

COMPETENCY TO REFUSE MEDICATION: REVISITING THE ROLE OF DENIAL OF MENTAL ILLNESS IN CAPACITY DETERMINATIONS

ELYN R. SAKS*

I. INTRODUCTION

If a patient refuses medication, the patient's guardian or the state may seek a judicial order authorizing substituted consent to take the medication and determine that the patient lacks the capacity to make his or her own decision.¹ In some jurisdictions, the patient's denial that he or she has a mental illness—referred to generally as a lack of “appreciation” of his or her mental illness—serves as the basis of the incompetency finding.² The patient's mere denial that he or she has a mental illness—the standard some courts use today³—should not be enough in and of itself to serve as the basis of an incompetency finding. In this Article, I will argue that in order to base a competency finding on a patient's lack of appreciation of his or her mental illness, the lack of appreciation should patently distort

* Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law; Adjunct Professor of Psychiatry, University of California, San Diego, School of Medicine; Faculty, New Center for Psychoanalysis.

¹ See, e.g., *In re Roe*, 421 N.E.2d 40, 51 (Mass. 1981) (requiring a guardian to obtain a court order before forcibly medicating his ward); *United States v. Charters*, 829 F.2d 479, 482 (4th Cir. 1987), *remanded on reh'g*, 863 F.2d 302 (4th Cir. 1988) (requiring a competency determination prior to forcibly medicating an individual in custody).

² Jessica Wilen Berg, Paul S. Appelbaum & Thomas Grisso, *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 355–57 (1996).

³ See *infra* notes 35–39 and accompanying text.

reality. In other words, when denial of mental illness is not a patently false belief, it should not be a basis for an incompetency finding.

In 1991, I proposed a four-part standard for determining a patient's capacity to refuse treatment.⁴ The first three parts proposed there and discussed in this Article are similar to other conventional standards,⁵ but the fourth part differs from more conventional tests examined previously.⁶ Like others, I would require the patient to understand the information he or she has been given, to reason with the information adequately, and to evidence a choice.⁷ The fourth component of capacity is "appreciation," and my view on this differs from the conventional wisdom.⁸

Appreciation refers to the beliefs one has about his or her illness and treatment.⁹ Unlike other theorists, I would require the patient's beliefs to *patently* distort reality in order to serve as the basis of an incompetency finding.¹⁰ I require a patently false belief because the truth is often unclear, and formulating one's own version of the truth is a part of autonomy.¹¹

What is a patently false belief?¹² Though hard to define, examples can illuminate the difference between patient beliefs that are patently false and those that are not. For example, a patient's belief that her doctor does not completely have her best interests at heart is probably not a patently false belief.¹³ However, if the patient believes her doctor is a malevolent devil, she likely holds a patently false belief.¹⁴ Similarly, a patient's belief that the medication may harm her is not likely to be a patently false

⁴ Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 962 (1991) [hereinafter Saks, *Competency to Refuse*].

⁵ *Id.* at 949–50. See, e.g., THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* (1998); Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 106 n.4 (1999) [hereinafter Saks & Behnke, *Competency to Decide*] (other studies and other instruments).

⁶ Saks, *Competency to Refuse*, *supra* note 4, at 962.

⁷ *Id.* at 949–50.

⁸ *Id.* at 962.

⁹ Berg et al., *supra* note 2, at 355–57.

¹⁰ Saks, *Competency to Refuse*, *supra* note 4, at 947.

¹¹ *Id.* at 950 ("Freedom to decide includes, within limits, freedom to decide what is true no less than what is good.").

¹² See *id.* at 962–63 (defining patently false beliefs as "extreme distortions"); see also Saks & Behnke, *Competency to Decide*, *supra* note 5, at 119 (defining patently false beliefs as "beliefs that are grossly improbable").

¹³ Saks, *Competency to Refuse*, *supra* note 4, at 987–88.

¹⁴ *Id.*

belief,¹⁵ but if she thinks the medicine is lethal poison, she probably holds a patently false belief.¹⁶

This Article examines the current standard of capacity required to refuse treatment,¹⁷ and then I turn to reexamine my arguments from my 1991 article.¹⁸

II. CURRENT STANDARD OF CAPACITY TO REFUSE TREATMENT

A. CURRENT STANDARD OVERVIEW

Current standards for assessing capacity to refuse treatment look at four elements. First, the patient must understand the information relevant to his or her decision.¹⁹ In order to be competent to make medical decisions, the patient must be able to understand information such as the treatment being proposed, its risks and benefits, the alternatives, and the risks and benefits of the alternatives.²⁰ The patient must also be able to track this information, and remember it long enough to make a decision.²¹

Second, the patient must also be able to do rudimentary reasoning about the medical treatment decision.²² He or she must give evidence of reasoning ability, showing, for example, an ability to compare alternatives and spin out likely consequences.²³ The patient does not need to be an expert logician but may not make gross logical errors.²⁴

Third, the patient must take the information provided by medical personnel and evidence a choice about the medical decision to be made.²⁵ If a patient does not evidence a choice, that choice cannot be honored

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *See supra* part II.A.

¹⁸ *See supra* part III.

¹⁹ Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCHIVES GEN. PSYCHIATRY 951, 953 (1982) ("The subject's understanding of the issues relevant to participation is the single factor that has been most widely accepted as a standard for competency.").

