Forensic Psychiatry: Critique of a Critique

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To paraphrase Mark Twain, "Forensic psychiatrists are the only psychiatrists that blush — or need to." Dr. Alan Stone attempts to measure forensic psychiatry with an ethical ruler and finds it sadly short.

The Hinckley trial was the most recent example that evoked yet another reexamination of the insanity defense and the role of psychiatrists in that process. Although this trial is never specifically discussed in Dr. Stone's paper, its importance as a precipitant is apparent in both the emphasis given to the insanity defense and in the search made for justification to condone psychiatric involvement in such proceedings.

I believe Dr. Stone's sweeping indictment of forensic psychiatry is based partially on his narrow definition of the field: child custody and insanity defense evaluations rather than a more general consultative role to the legal system. The news media choose to highlight these cases and, therefore, psychiatrists who perform such evaluations have been most vulnerable to being depicted as "hired guns." However, employing the kind of definition Stone suggests can be very misleading as illustrated by the following examples:

1. Dr. A testifies that Mr. B is a chronic schizophrenic who is frequently delusional to a degree that has precluded his ability to work for the past ten years. Hospitalizations have occurred on an average of three times per year during the past three years. He concludes that he meets the criteria for social security disability.

2. Dr. C testifies that Dr. D was negligent in allowing a patient a home visit four days after admission precipitated by a suicide attempt. The patient had continued to express suicidal impulses to the nursing staff, but the doctor had not reviewed the chart prior to his decision. While on the visit the patient committed suicide.

3. Dr. E testifies that Mr. F does not meet the standards for civil commitment although he needs and could benefit from treatment.

4. Dr. F is employed by the U.S. Government and is asked to screen applicants for their fitness to work.

5. Dr. G, in his consultant role to the FBI, develops a psychological profile of a suspect.

What do these situations have in common? First they are all situations that require psychiatric opinions within a forensic framework, that is, examinations by an expert to help resolve legal questions. Such evaluations, if they contribute to the ultimate loss of a job or incarceration of an individual, may not be "therapeutic" from the individual's perspective. Yet without the goal of doing "the best he can to ease his patient's suffering," the justification for psychiatric involve-

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ment disappears for Dr. Stone. The countertransference problems are too overwhelming. Yet even the “therapeutic” boundary is far from clear as the above examples illustrate.

Second, these examples present a distinctly unique consultative role for the psychiatrist in that his/her involvement in these matters is nontherapeutic or nonhealing in its primary purpose. Furthermore, these evaluations do not create a legal duty on the part of the psychiatrist to care for the “patient,” nor are these individuals in fact “patients.” Therefore, calling these individuals “patients,” as Stone refers to them, is to fundamentally misinterpret the nature of the relationship.

Stone questions whether we have anything “truthful” to say that is worthy of the courts’ attention. Actually, the judgments, inferences, and conclusions that forensic psychiatric experts are asked to consider vary widely. On the one hand, drawing a conclusion regarding a standard of care in a malpractice action, for example, whether a doctor fell below an acceptable professional standard by not reviewing nursing notes in the above example or in cases of sexual contact between patients and therapists, is easy. It is substantially and qualitatively different from assessing the presence of an irresistible impulse in an insanity defense trial. Moral judgment is involved in both, for both include an estimation of blameworthiness according to relevant standards.

The lack of strict ethical guidelines in forensic psychiatry is better cast in the lack of guidelines for all psychiatrists and physicians in nonhealing or “consultant” roles. The ethical issues confronting psychiatrists and the physicians in the employ of the armed forces when deciding to return men to front lines or discharge are really quite similar to those of many called “forensic.”

Thus the response to Dr. Stone’s first boundary question (Does psychiatry have anything true to say that the courts should listen to?) is certainly a qualified yes, depending on the nature of the questions posed.

Insofar as the discussion is limited to the insanity defense and psychiatric testimony, I think the questions posed raise some valid concerns that should be carefully considered by the profession.

