Hypotheticals, Psychiatric Testimony, and the Death Sentence

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"Doctor . . . do you have an opinion within reasonable psychiatric certainty whether or not there is a probability that the defendant . . . will commit criminal acts of violence that would constitute a continuing threat to society?"

"Yes, he most certainly would."

"Would you state whether or not that would be true regardless where he is?"

"It wouldn't matter whether he was in the penitentiary or whether he was free. Wherever he is he's going to continue what he's already been doing."

"Would you state whether or not, Doctor, you have an opinion within reasonable psychiatric certainty as to the degree of that probability that you have just expressed to this jury?"

"Well, yes, sir, I would put it at one hundred percent and absolute."[1]

There are a number of noteworthy aspects of this excerpt from a Texas capital sentencing hearing, at which the defendant was condemned to die. Although the responses of the psychiatrist to the district attorney's questions evoke concern about the ability of psychiatrists to predict long-term future dangerousness,[2] the relevance of environmental factors to predictions of future behavior,[3] and the degree of certainty with which psychiatric conclusions can be expressed, the most remarkable aspect of all is the fact that the psychiatrist had, at the time of his testimony, never examined the defendant about whom he spoke. Indeed, his acquaintance with the defendant was based on no information — not a review of past records, not interviews with family and friends, not even courtroom observations during the trial itself — other than a hypothetical question that had just been put to him on the witness stand by the prosecuting attorney. How such a situation came about and the legitimacy of psychiatric testimony in these circumstances are the subjects this article addresses.

Psychiatric Testimony

The history of psychiatric participation in death sentencing proceedings is intimately bound up with the peculiar course of U.S. Supreme Court decisions about the death penalty. The Court's initial decision in *Furman v. Georgia* in 1972 rejected the constitutionality of existing statutes that failed to provide guidance to decision makers as to which defendants, among all those convicted of capital offenses, ought to receive the ultimate penalty.[4] Apparently disturbed by the disproportionate number of death sentences meted out to black defendants, the Court rejected this "arbitrary and capricious" decision-making process.

A number of states took the Court's opinion as an invitation to impose manda-

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tory death penalties, thus ostensibly eliminating the potential for discrimination. In five 1976 cases considered as a group, however, the Court rejected this approach as well.[5-9] Justice Stewart's opinion in *Woodson v. North Carolina* insisted "that in capital cases the fundamental respect for humanity underlying the Eighth Amendment . . . requires consideration of the character and record of the individual offender and the circumstances of the particular offense as a constitutionally indispensable part of the process of inflicting the death penalty."[9] Two years later, the Court's decision in *Lockett v. Ohio* suggested that statutes that limited the introduction of mitigating evidence at the death penalty hearing violated both the Eighth and Fourteenth Amendments.[10]

The result of this series of decisions has been the creation of a statutory framework that encourages, and at times all but mandates, the previously rare use of psychiatric testimony at the sentencing hearing.[11] Psychiatric testimony is commonly employed by defendants, either to prove the presence of specified mitigating circumstances (for example, the Pennsylvania statute inquires about impairments of the defendant's ability to control his acts[12]) or to provide background information about the formative influences in the defendant's life. Prosecutors, who are limited to presenting statutorily specified aggravating circumstances, will use psychiatrists similarly, either to prove aggravating circumstances or to rebut defense contentions.

The use of psychiatric testimony, especially for the purposes of aiding the prosecution, has been the subject of considerable adverse commentary.[11,13-15] Psychiatrists are most commonly called by prosecutors to fulfill statutory requirements, as in Texas, that the defendant's likely future dangerousness be proved before a death penalty can be imposed.[11] Given the on-going debate about the validity of psychiatric predictions of dangerousness[2] (the California Supreme Court has totally excluded psychiatric testimony about future dangerousness as unreliable[16]), much criticism has been leveled at the employment of psychiatrists for this purpose.[11,13-15] Other points of contention have concerned the legitimacy of testimony that speaks in the language of the statute directly to the aggravating circumstances,[17] the introduction of the diagnosis of sociopathy and the conclusions that can be drawn therefrom,[13] and whether defendants should be informed that the results of pretrial psychiatric interviews may later be introduced at the sentencing phase.