²⁰ *Id.*

²¹ *See id.*

²² *Id.* at 954.

²³ *See id.*

²⁴ *See id.* (noting that having insane delusions has been taken to mean that a person is not rational).

²⁵ *Id.* at 952-53.

because those involved simply do not know what the patient wants.²⁶

Finally, the patient must appreciate the matters relevant to the treatment decisions. One standard of measuring beliefs that I proposed are “patently false beliefs.”²⁷ I define a patently false belief as one of three types of belief: (1) a belief that is impossible (for example, “thoughts can kill”); (2) a belief that is so improbable that one does not even need evidence of its falsehood (for example, “one is able to calculate as fast as a supercomputer”), or; (3) a demonstrably false empirical belief (for example, “a large spaceship lies in the middle of New York’s Central Park”).²⁸

Courts use these four elements—understanding, reasoning, choice, and patently false beliefs—to determine if a person has the capacity to refuse medical treatment.

B. JUDICIAL CAPACITY DETERMINATIONS

Many jurisdictions require a judicial finding of incompetency before imposing nonemergency medication on a patient.²⁹ There are, however, few appellate cases defining incompetency.³⁰ Applying a capacity standard is difficult, because courts do not apply a uniform standard. For example, many appellate courts simply state that the lower court assessed capacity and rely on the outcome of this assessment.³¹ The basis of the finding is not spelled out and cannot, therefore, provide guidance for others.³²

When assessing capacity, courts sometimes cite to impairments such as the person being “too emotionally distrustful to listen to her doctor”³³ or being “unable to process provided info.”³⁴

At least fourteen courts have considered a patient’s denial that he or she has a mental illness (in other words, lack of insight, or failing to

²⁶ *Id.* at 953 (advocating to wait if a patient’s choice is ambiguous).

²⁷ Saks, *Competency to Refuse*, *supra* note 4, at 947–48.

²⁸ *See, e.g.*, Saks & Behnke, *Competency to Decide*, *supra* note 5, at 119.

²⁹ *See, e.g.*, *Riese v. St. Mary’s Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 210 (Ct. App. 1987) (California); *Rivers v. Katz*, 495 N.E.2d 337, 343–44 (N.Y. 1986) (New York); *In re Roe*, 421 N.E.2d 40, 51 (Mass. 1981) (Massachusetts).

³⁰ *But see* cases cited *supra* note 29.

³¹ *See, e.g.*, *Rivers*, 495 N.E.2d at 340.

³² *See, e.g.*, *id.*

³³ *In re Michael L.*, 809 N.Y.S.2d 194, 195 (N.Y. App. Div. 2006).

³⁴ *In re Perra*, 827 N.Y.S.2d 587, 588 (N.Y. Sup. Ct. 2006).

perceive one's mental illness) to lead to a finding of incapacity.³⁵ In some of these cases, the patient's denial is clearly the basis of the incapacity finding.³⁶ In others, denial is one factor among many that the courts look to, or at least mention, in deciding capacity.³⁷ And in at least one case, the court did not permit the patient's doctor to introduce evidence of denial because the state statute referred solely to the nature, risks, and benefits of the treatment.³⁸ That court used, in part, a patently false belief standard, and perhaps was influenced by my earlier work that stated a denial should not be a basis for finding incompetency.³⁹

Note that the aforementioned cases⁴⁰ are all appellate decisions. To date, there has been no thorough study of trial courts' use of a patient's denial in capacity determinations. I have surveyed judges in California, Massachusetts, and New York about their competency findings, including those on denial of mental illness; these findings will be reported in a future study.⁴¹

As shown above, a number of courts have stated or suggested that a denial of mental illness is sufficient for incompetency.⁴² This Article argues that a patient's denial of his or her mental illness is usually not a patently false belief and, therefore, should not be a basis for an incompetency finding. The rest of this Article demonstrates why this is so.

³⁵ See *In re Jones*, 673 N.E.2d 703, 705 (Ill. App. Ct. 1996); *In re Kordylewska*, 816 N.Y.S.2d 892, 896 (N.Y. Sup. Ct. 2006); *In re L.A.*, 912 A.2d 977, 979 (Vt. 2006); *In re Lisa P.*, 887 N.E.2d 696, 700 (Ill. App. Ct. 2008); *In re McConnell*, 538 N.Y.S.2d 101, 102 (N.Y. App. Div. 1989); *In re Michael L.*, 809 N.Y.S.2d at 195; *In re Perra*, 827 N.Y.S.2d at 590; *In re Sawyer*, 891 N.Y.S.2d 813, 815 (N.Y. App. Div. 2009); *In re Virgil D.*, 524 N.W.2d 894, 896 (Wis. 1994); *J.S. v. Ctr. for Behavioral Health*, 846 N.E.2d 1106, 1109 (Ind. Ct. App. 2006); *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238, 240 (Alaska 2006); *Rabenberg v. Rigney*, 597 N.W.2d 424, 427 (S.D. 1999); *Woodland v. Angus*, 820 F. Supp. 1497, 1502-03 (D. Utah 1993).

³⁶ See *In re Kordylewska*, 816 N.Y.S.2d at 896.

³⁷ See *In re Lisa P.*, 887 N.E.2d at 701-02.