There is no doubt that psychiatrists and psychiatry receive bad press from the relatively few contested insanity defense cases. The situation in which five psychiatrists reach different diagnoses as far ranging as chronic schizophrenia to a personality disorder seems embarrassing in the courtroom though commonplace in the clinical setting. The fact that there is no clear boundary between a severe obsession and a delusion is lost sight of when either individual opinions or adversarial argument polarizes the issues.

Validity of Expert Opinion

Such basic diagnostic disagreements raise questions of the validity of psychiatric expert opinion and the level of truthfulness or accuracy that is presently attainable. Dr. Stone implies the level is too low by any reasonable standard to justify involvement. What level would be adequate and how do we know when we have crossed the threshold? Few medical specialties have not substantially
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collapsed over the past 100 years, nor do they expect to remain the same over the
next century. In the vast majority (80 percent) of successful insanity defenses,
there is no disagreement regarding diagnosis or whether the criteria for the legal
test has been met. The contested cases often reflect those areas where competent
experts may reasonably disagree given the present state of knowledge (as well as
some cases where testimony is not competent). These cases form the focus of
ethical debate. The administration of the criminal justice system may require the
resolution of questions with data that fall short of the specific nucleic acid se-
quencing in DNA molecules. In balancing the requirements of equality and indi-
vidualization under the law, the defendant’s ability to put forward information
regarding his motives, character, and mental state generally are quite limited.
The insanity defense and presentence hearings are two exceptions. The moral and
ethical foundations of the criminal law are stronger because of the unacceptability
of a strict liability approach. The “reasonable medical probability” standard
symbolizes the acceptance of the limitations of medical knowledge.

In my experience much bad press about forensic psychiatry is not primarily a
result of bad science or because the field is too inadequately developed to warrant
the denotation of “expert witness.” Rather, psychiatrists are inadequately pre-
pared as to their task and their ability to function in the arena of the court. Leston
Havens has characterized (caricatured) medical school as training future doctors
in the art of “asking questions and giving prescriptions.” This training is antithet-
cal to a courtroom role. Bad press and bad testimony frequently derive from
inadequate examinations, unfamiliarity with records, and conclusions based on
speculative inference from inadequate data. While such inferences and specula-
tion are welcomed in clinical settings, they are inappropriate in courtrooms, and
even if they do not harm the defendant, they harm the profession.

Dr. Stone’s example of Dr. Leo is a case in point. In 1800, psychiatrists or
alienists rarely were used as expert witnesses. It was during the following century
that psychiatrists gradually emerged as playing a larger role in the courts. The
role developed as the standards of insanity evolved from “raving lunacy,” which
required no expertise to identify, to lesser degrees of illness requiring far more
refined judgments. Dr. Leo’s testimony is not at issue, as we have none to review.
It is his qualifications and his biases that are being addressed. The adversary
system in this context functions at its best. Wearing my psychiatric hat, I am
embarrassed to see a colleague and the profession made a fool of; but the alterna-
tive of blind acceptance of “expert” opinion seems equally embarrassing and
inappropriate. If one develops a reputation as an unreliable or biased witness,
those biases or inadequacies should be made explicit. Unfortunately, psychiatry
has not reached quite the same status as other medical specialties wherein, for
example, bad orthopedic testimony is not so immediately taken as indicative of an
inadequate scientific basis of orthopedic medicine.

Dr. Stone raises Dr. Grigson’s appearance at capital sentencing hearings as the
other symbol of psychiatric participation in the legal system, which lacking an
ethical basis for its removal, justifies absence from the courtroom for psychia-
trists. He believes we think his testimony is unethical because most of us wish to

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ease suffering of patients and therefore feel antipathy in hearing someone testify to a position that would enhance the use of the death penalty. This seems too simple. I have to agree with Stone’s analysis that there is not a neutral principle that would exclude testimony to hypotheticals. Yet in civil commitment we value and mandate the need for a personal examination prior to certifying or testifying in a commitment proceeding not just because the law requires it, but because of ethical values as well. Is the death penalty less demanding than civil commitment? The Supreme Court has given some direction:

This conclusion rests squarely on the predicate that the penalty of death in its finality, differs more from life imprisonment than a 100-year prison term differs from one of only a year or two. Because of that qualitative difference, there is a corresponding difference in the need for reliability in the determination that death is the appropriate punishment in a specific case (Furman v. Georgia 408 US 238, 1972).