Right to Refuse Examination

This latter issue was raised before the U.S. Supreme Court in *Estelle v. Smith*, a case that promises to increase the frequency of situations such as that described at the beginning of this paper.[18] In *Smith*, the defendant had been interviewed (ostensibly to determine competency to stand trial) by a psychiatrist who later testified at the sentencing hearing. The Supreme Court ruled that the defendant's Fifth and Sixth Amendment rights required he be given notice of the possible use of the information generated in the encounter for sentencing purposes, an opportunity to consult with his attorney, and the right to refuse the examination.

The decision in *Smith* posed something of a dilemma for the Texas prosecutors who had come to rely on psychiatric testimony for the prediction of dangerous-

ness. If defendants had a right to refuse examinations by psychiatrists who might testify to their disadvantage at sentencing, it was unlikely (especially given the reputation of the psychiatrist most frequently called on for this purpose[19]) any defendants would consent to the interview. Although the Texas statute does not mandate the use of psychiatric testimony on dangerousness,[20] prosecutors appeared convinced of its importance. Even before *Smith,* they had begun to experiment with alternate means of introducing the testimony they desired.

One technique employed was to have the prosecution psychiatrist base his/her opinion on a review of the defendant's records and interviews with friends and with casual acquaintances of the defendant. This technique, however, was rejected by the Texas Court of Criminal Appeals, which in *Holloway v. State* reaffirmed that the expert's opinion "is without value, and is inadmissible, if based upon facts and circumstances gleaned by him from *ex parte* statements of third persons, and not estabilised by legal evidence before a jury trying the ultimate issue to which the opinion relates."[21]

Hypotheticals

Another approach, not addressed by the decision in *Holloway,* was for Texas prosecutors to fall back on a widely used device for eliciting all types of expert testimony, the hypothetical question. Prosecutors offered their expert witnesses elaborate hypotheticals, detailing aspects of the defendant's behavior they thought relevant to the psychiatrist's determination, but beginning with, "Doctor, I will ask you to assume. . . ." The U.S. Supreme Court decision in *Smith v. Estelle,* in combination with *Holloway,* all but forces prosecutors who wish to introduce psychiatric testimony to resort to hypothetical questions.

Hypotheticals are often relied on to introduce the facts on which an expert's opinion is based even when the expert has had direct contact with the subject of his examination. In addition, they play a useful role in allowing attorneys to demonstrate to courts and juries the effect of a change in factual assumptions on an expert's conclusions. Here, however, we are looking at a different use of hypotheticals, namely as the sole source of evidence for a psychiatric opinion, a use that raises enormous problems of the validity of expert judgments. To understand why, one must consider the nature of psychiatric forensic expertise.

There are two components to expert knowledge: the knowledge of how to conduct an investigation so as to obtain relevant data, and the knowledge of how to assess the data that result from the examination. The use of hypotheticals as the sole basis for an expert judgment (that is, when no direct examination of the subject has been performed) short-circuits the first component of expert knowledge and thereby endangers the validity of the second component.

Physicians are trained to make diagnostic judgments on an inductive basis.[22] Beginning with a data source and an initial list of possible explanations for the phenomenon in question (for example, antisocial behavior), physicians are taught to ask a series of questions that enables them to rule out some possibilities and that strengthens the likelihood that others will account for the phenomenon (for example, psychosis, alcoholism, depression, antisocial personality disorder). As

the investigation proceeds, the inquiry becomes increasingly specific. Physicians search for crucial data that would confirm or eliminate one of the remaining possible explanations (for example, the absence of delusions or hallucinations makes psychosis an unlikely explanation for the behavior). Although ideally this process results in a single explanation that is supported by the existing data or has failed to be disproved by all the questions asked, often the inability to obtain answers to crucial questions (for example, the subject's suspiciousness may or may not reach delusional proportions), leaves several possibilities remaining. The expert may still be able to make a judgment as to which of these possibilities is most likely, but the less specific the data collected and the greater the number of crucial questions that remain unanswered, the less the degree of certainty with which the physician can estimate or even rank the relative probabilites of the remaining explanations.