³⁸ *In re Virgil D.*, 524 N.W.2d at 899-900.

³⁹ See, e.g., Saks, *Competency to Refuse*, *supra* note 4. For a discussion of the patently false belief standard in the criminal context, see Elyn R. Saks, *Retributive Constraints on the Concept of Competency: the Required Role of "Patently False Beliefs" in Understanding Competency to be Executed*, 27 BEHAV. SCI. & L. 1 (2009); see also Saks & Behnke, *Competency to Decide*, *supra* note 5.

⁴⁰ See *supra* note 35.

⁴¹ Elyn R. Saks, *Surveys on Competency Findings* (in preparation) (on file with author).

⁴² See, e.g., *In re Kordylewska*, 816 N.Y.S.2d at 896; *In re Lisa P.*, 887 N.E.2d at 701-02.

III. DENIAL OF A MENTAL ILLNESS AS A BASIS FOR INCOMPETENCE

The issue of denial of a mental illness as the basis for an incompetency finding was discussed in my 1991 article, *Competency to Refuse Treatment*.⁴³ At that time, some jurisdictions used merely a patient's denial that he or she has a mental illness as a basis to find him or her incompetent.⁴⁴ The 1991 article, however, proposed a standard requiring that a patient's beliefs patently distort reality to justify a finding of incompetency.⁴⁵

Today, some of the arguments put forth in 1991 still appear to be valid, while others are not as strong. This two-part section reexamines the arguments I made in 1991, benefitting now from over two decades of hindsight. Part III.A provides an overview of the main arguments of the 1991 article and examines the strengths and weaknesses of those arguments. Part III.B revisits the issues of denial of mental illness and other beliefs relating to incompetency in a new light.

A. 1991 REVISITED

The 1991 article extensively discussed the issue of denial of a mental illness as evidence of incompetence.⁴⁶ The article's argument for thinking that denial of mental illness is not usually a patently false belief is several-fold.⁴⁷ First, some denial about one's mental illness is a rational attempt to avoid negative consequences; it is a common, understandable, and adaptive defense.⁴⁸ Second, it is often hard to prove a mental health diagnosis beyond a reasonable doubt, because a mental illness diagnosis is often less certain than most physical illness diagnoses.⁴⁹ Thus, if it is reasonable to doubt a mental illness, it cannot patently distort reality to do so.⁵⁰ Third, many people think at least some mental illness is just a response to stress⁵¹ or a failure of will.⁵² Therefore, if some in the public

⁴³ See generally Saks, *Competency to Refuse*, *supra* note 4.

⁴⁴ *Id.* at 988. See, e.g., *In re Kordylewska*, 816 N.Y.S.2d at 896.

⁴⁵ Saks, *Competency to Refuse*, *supra* note 4, at 988.

⁴⁶ See *id.* at 988–89.

⁴⁷ See *id.* at 988–92.

⁴⁸ *Id.* at 989–90.

⁴⁹ *Id.* at 989.

⁵⁰ *Id.*

⁵¹ Kirsten Weir, *The Beginnings of Mental Illness*, 43 MONITOR ON PSYCHOL. 36, 36 (2012), available at <http://www.apa.org/monitor/2012/02/mental-illness.aspx>.

and even some psychiatrists can deny the existence of mental illness,⁵³ why must patients accept its existence to be considered competent? The next section evaluates the strengths and weaknesses of these arguments.

1. Greater Agreement About Mental Illness

Recognizing that more than two decades have passed since *Competency to Refuse Treatment* was published, some of the arguments are no longer as strong as they were in 1991. In particular, there appears to be more of a consensus today about mental illness being a real illness and greater agreement regarding when a particular person has a mental illness than was the case twenty years ago.⁵⁴ For example, the idea that it is always or generally reasonable to doubt a diagnosis is perhaps no longer valid. Doubting a diagnosis may still be common in the insanity context, for example, because people have an interest in malingering.⁵⁵ In other contexts, however, diagnoses, at least of major mental illnesses, are less likely to be questioned.⁵⁶ Thus, doctors may disagree on whether a patient has schizophrenia or schizotypal personality disorder, but not that the patient has a serious mental illness.⁵⁷

Similarly, the 1991 article noted that even some psychiatrists doubt the existence of mental illness.⁵⁸ The Article argues that if these psychiatrists' views are not considered crazy, neither should those of patients who also hold these beliefs.⁵⁹ At the time, this was perhaps a plausible view, but most people in the scientific community today would

⁵² Amanda C. Pustilnik, *Criminal Law: Prisons of the Mind: Social Value and Economic Inefficiency in the Criminal Justice Response to Mental Illness*, 96 J. CRIM. L. & CRIMINOLOGY 217, 242 (2005).

⁵³ Saks, *Competency to Refuse*, *supra* note 4, at 989.

⁵⁴ See Amanda Clark, Comment, *The Patient Protection and Affordable Care Act and Efforts of the Mentally Ill to Achieve Equal and Adequate Health Coverage*, 88 U. DET. MERCY L. REV. 357, 359–62 (2010).

