *Dusky–Drope* standard or retraining forensic experts on the importance of attorney–client collaboration. Instead, those troubled by forensic examiners' attitudes toward PDs may want to turn their attention to scrutinizing the overrepresentation of individuals with PDs in the criminal legal system.[578] That is, instead of making criminal court processes more accommodating to individuals with PDs, it may be more impactful to try to prevent the criminalization of individuals diagnosed with PDs.[579] Such an approach promotes disability justice by interrupting one important debilitating process—criminalization. It is also compatible with disability rights because even if the goal is formal legal equality, preventing criminalization in the first instance eliminates the need for accommodations. Robust investment in mental health services, education, and the catalysts for economic prosperity can help fortify communities most at risk for criminalization.[580]

The case survey contained in this Essay also illuminates the ambivalent role of mental health expertise in advancing the interests of individuals with disabilities. Mental health specialists typically embedded in criminal courts play an enabling role, producing knowledge about disabilities that facilitates, rather than moderates, the state's capacity for criminalization.

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576. See, e.g., Stork, supra note 22, at 968 (explaining that because "clients with personality disorders may . . . have more difficulty working with their attorneys," they may "have a low likelihood of meeting the second prong of the *Dusky* competency standard (ability to assist counsel)").

577. See supra note 46 and accompanying text.

578. See William H. Reid, Borderline Personality Disorder and Related Traits in Forensic Psychiatry, 15 J. Psychiatric Prac. 216, 216 (2009) (explaining that "individuals with borderline pathology" are "overrepresented in" criminal punishment due to their clinical characteristics and involvement in society); Robert L. Trestman, Julian Ford, Wanli Zhang & Valerie Wiesbrock, Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails, 35 J. Am. Acad. Psychiatry & L. 490, 490 (2007) (demonstrating the high volume of PDs among incarcerated people in Connecticut's jails).

579. See Elyn R. Saks, The Status of Status Offenses: Helping Reverse the Criminalization of Mental Illness, 23 S. Cal. Rev. L. & Soc. Just. 367, 382 (2014) (arguing "against the status quo that criminalizes mental illness" in favor of "alternative responses").

580. Elise Jácome, Stan. Inst. for Econ. Pol'y Rsch., How Better Access to Mental Health Care Can Reduce Crime 2 (2021), https://drive.google.com/file/d/1j9JOhi3v-gE9cPNMBNh9BBEu9APuX14S/view (on file with the *Columbia Law Review*); John Jay Coll. Rsch. Advisory Grp. on Preventing & Reducing Cmty. Violence, Reducing Violence Without Police: A Review of Research Evidence (2020), https://johnjayrec.nyc/wp-content/uploads/2020/11/AV20201109_rev.pdf [https://perma.cc/KT34-NQU6].

More empirical work is needed to investigate how court examiners' professional formation and work culture produce these outcomes. But if CST experts are not exceptional but instead reflect attitudes and approaches pervasive in psychology and psychiatry, their practices in CST proceedings hold a cautionary lesson for carceral reforms that rely on mental health specialists. Indeed, across jurisdictions, criminal court actors have embraced alternatives to incarceration, particularly for those with psychiatric needs.[581] In such cases, people accused of crimes can undergo treatment, broadly defined, as their sentence. To implement these alternatives, courts have assembled teams of interdisciplinary experts to identify those who stand to benefit from softer penal interventions.[582] Mental health specialists play a critical role in these efforts, drawing on their diagnostic expertise to educate judges, prosecutors, and defense attorneys about neurodivergence and appropriate interventions.[583] Their integration into the criminal courts has been hailed as a humanizing countervailing force to the sharpest edges of sentencing.[584] But CST proceedings suggest that the diagnostic framework mental health experts deploy is not distinct from criminal law's deontological framework. Embedding more psychologists, psychiatrists, and social workers into criminal legal processes is not necessarily an alternative to criminalization.[585] Individuals with PDs may be locked out, once again. If mental health experts, who play an important role in designing more therapeutic processes, have difficulty accepting certain categories of disabilities, therapeutic reforms may be inherently exclusionary.

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581. See Lowry & Kerodal, supra note 54, at 6, 11 (reporting a study that found 55% of the 220 responding prosecutors' offices offered some type of diversion program, including mental health treatment); Collins, Problem of Problem-Solving, supra note 54, at 1575 ("There are now more than 4,000 specialized courts throughout the country dedicated to an ever-expanding roster of issues, which currently includes mental health courts . . . .").

582. See All Rise, Adult Treatment Court Best Practice Standards 26 (2025), https://allrise.org/wp-content/uploads/2025/03/Adult-Treatment-Court-Best-Practice-Standards_07.28.2025.pdf [https://perma.cc/76TF-W32M] ("Studies indicate that treatment professionals, such as licensed addiction or mental health counselors, social workers, and psychologists, serve a crucial role as core members of the treatment court team.").

583. See id. at 16 (discussing the importance of multidisciplinary teams operating treatment courts as alternatives to incarceration).

584. See Johnson & Ali-Smith, supra note 57, at 2–3 (arguing that diversion programs are overall beneficial because they help to minimize contact with the criminal legal system and focus on addressing root problems, including homelessness, job and food insecurity, substance use disorders, and unmet mental health needs).

585. See Drug Pol'y All., Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use 2 (2011), https://drugpolicy.org/wp-content/uploads/2023/09/Drug-Courts-Are-Not-the-Answer_Final2.pdf [https://perma.cc/S9KA-M45X] ("Drug courts have made the criminal justice system more punitive toward addiction—not less." (emphasis omitted)).

CONCLUSION

Even procedural rights granted to disabled defendants, shorn of dignity as they may be, are constrained by substantive criminal law's irresistible urge to blame defendants for all manner of perceived misconduct. While popular fascination with the insanity defense overstates its doctrinal importance and statistical significance, this Essay shows how the defense infuses CST proceedings to produce only the most limited exception to the norm of accountability. Background conditions—for instance, unsettled issues in the field of psychology and psychiatry, a cultural antipathy toward PDs, PDs' exclusion from insanity defenses, and generalized mistrust toward defendants in the criminal legal system—may empower clinical experts to pass judgments about defendants with these diagnoses. More research is needed to understand examiners' motivations and why their opinions reinforce criminal law's deontological framework. This Essay also provides some evidence that mental health expertise is not the hoped for antidote to criminalization, nor is it sufficient for disability justice.