In the clinical setting, this problem is frequent, but except in emergencies, rarely troublesome. A physician often can settle on one likely explanation for the presenting problem (for instance, depression) while leaving open the possibility of his/her judgment being incorrect (the patient may have schizophrenia). Ideally, the next step the physician takes (perhaps initiating treatment with antidepressants) has two ends: to begin treatment of the presumptively diagnosed disorder and to further refine the diagnostic judgment (if the patient improves, the validity of the original diagnosis of depression is confirmed; if the patient becomes agitated and begins hearing voices, the diagnosis of schizophrenia becomes more likely). Diagnostic judgments and treatment can then both be adjusted in reciprocal, empirical ("trial and error") fashion until the proper combination of each is arrived at.

Of course, even in the *usual* forensic evaluation, the problem of accuracy is compounded by the frequent inability of the psychiatrist to engage in this process: to follow the defendant over a substantial period of time and to observe the defendant's responses to therapeutic interventions. This degree of uncertainty is magnified dramatically, however, when even the initial investigative process is stymied. When the psychiatrist has no opportunity to examine the defendant and to ask those questions crucial to the psychiatrist's diagnostic process, the potential invalidity of the conclusions reached becomes so great as to make the use of the resulting opinion in capital proceedings highly questionable. Indeed, even in the usual clinical setting (in which, as noted, most decisions are reversible), it would be poor clinical practice for a psychiatrist to base a treatment decision on information gathered by someone else, even another professional, unless the psychiatrist had determined that this person followed essentially the same diagnostic process as he/she would have undertaken.

Bias

There are further problems. Those facts selected by the prosecution for inclusion in the hypothetical are likely to be biased in favor of the conclusion he/she desires. In addition, whereas other kinds of experts may base their judgments on physical evidence or observable behaviors, it is the essence of psychiatric diagno-

ses that they rely on educated observations of evanescent patterns of mood and thought, which often can be elicited only by the examiner's own words and emotional responses to the subject. It is unlikely that the data required for judgments in this area could be gathered by anyone not an expert in psychiatry, a fact situation that would vitiate the need for hypothetical questions.

Given the opinion in *Holloway,* which rejected the introduction of psychiatric testimony based entirely on interviews with third parties and record reviews, one might expect that Texas courts would be similarly perturbed by the introduction of testimony based solely on hypothetical questions. Interestingly, they have not been sufficiently concerned to bar the practice. This may be, in part, because of the entrenched role of hypothetical questions in the law of evidence, or perhaps because the courts have failed to recognize the distinction between the use of hypotheticals as a means of introducing opinions generated by direct examination, rather than as the sole basis of the information on which the expert's opinion is formulated. A Texas federal district court, however, has recognized (in *dicta*) the problems presented by hypotheticals:

> This court has serious reservations about the use of psychiatric predictions based on hypotheticals and doubts their validity when the doctor has had no previous contact with the defendant. The prevailing view among psychiatrists and professional psychiatric associations, a view to which this court subscribes, is that to the extent that long-range dangerousness can be predicted (a view not accepted by the psychiatric community), an opinion as to an individual's future penchant for violence which does not follow extensive examination and is not based on a great deal of complex and in-depth information, is not a professional, but a lay opinion. However, when this lay opinion is profered [sic] by a witness bearing the title of "Doctor," its impact on the jury is much greater than if it were not masquerading as something it is not" (citations omitted).[23]

The U.S. Supreme Court has recently considered this problem in a case, *Barefoot v. Estelle,* in which the use of hypotheticals as the sole basis for a psychiatric opinion on future dangerousness is an important issue.[24] Since the testimony of the two psychiatrists involved in that case demonstrates concretely the difficulties discussed above, it may be worthwhile to examine it in some detail.