⁵⁵ Heather Woolwine, *Malingering, Faking Mental Illness Discussed at Day of Discovery*, CATALYST ONLINE (June 10, 2005), <http://www.musc.edu/catalyst/archive/2005/co6-10mali.html> (“[Malingering] is an intentional and conscious action where the payoff could be money or getting out of responsibility; not to be confused with someone who is suffering real symptoms as a result of an unconscious need to resolve some conflict in the mind.”).

⁵⁶ *But cf.* Saks & Behnke, *Competency to Decide*, *supra* note 5, at 117 (“The reliability and validity of psychiatric diagnoses are often in doubt.”).

⁵⁷ *But cf. id.* (“Doctors often disagree about diagnoses, and sometimes disagree about the category of illness (e.g. psychotic disorder vs. mood disorder vs. personality disorder) and about whether a patient even has a significant illness.”).

⁵⁸ Saks, *Competency to Refuse*, *supra* note 4, at 989.

⁵⁹ *Id.*

say it *is* crazy to doubt the existence of mental illness.⁶⁰

However, other members of the public may still deny the existence of mental illness and of most cases of mental illness. These people may think that people alleged to be mentally ill are actually just failing to control their behavior⁶¹ or responding to stress.⁶² It is an open question how many people hold beliefs like these.

As a policy matter, it seems problematic to allow patients to deny the existence of mental illness because of the public's ignorant views.⁶³ In sum, two perspectives on this issue are possible: (1) patients who deny the existence of mental illness hold beliefs distorted enough such that decisions based on these beliefs must be incompetent, or; (2) patients who deny the existence of mental illness are wrong but not beyond the realm of normal. Therefore, if a patient believes that there is no such thing as mental illness for reasons like those outlined above, as a policy matter these beliefs should not weigh in favor of finding incapacity.

This policy seems to be a close call. At the very least, doctors and judges should probe the patient's denial of the existence of mental illness to see if it is of the kind described above. Even if the patient's beliefs are like those described above, the patient may still be found incompetent if there are other bases for this finding.

The central point, then, is that there is more consensus around, and acceptance of, mental illness as a medical illness today than in 1991.⁶⁴ Indeed, some mental illnesses are now being characterized as "brain

⁶⁰ Of course, if this is one's only craziness, one would probably not be deemed crazy, full stop. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT BY THE SURGEON GENERAL 3 (1999), available at <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf> (A report is "prepared against a backdrop of growing awareness in the United States and throughout the world of the immense burden of disability associated with mental illnesses.").

⁶¹ Pustilnik, *supra* note 52, at 242 ("People who behave in a manner currently termed 'mentally ill' are failing to control themselves and must have greater measures of control imposed on them to bring them in line with accepted behaviors.").

⁶² Weir, *supra* note 51, at 36; see also Vernon Coleman, *The Truth About Mental Illness (And the Scary Truth About Psychiatry)*, VERNON COLEMAN WEBSITE, <http://www.vernoncoleman.com/mentalill.html> (last visited Apr. 13, 2013) ("[A]ll mental illness is a response to stress.").

⁶³ See *supra* notes 61–62.

⁶⁴ See Patrick W. Corrigan & Amy C. Watson, *At Issue: Stop the Stigma: Call Mental Illness a Brain Disease*, 30 SCHIZOPHRENIA BULL. 477, 477 (2004) (describing how, over the last decade, some advocates have characterized mental illness as a medical disorder in order to change public attitude toward mental illness).

disorders,⁶⁵ and the public sees mental illness as physically based in the brain.⁶⁶ Other professionals similarly argue that mental illnesses are disorders of the brain—paralleling other illnesses that are disorders of other organs that manifest physical and mental symptoms.⁶⁷ With this change in understanding of mental illness, the public has inevitably become more accepting and aware of the existence of mental illness and its potential for incapacitating individuals.⁶⁸ Therefore, today denial of mental illness is not as easily dismissed as a basis for incompetency.⁶⁹

That being said, some arguments remain concerning the acceptance of mental illness and scientific evidence.

2. Scientifically Proving Mental Illness

Though scientific evidence of mental illness is lacking in some respects when compared to the evidence available for physical illness, there are similarities. Moreover, the differences merely reflect the status of the mental health field in treatment and diagnosis today, rather than negate the existence of mental illness overall. One particular weakness is that the certainty of mental illness compared to the certainty of physical illness is diminished, since there are no physical tests for mental illness.⁷⁰ It is hard to deny that one has a broken arm when looking at the x-ray or that one has cancer when the pathology report comes back.⁷¹

However, many physical illnesses are also hard to diagnose or rule out.⁷² For example, there are no foolproof tests to diagnose Chronic Fatigue Syndrome or the Epstein-Barr virus.⁷³ Interestingly, some

⁶⁵ See, e.g., *Brain Disorders*, MCGOVERN INST. FOR BRAIN RESEARCH AT MIT, <http://mcgovern.mit.edu/brain-disorders> (last modified Feb. 23, 2012).

⁶⁶ See, e.g., Corrigan & Watson, *supra* note 64, at 477. Interestingly, it has been found that this belief fails to accompany a reduction in stigma. *Id.*

⁶⁷ Kirsten Weir, *The Roots of Mental Illness*, 43 *MONITOR ON PSYCHOL.* 30, 30 (2012), available at <http://www.apa.org/monitor/2012/06/roots.aspx>.