The need for reliability might argue for ethical if not legal guidelines regarding the nature and minimal basis of psychiatric testimony. A few months ago the Supreme Court in Barefoot v. Estelle (51 LW 5189 (1983)) did not find a Constitutional requirement for a personal examination or for better reliability and validity in predicting dangerousness before deeming it admissible.

The court’s resolution was legally correct in my view. To avoid arbitrary imposition of the death penalty the court has mandated a high degree of individualization by declaring unconstitutional those statutes that impose the death sentence solely upon conviction for certain crimes. At hearings where the imposition of the death penalty is considered, the defendant is allowed to introduce any evidence in his/her behalf that he/she chooses. The prosecution was recently (Smith v. Estelle 602 F.2d 694 (1979)) limited in introducing psychiatric testimony when the psychiatrist did not inform the defendant of the purpose of the evaluation. If the prosecution is thus limited in its ability to force a personal examination, should the state not be allowed to have experts respond to hypothetical questions? The court in balancing these issues concluded that rebuttal testimony could have been introduced by the defense to counter such bad testimony rather than requiring some Constitutionally mandated threshold of validity in predicting dangerousness to insure “reliability” in those proceedings. This Constitutional ruling does not preclude state rules of evidence or ethical guidelines from excluding such testimony.

“Hired-Gun” Psychiatrist

Another problem framed by Dr. Stone as inherent in the adversarial system is that forensic psychiatrists would argue that “they have no ethical problems because they openly accept the responsibility for putting forward the best possible case for their side.” I do not know any forensic psychiatrists who would subscribe to that view. I believe most would distinguish between consultant to an attorney (under the attorney-client privilege in preparing or reviewing a case) and courtroom testimony. In discussion with the attorney, a consultant may try to present the best possible case; but once on the stand, the role is to be an expert and not
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present a biased view even if the testimony may be detrimental to the consultee's case. Psychiatrists in the expert forensic role have a responsibility not to be biased beyond their data. They must use their skills to assess the transference and countertransference issues in such a fashion as they would in a psychotherapeutic setting. Cross-examination is designed to expose and examine such biases. If the "best possible case" were the guideline for courtroom testimony, then fundamental ethical questions regarding truthfulness are raised. To add this to the burden of already complicated ethical questions in the consultative role would preclude appropriate participation in the process.

The caricature of the "hired-gun" psychiatrist should set us to examine our ethical guidelines and develop them so that our most public presentation is not so easily disparaged. Clinical inferences that are tolerable and acceptable in clinical settings are not acceptable in the court. The demand for a threshold of "reasonable medical certainty" and the understanding that a psychiatric opinion alone is not sufficient basis for judicial acceptance has not been obvious to our profession. That someone may be schizophrenic yet competent in a variety of settings should make it clear that more is needed than a diagnosis to establish a criminal defense. The dangers that Dr. Stone highlights are real and need attention. His analysis of validity is not sufficient or specific enough to demand withdrawal from the field. In fact, moral and ethical values would support the concept of individualization in the narrow context of the insanity defense especially in this area of retributive justice and trends toward fixed sentencing.

I do not believe it is possible to practice psychiatry in this era and not be placed in a forensic role during one's career. As attorneys in corporate consultative roles also struggle to find ethical guidelines for their work, we need to evolve guidelines that preserve participation in the process without embarrassing ourselves and our profession as being morally and ethically bankrupt. The best hope for ethical participation is to acknowledge the limitations of our expertise and to be effectively trained for this role.