The testimony of the first psychiatrist was based on a hypothetical question that extended over 17 pages of trial transcript. In response, the psychiatrist, to whom I will refer as Dr. A, diagnosed the defendant as a "criminal sociopath." Assuming that Dr. A meant by this that the defendant met the criteria for antisocial personality disorder (A-SPD) in DSM-III,[25] it is clear that he had inadequate information on which to base that diagnosis. DSM-III requires onset of symptoms before age 15 for a diagnosis of A-SPD to be made. The hypothetical question that was presented to Dr. A began when the defendant was age 24. DSM-III requires that four of eight specified behaviors be manifested after the age of 18. There was information in the hypothetical dealing with only two of these behaviors.

The diagnostic criteria for A-SPD also require "a pattern of continuous antisocial behavior in which the rights of others are violated with no intervening

period of at least five years without anti-social behavior between age 15 and the present time." Since information about the defendant's functioning between age 15 and 24 was completely lacking, it would be impossible to say whether the defendant met this criterion.

Finally, the criteria require that the individual's antisocial behavior not be due either to severe mental retardation, schizophrenia, or manic episodes. The information in the hypothetical contained no information about any of these diagnoses being present or absent. Thus, Dr. A could not have reasonably concluded that the pattern of behavior described was not attributable to schizophrenia, manic-depressive illness, or some other psychiatric disorder. Of course, this is precisely the kind of information that would be available from a personal examination. It is, therefore, clear that Dr. A could not have reached the conclusion that the defendant was suffering from an antisocial personality disorder, at least using the generally accepted criteria of DSM-III.

Personal Definition

Dr. A, however, noted that he had his own definition of a "sociopath." Yet, looking closely at his testimony, it is clear that he did not even have adequate information to determine whether the defendant met his own criteria. After giving the diagnosis of the defendant as a criminal sociopath, Dr. A defined that condition as "one who continues to demonstrate from early life into adulthood anti-social behavior." As noted, there was no information in the hypothetical about the defendant's functioning in early life, since the hypothetical description began at age 24. Dr. A elaborated by noting "the person is normally extremely self-centered and self-serving." There was little information in the hypothetical, which dealt with the bare outlines of the defendant's behavior over a period of years, as to the defendant's self-centered behavior, and none concerning the presence or absence of other-centered behavior. Dr. A also noted that "other people are just not important to them." Again, the hypothetical contained no information as to whether the defendant, in fact, valued other people or not. Dr. A continued, "They do not form loyalties to the normal institutions such as family, friends, politics, law, religion or any institution that most people tend to live by." Again, there was no information in the hypothetical as to the defendant's attachment to institutions, family, or friends, religious practices, or political affiliations. Dr. A did note several instances of the defendant's lying as enumerated in the hypothetical.

Dr. A continued, "the sociopath also finds pleasure in controlling and exercising power over other people for manipulation . . . it makes them feel good." Without an opportunity to interview the defendant, it would ordinarily be impossible to say what sorts of activities he derived pleasure from. There was certainly no information about this in the hypothetical. Despite this, Dr. A concluded, "So we have here, probably 6 or 7 major criterias [*sic*] for the sociopath in the criminal area within reasonable medical certainty." In fact, as we have demonstrated, most of the criteria cited by Dr. A were not established (or disconfirmed) by information provided in the hypothetical question.

Dr. A further concluded that it was his opinion that the defendant's behavior would not change in the future and that, in fact, he anticipated that it would "become accelerated." The basis for this judgment was not given. Even if we assume that psychiatric prognoses of some forms of future behavior may sometimes be valid, Dr. A's inadequate data base, even in terms of his own criteria, makes such a prognostication in this case dubious. The use of this testimony for capital sentencing purposes is most distressing.