⁶⁸ See Corrigan & Watson, *supra* note 64, at 478; see also Aphroditi Zartaloudi & Michael Madianos, *Stigma Related to Help-Seeking From a Mental Health Professional*, 4 *HEALTH SCI. J.* 77, 81 (2010).

⁶⁹ See Elyn R. Saks, *Some Thoughts on Denial of Mental Illness*, 166 *AM. J. OF PSYCHIATRY* 972, 973 (2009) [hereinafter Saks, *Some Thoughts*].

⁷⁰ Weir, *supra* note 67, at 30.

⁷¹ *Id.*

⁷² *Id.*

⁷³ See, e.g., R. Baker & E. J. Shaw, *Diagnosis and Management of Chronic Fatigue Syndrome or Myalgic Encephalomyelitis (or Encephalopathy): Summary of NICE Guidance*, 335 *BRIT. MED. J.* 446, 447 (2007); Oludare A. Odumade, Kristin A. Hogquist & Henry H.

physicians and agencies have denied that these illnesses are real, but the professional consensus is that they are real illnesses.⁷⁴ Soft tissue damage is another example.⁷⁵ Physical tests can be inadequate in diagnosing a soft tissue injury, but most professionals accept that soft tissue damage is real and can cause real disability.⁷⁶

Given this analysis, the most sensible argument is not that mental illness does not exist but that it is hard to prove it exists. The argument “is epistemological, not ontological.”⁷⁷

What do these “proof” arguments add to our capacity analysis? On the one hand, the fact that mental illness is hard to “prove” makes a diagnosis of mental illness less certain and more plausibly denied. On the other hand, the lack of definitive proof of mental illness does not mean that a person is not mentally ill. Therefore, the fact that mental illness is hard to prove can weigh in favor of finding capacity or incapacity.

B. BELIEFS, SELF-AWARENESS, AND CAPACITY

Part III.B of this Article discusses how beliefs held by patients and patients’ levels of self-awareness affect determinations of capacity. Part III.B.1 argues that lack of insight in psychiatric patients (as in neurological patients) may be a form of anosognosia, and asks how this affects denial of mental illness as a basis for incompetency. Part III.B.2 continues the discussion from above about why denial of mental illness may be plausible and understandable and, therefore, not a basis for incapacity. Part III.B.3 discusses false beliefs behind denial that should themselves lead to an incompetency finding.

Balfour, Jr., *Progress and Problems in Understanding and Managing Primary Epstein-Barr Virus Infections*, 24 *CLINICAL MICROBIOLOGY REVIEWS* 193, 196–97 (2011); Richard Lord, *Daze of Their Lives*, *S. CHINA MORNING POST* (Feb. 5, 2013), <http://www.scmp.com/lifestyle/health/article/1143171/daze-their-lives>; *Chronic Fatigue Syndrome (CFS): Diagnosis*, CDC, <http://www.cdc.gov/cfs/diagnosis/index.html> (last updated May 14, 2012); *Epstein-Barr Virus and Infectious Mononucleosis*, CDC, <http://www.cdc.gov/ncidod/diseases/ebv.htm#diagnosis> (last updated May 16, 2006).

⁷⁴ Hillary Johnson, *A Case of Chronic Denial*, *N.Y. TIMES*, Oct. 21, 2009, at A31.

⁷⁵ Saks & Behnke, *Competency to Decide*, *supra* note 5, at 120.

⁷⁶ *See id.*; Robert L. Samilson, *Shoulder Pain: Diagnosis and Treatment of Injuries to Soft Tissues*, 102 *CAL. MED.* 23, 23–24 (1965); Conference Report, James L. Mitchell, Jr., *Proving Difficult Damages: Soft Tissue Injuries*, Univ. of Hous. Law Found. Handling Insurance & Tort Claims (Aug. 26–27, 1999, Sept. 2–3, 1999), available at <http://www.paynemitchell.com/objectfiles/PMLG.Web.Data.Publication/60/SOFTTISS-2.pdf>, at Q-1 to Q-2.

⁷⁷ Saks & Behnke, *Competency to Decide*, *supra* note 5, at 120.

1. Anosognosia, A Deficit of Self-Awareness

Anosognosia, or a deficit of self-awareness, is a symptom of certain neurological disorders.⁷⁸ For example, a patient who has suffered the amputation of his or her arm might deny that he or she no longer has an arm.⁷⁹ Similarly, a stroke victim who is paralyzed might say she could move if she wanted to.⁸⁰

Likewise, about fifty percent of people with schizophrenia deny that they have schizophrenia.⁸¹ Many theorists assert that this denial is nothing more than a psychodynamic response⁸² of self-protection.⁸³ These theorists claim that people with schizophrenia may intrinsically know that they are

⁷⁸ See E. Fuller Torrey & Ken Kress, *The New Neurobiology of Severe Psychiatric Disorders and Its Implications for Laws Governing Involuntary Commitment and Treatment* (Univ. of Iowa Legal Studies Research Paper Series, Paper No. 04-04, 2004), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=634243, at 33 n.70 (citing Morton Nathanson et al., *Denial of Illness: Its Occurrence in One Hundred Consecutive Cases of Hemiplegia*, 68 ARCHIVES NEUROLOGY & PSYCHIATRY 380–87 (1952) for a discussion of anosognosia in neurology). See also *id.* at 34 n.73 (citing ANTONIO DAMASIO, DESCARTES' ERROR: EMOTION, REASON, AND THE HUMAN BRAIN 63–64 (1994) and noting that “[o]n this subject, Weinstein and Kahn add: ‘Anosognosic patients seemed to maintain a serene faith that they were well which remained firm despite all disbelief by others.’ [EDWIN A. WEINSTEIN & ROBERT L. KAHN, DENIAL OF ILLNESS: SYMBOLIC AND PHYSIOLOGICAL ASPECTS 18 (1955)].”) See also Edwin A. Weinstein & Robert L. Kahn, *Personality Factors in Denial of Illness*, 26 ARCHIVES NEUROLOGY & PSYCHIATRY 355 (1954).

⁷⁹ See Herta Flor, *Phantom-Limb Pain: Characteristics, Causes, and Treatment*, 1 LANCET NEUROLOGY 182 (2002) (describing phantom limb and other post-amputation-of-limb phenomena).

⁸⁰ Torrey & Kress, *supra* note 78, at 32.

⁸¹ Melissa Churly, *Anosognosia vs. Denial: Making Sense of One of the Most Misunderstood Symptoms*, MENTAL WELLNESS TODAY, <http://www.mentalwellnesstoday.com/mental-illnesses/about-schizophrenia/schizophrenia-articles/14-schizophrenia-recovery/174-anosognosia-vs-denial> (last visited Apr. 13, 2013). See, e.g., Xavier F. Amador et al., *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 ARCHIVES GEN. PSYCHIATRY 826, 834 (1994) [hereinafter Amador et al., *Awareness of Illness*]; Faith B. Dickerson et al., *Lack of Insight Among Outpatients with Schizophrenia*, 48 PSYCHIATRIC SERV. 195, 197 (1997); Berg et al., *supra* note 2, at 381 n.106 (citing Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149 (1995)); Xavier F. Amador et al., Abstract, *Awareness Deficits in Neurological Disorders and Schizophrenia*, 24 SCHIZOPHRENIA RES. 96, 96 (1997) [hereinafter Amador et al., *Awareness Deficits*].

⁸² See Saul McLeod, *Psychodynamic Approach*, SIMPLYPSYCHOLOGY, <http://www.simplypsychology.org/psychodynamic.html> (last visited Apr. 13, 2013) (explaining that the psychodynamic approach to psychology studies human behavior in the context of the relation between conscious and unconscious processes and feelings that direct thoughts, behavior, and personality).

⁸³ Xavier F. Amador, *It's Not About "Denial,"* SCHIZOPHRENIA DIG., Winter 2007, at 38–39, available at <http://www.xavieramador.com/files/schiz-digest-winter-07.pdf>.

ill but deny their illness in order to protect themselves from the painful truth that they have schizophrenia.⁸⁴ However, anosognosia may be more than a psychodynamic response to schizophrenia;⁸⁵ it can also be an anatomical symptom of schizophrenia wherein brain lesions physically prevent people with schizophrenia from understanding their illness.⁸⁶

⁸⁴ *Id.*

⁸⁵ *Id.* At the time that initial studies on anosognosia and schizophrenia were performed, little was known about the insight of mentally ill patients in the acknowledgment and acceptance of their illness. See e.g., Joseph P. McEvoy et al., *Measuring Chronic Schizophrenic Patients' Attitudes Toward Their Illness and Treatment*, 32 HOSP. & COMMUNITY PSYCHIATRY 856, 856 (1981) (finding that among patients with schizophrenia, only thirteen percent knew they were ill and only twenty-seven percent understood that they needed medication); see also Joseph P. McEvoy et al., *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, 30 COMPREHENSIVE PSYCHIATRY 13, 15 (1989).

Since the initial studies into anosognosia and schizophrenia, researchers have developed a variety of tools and scales by which to measure a mentally ill patient's insight into his or her own illness, including the ITAQ, SUMD, and SAI scales. See Xavier F. Amador et al., *Assessment of Insight in Psychosis*, 150 AM. J. PSYCHIATRY 873, 873–74 (1993); see also Xavier F. Amador et al., *Awareness of Illness in Schizophrenia*, 17 SCHIZOPHRENIA BULL. 113, 114–16 (1991) (concluding that many of the self-awareness deficits of schizophrenic patients are diagnostically significant and rooted in neural abnormalities); see also Anthony David et al., *The Assessment of Insight in Psychosis*, 161 BRIT. J. PSYCHIATRY 599, 599–600 (1992) (suggesting that insight into mental illness does not have a unitary cause, but rather is a culmination of many factors). Studies comparing the scales that measure anosognosia have found a significant correlation between the scales and the results they produce. See M. Sanz et al., *A Comparative Study of Insight Scales and Their Relationship to Psychopathological and Clinical Variables*, 28 PSYCHOL. MED. 437, 439 (1998).

A severe lack of insight into one's mental illness is a prevalent feature of schizophrenia, so much so that anosognosia is more common in schizophrenia than in other mental illnesses. See Amador et al., *Awareness of Illness*, *supra* note 81, at 834; see also Faith B. Dickerson et al., *Lack of Insight Among Outpatients with Schizophrenia*, 48 PSYCHIATRIC SERV. 195, 197 (1997); see also Berg et al., *supra* note 2, at 381 n.106 (citing Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149 (1995)); see also Amador et al., *Awareness Deficits*, *supra* note 81, at 96.