Nonetheless, Dr. A testified that his opinions were based "within a reasonable psychiatric certainty." It is somewhat unclear what this term means, given its derivation in law, rather than in psychiatry. However, a reasonable interpretation of this term is "the degree of certainty that would be sufficient in a clinical setting as a basis for treatment decisions." While it is likely that even this degree of certainty is constitutionally inadequate in capital sentencing procedures (given that psychiatric judgments in the clinical setting usually are predicated on the possibility of correcting conclusions, which is not possible in the sentencing process), we should note that Dr. A's testimony does not even meet this clinical standard. No responsible psychiatrist would be willing to initiate treatment on the basis of a brief outline of an individual's behavior over a number of years, without any attention to the individual's behavior prior to age 24, family history, social history, or the details of his past and current mental state. If Dr. A's opinion can be deemed to have fallen within the purview of "reasonable psychiatric certainty," that term is bereft of all meaning.

The testimony of the second psychiatrist in the case, Dr. B, suffered from identical problems. Yet, Dr. B was the psychiatrist quoted at the beginning of this paper who said that his certainty about his conclusions was "100 percent and absolute."

A close analysis of the testimony in this case reveals that all the expected difficulties with reliance on hypothetical questions as the sole source of information for a psychiatric opinion in fact materialized. The crucial data needed to rule out alternative hypotheses and to confirm the psychiatrists' impressions were lacking, whether measured by the standards generally accepted by the profession (DSM-III) or by the idiosyncratic criteria of Drs. A and B.

The difficulties with hypothetical questions as the sole basis for psychiatric testimony demonstrated in this case are not unique. To be sure, the testimony just discussed seems to have overstepped the permissible bounds of extrapolation from the data available. Even more cautious psychiatrists, however, who are asked to draw conclusions solely on the basis of a hypothetical question, almost inevitably will find themselves with inadequate data to support their findings. In such circumstances, at the least, a proper differential diagnosis almost never can be made, since the opportunity to follow up alternative diagnoses is lacking. Data available is likely to be biased by the advocacy needs of the side offering the question, and the intangible, but very real, value of "experiencing" the subject as a person is lost. Even if the courts would like to accept such testimony in some cases as "the best available," the level of certainty morally, as well as constitutionally, required in capital sentencing cases demands a rejection of such testimony in those circumstances.

This is not to imply that hypothetical questions ought to be excluded entirely from the capital sentencing proceeding. Used by opposing attorneys to clarify the basis for an expert's judgments, hypotheticals may have a valid role to play. But they ought to be inadmissable as the *sole* basis for a psychiatric opinion.

Negative Effects

Can any negative effects be anticipated from such a move? A rule excluding testimony based on hypothetical questions, taken in concert with the U.S. Supreme Court's decision in *Smith v. Estelle*, might have the effect of denying prosecutors the opportunity to offer psychiatric testimony relative to aggravating circumstances in death penalty hearings.[18] Of course, the U.S. Supreme Court in *Jurek v. Texas* noted that psychiatric testimony was not essential for asserting a defendant's future dangerousness in the Texas statutory scheme.[6] Further, the Texas courts may wish to limit the defendant's use of psychiatric testimony in mitigation if the defendant refuses to cooperate with an examination by the state's psychiatrist. In any event, the benefits from excluding highly unreliable psychiatric testimony from capital sentencing proceedings outweigh the loss of additional data.

Unfortunately, the U.S. Supreme Court chose, in its recent decision in *Barefoot v. Estelle*, not to accept the argument that testimony based solely on hypothetical questions is so unreliable as to be constitutionally impermissible.[24] The court's conclusion rested largely on the long use of hypothetical questions in court proceedings, albeit generally not in situations involving life-and-death decisions. Justice Byron White's majority opinion cited four cases, the most recent dating from 1897, in support of this position.

If the enormous problems raised by the use of hypothetically derived testimony in capital cases are to be addresed, therefore, it will have to be by the psychiatric profession, not by the federal courts. Psychiatrists should openly acknowledge the invalidity of such testimony and should be willing to appear in rebuttal for the defense when such testimony is introduced. Efforts should be made to educate attorneys as to the difficulties with testimony based on hypothetical questions, both to discourage their use and to enable more effective cross-examination of experts who place sole reliance on hypotheticals for their conclusions. Despite the failure of the federal judiciary to respond to this issue, a strong stand by the profession may prompt state courts and legislatures to prohibit this most regrettable practice.

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