⁸⁶ Studies have found a correlation between the frontal lobe dysfunction of patients with schizophrenia and their poor insight. See Joseph McEvoy et al., *Common Sense, Insight, and Neuropsychological Test Performance in Schizophrenia Patients*, 22 SCHIZOPHRENIA BULL. 635, 639 (1996); see also P.H. Lysaker et al., *Neurocognitive Function and Insight in Schizophrenia: Support for an Association with Impairments in Executive Function but Not with Impairments in Global Function*, 97 ACTA PSYCHIATRICA SCANDINAVICA 297, 300–01 (1998) (linking poor insight to frontal lobe dysfunction by finding no difference in insight based on cognitive function, memory, or vigilance); see also Peter F. Buckley et al., *Insight and Schizophrenia*, 42 COMPREHENSIVE PSYCHIATRY 39, 41 (2001). Further, studies have indicated that poor insight in patients with schizophrenia not only emanates from frontal lobe dysfunction, but also from a multitude of other issues stemming from the illness. See Thomas E. Smith et al., *Insight, Symptoms, and Neurocognition in Schizophrenia and Schizoaffective Disorder*, 26 SCHIZOPHRENIA BULL. 193, 197–99 (2000); see also Somaia Mohamed et al., *Insight in Schizophrenia: Its Relationship to Measures of Executive Functions*, 187 J. NERVOUS &

Separating the psychodynamic cause from the anatomical cause of anosognosia raises a number of issues. First, the assertion that anosognosia is either exclusively caused by a psychodynamic response or by a brain disease is inaccurate.⁸⁷ Both can be true.⁸⁸ For example, stroke victims can simultaneously feel the need to deny their illness in order to psychologically protect themselves and have a biological dysfunction that physically prevents them from acknowledging their illness. Second, and perhaps more importantly, the psychodynamic defense may intrinsically have a biological component as all thought is biologically based.⁸⁹

2. Psychological Impetus in Denying Mental Illness

The second issue to be discussed is that a patient's denial of his or her own mental illness should not, in and of itself, support an incompetency finding, because reasoning used by competent as well as incompetent people may lead to such denial. Using myself as a subject, I discussed in a recent article three ways a person, even in the face of florid schizophrenic symptoms, could deny their own mental illness.⁹⁰

First, even though one might acknowledge that one looks like he or she has a mental illness, one still might have reasons to doubt its existence.⁹¹ This would be because of one's belief that if more information were available on mental illness, it would show he or she did not in fact have a mental illness.⁹² Analogously, it is like the screening for breast cancer before the advent of biopsies.⁹³ For some women, lumps in their breasts can indicate the presence of breast cancer, while for other women, lumps can mean nothing and have no effect on life expectancy.⁹⁴ The

MENTAL DISEASE 525, 525 (1999) (finding that poor insight is associated with the executive functioning of people with schizophrenia); see also S.L. Rossell et al., *Insight: Its Relationship with Cognitive Function, Brain Volume and Symptoms in Schizophrenia*, 33 PSYCHOL. MED. 111, 116-18 (2003) (finding a correlation between poor insight among people with schizophrenia and psychopathology and executive performance).

⁸⁷ See Smith et al., *supra* note 86, at 193; see also Buckley et al., *supra* note 86, at 39.

⁸⁸ See Smith et al., *supra* note 86, at 193; see also Buckley et al., *supra* note 86, at 39.

⁸⁹ See *From Neurons to Thought: Coherent Electrical Patterns Observed Across the Brain*, NAT'L INST. OF MENTAL HEALTH (Jan. 25, 2010), <http://www.nimh.nih.gov/science-news/2010/from-neurons-to-thought-coherent-electrical-patterns-observed-across-the-brain.shtml>.

⁹⁰ See Saks, *Some Thoughts*, *supra* note 69, at 972-73.

⁹¹ *Id.* at 972-73.

⁹² *Id.* at 972.

⁹³ *Id.*

⁹⁴ *Id.*

advent of biopsies provided more information and allowed diagnoses to be more accurate.⁹⁵ Therefore, some with mental illness may see themselves as being in the position of the woman who does not have breast cancer despite having a lump in her breast: disease-free despite the diagnosis, for lack of a more accurate method of detection.⁹⁶ In another example, before the time of electroencephalograms (EEGs), a hysterical seizure could be confused with a real seizure.⁹⁷

Second, one could manifest denial by believing that everyone has the thoughts (including violent ones), feelings, and fears that the person with schizophrenia has but that they are just better at hiding them.⁹⁸ With this view, one would believe the floridly schizophrenic person is actually just socially maladroit⁹⁹ and that his or her apparent illness consists of saying aloud what everyone else experiences.¹⁰⁰

This view is also plausible. Nobody has direct access to others' minds, and it is usually a safe bet that others feel the same kinds of things that any given person does.¹⁰¹ She understands others' mental states as similar to her own.¹⁰²

I thought this way for a long time.¹⁰³ My mind changed when I received an adequate dose of medication and found my mind clearing.¹⁰⁴ I now assume that most people have the clear mind I now have.¹⁰⁵ But before that, it was plausible to think that others had the mental chaos I used to have.¹⁰⁶

Third, one may manifest denial by over claiming agency about her own mental state.¹⁰⁷ She may believe the symptoms of her illness are

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ Robert J. Cohen & Cary Suter, *Hysterical Seizures: Suggestion as a Provocative EEG Test*, 11 ANNALS OF NEUROLOGY 391, 391 (1982).

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ David Premack & G. Woodruff, *Does the Chimpanzee Have a Theory of Mind?*, 4 BEHAV. & BRAIN SCI. 515, 515 (1978) ("An individual has a theory of mind if he imputes mental states to himself and others.").

¹⁰² *Id.*

¹⁰³ Saks, *Some Thoughts*, *supra* note 69, at 972.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

things she chooses to do or think rather than things that happen to her.¹⁰⁸ Therefore, her symptoms are not an illness, but a choice.¹⁰⁹

For instance, a friend on the medication Navane complained that she kept tapping her toes and it was driving her crazy.¹¹⁰ I was taking Navane, too, and I noticed that I, too, was tapping my toes.¹¹¹ But I believed it to be something I was choosing to do and not something happening to me.¹¹² When I changed medications, my toes stopped tapping.¹¹³ I was claiming as a choice something that I actually had no control over.¹¹⁴ Because all three of these types of beliefs are understandable, denying mental illness on their basis should not serve as a basis for finding incompetence.

3. Beliefs and Incompetency

The third issue is whether there are beliefs about one's illness that should lead to a finding of incompetency. There are at least three types of beliefs that should. First, denial of grossly demonstrable symptoms (such as not sleeping or pacing) should be considered patently false beliefs. Second, not accepting that one's doctor believes one is ill and in need of treatment should be considered a patently false belief. Third, even if the patient is not required to accept he or she has an illness, the patient must at least acknowledge that "something is wrong." Failing to recognize this basic fact should be considered a patently false belief capable of serving as a basis for a judgment of incompetency.

It is important to distinguish between denial of mental illness that is based on patently false beliefs, such as those listed above, and denial of mental illness in general. Notably, the people who most vehemently deny they are mentally ill—namely, those who are not actually ill—have the strongest reasons to object to treatment. For example, Soviet psychiatrists may have claimed that anti-communist agitators were mentally ill; and when the agitators refused medication for their alleged mental illness, the psychiatrists could have cited the agitators' denial as a basis to find them incompetent to refuse.

It is important not to second-guess the patient's choice, but instead to

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 973.

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

investigate the reasoning behind that choice.¹¹⁵ We do not want to say a patient lacks capacity because he or she made the “wrong” treatment choice—such as the choice to refuse medication—because then any refusal is deemed to be without basis, and we become the Soviet psychiatrists. But it is a short distance from here to the belief that a patient lacks capacity because the patient disagrees that he or she is mentally ill. Just as failure to agree with one’s doctor about a treatment plan is not a gross distortion of reality and should not be a basis for finding incompetency,¹¹⁶ so too the failure to agree with one’s doctor about the existence of mental illness is not necessarily a gross distortion of reality and should not also be a basis for incompetency.¹¹⁷ The patient’s autonomy to choose beliefs different from those of his or her doctor must be safeguarded.

IV. CONCLUSION

Given all of this, we can take one of two approaches to the role a patient’s denial of his or her mental illness should have in competency determinations: (1) we can rule out denial of mental illness as a basis for an incompetency finding entirely, or; (2) we can probe the patient’s basis for the denial and find incompetency only if the patient has a patently false belief about his or her illness. For example, if a patient denies medication because the patient believes he or she is suffering to save humanity and therefore should not or cannot be cured, his or her denial should lead to a finding of incompetency. But if probing the patient’s denial does not uncover some such patently false belief, his or her denial alone should not be the basis for a finding of incompetency.

Future research is needed to determine what categories of denial should be a basis for an incompetency finding. If future study shows denial of mental illness rarely involves the denial of grossly demonstrable symptoms or patently false beliefs, it might be more efficient not to take notice of denial at all when determining competency. On the other hand, further study of anosognosia in psychiatric patients may reveal a

¹¹⁵ See Saks, *Competency to Refuse*, *supra* note 4, at 984–88 (presenting various reasons why psychiatric patients refuse treatment—including dislike of a medication’s side effects, the wish to avoid a medication’s risks, and idiosyncratic values and beliefs—and arguing that these reasons should be evaluated in light of whether they are delusional or not).

¹¹⁶ *Id.* at 988.

¹¹⁷ See *id.* (arguing that although the doctor’s beliefs and “the treatment’s typical effects, may be indisputable” because the effects on the “particular individual are not so clear Failure to agree with the doctor does not amount to a gross distortion of reality.”).

biological basis, which, if correctable by medication, could impact this Article's analysis of denial. Finally, further theoretical research on the role of denial would be welcomed.

In conclusion, while the arguments for excluding denial as a basis for a finding of incompetency are not quite as strong as they once were, there are still important reasons for investigating the reasoning behind a patient's denial before using it as a basis for incompetency. In light of the need for continued research in this field, courts should be cautious when using denial as a basis for incompetency. In the absence of other bases for finding a patient incompetent, we should allow the patient full choice over treatment.