Who's Afraid of Forensic Psychiatry?

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Forensic psychiatry has come under mounting criticism from the press and other medical professionals, largely for its participation in the insanity defense. The author argues that the expertise available from the specialty is of increasing importance to psychiatry as a whole, as more and more legal issues become relevant to the practice of general psychiatry, and should be actively encouraged and legitimized rather than ostracized. All psychiatrists should be exposed to forensic principles and practices during their training, and the ability of forensic psychiatrists to serve as transducers between the clinical and the legal/judicial should be increasingly used to present the clinical viewpoint effectively in courts and legislatures.

Alan Stone surveyed forensic psychiatry from his ivory tower and concluded that it has nothing to offer the law.[1] Another president of the American Psychiatric Association, Paul Fink, in his 1988 address to the American Academy of Psychiatry and the Law,[2] stated that the spectacle of opposing expert psychiatric witnesses in court was an embarrassment to the profession and called upon the Academy to solve the dilemma.

Such editorial comments echo those of many past leaders of our profession over the years who have suggested that we should not become involved in problematic areas of practice which might embarrass our more retiring colleagues. The ivory tower perceives itself as being under siege on a number of fronts and has selected forensic psychiatry as a convenient scapegoat for many of its public relations difficulties instead of viewing it as a potential ally in the development of solutions. In this presentation, I shall argue that forensic psychiatry as a profession is more than a few psychiatrists testifying in notorious criminal trials, and that its expertise is essential in assisting a profession whose ivory tower has become as protective as the Maginot Line.

Definitional Issues

One of the major difficulties which arises in discussing the subject of forensic psychiatry is the threshold question of definition. Although in most discussions it is tacitly assumed that forensic psychiatry is synonymous with evaluations of criminal defendants, particularly evaluations of their sanity at the times that they committed notorious

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crimes, such a limited definition is neither theoretically nor practically sufficient. One cannot (and *should* not) separate the evaluation of criminal responsibility (which has led to the great majority of criticism of forensic psychiatry, both from within and outside the profession) from the variety of other functions subsumed under the broader term "forensic psychiatry" as I shall use it for the purposes of this presentation.

Seymour Pollack has distinguished "forensic psychiatry," which he characterized as "the application of psychiatry to legal issues for legal ends,"[3] (p.2) from the broader term "psychiatry and law," which "can be considered the broad, general field in which psychiatric theories, concepts, principles, and practice are applied or related to any and all legal matters"[3] (p.2); as such, it relates to other areas such as social and administrative psychiatry. Pollack emphasized the difference in goals for the two categories—forensic psychiatry addresses legal ends, whereas psychiatry and law preserves clinical goals and approaches to problems at the psychiatry-law interface. Other forensic psychiatrists have also attempted to define the field: Diamond[4] would include writing law review articles and legal briefs as part of what he conceives as a missionary role for forensic psychiatry. Robitscher[5] included professors, trainers, evaluators, testifiers, treaters, and even critics in his definition and argued that the forensic psychiatrist is the main emissary of psychiatry to society at large; he preferred the term "social-legal psychiatry" corresponding to Pollack's "psychiatry and law."[6] Robey and Bogard[7] emphasized that forensic psychiatrists must be familiar with the latest in diagnosis, treatment, and research, and be able to translate their knowledge into terms understandable by lay decision-makers. Dietz, as far back as 1978,[8] (p.13) stated that "in an era in which virtually every psychiatrist must take cognizance of certain medicolegal principles, an argument could be made that 'forensicity' is a continuous variable distributed unevenly over the entire population of psychiatrists."

The "official" definition of forensic psychiatry promulgated by the American Board of Forensic Psychiatry and adopted in the Ethical Code of the American Academy of Psychiatry and the Law[9] is "a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional, or legislative matters."

I shall use an extension of Pollack's broad definition of "psychiatry and law." This approach emphasizes, I believe correctly, the essential process of applying clinical knowledge and experience to legal or administrative decision-making, and is not distracted by attempting to differentiate among evaluations of which various practitioners or theorists approve or disapprove. I believe that this conceptualization leads to the development of a coherent role for forensic psychiatry which has not been fully explored previously, but which is becoming increasingly important to the profession of psychiatry as a whole.

The Insanity Defense

Although I believe that the issues involved in the insanity defense are conceptually indistinguishable from other areas of forensic practice, it is important to address them initially in order to place them in the broader context of our discussion. The real reason, of course, why the insanity defense has been the recipient of so much attention from both legal and clinical critics is not that clinicians are less competent to offer those particular opinions, but that such opinions have (or at least *appear* to have) a powerful and direct impact on decisions of direct interest to society, and are presented publicly, often with widespread media coverage.[10] No other clinical opinion has the effect or enabling defendants to be found "not guilty" of criminal acts which can be proven that they committed, or to be released from custody earlier than would be the case if they had been found responsible for their behavior.[11]

Psychiatry is, of course, not without fault in the creation of our current problems with the insanity defense. From the psychiatrists at McNaghten's trial who made confident pronouncements on his sanity from observing him in the dock,[12] through Isaac Ray, the patron saint of forensic psychiatry who proclaimed that only psychiatrists were competent to determine the criminal responsibility of defendants,[13] to contemporary practitioners who seek either to excuse or condemn criminal defendants through the manipulation of clinical jargon to implement their ideological agendas,[14-17] psychiatrists have not waited for an invitation before volunteering for the judicial arena.

Unfortunately, organized psychiatry continues to play the ostrich in public, reacting to intractable social problems which don't affect the practices of the majority of its members directly by calling for psychiatry to abandon the institutions society has created to deal with them. From Solomon's call for psychiatrists to refuse to work in state mental hospitals because of the (admittedly terrible) conditions existent at the time,[18] to present calls for the abolition of the insanity defense (or at least psychiatric participation in its operation), the profession has attempted to deal with difficult problems by disclaiming responsibility for them.

Critics from within the profession have argued largely on theoretical grounds that psychiatry should abandon the criminal courts altogether. Halpern,[19] Goldstein and Katz,[20] and Morse[21] have called for the abolition of the insanity defense; and Menninger[22] and Halleck[23] have argued that psychiatrists should not participate in its implementation. In a purely political response to the post-Hinckley backlash, the American Medical Association's Board of Trustees initially voted to recommend abolition of the insanity defense,[24] whereas the American Psychiatric Association[25] recommended abolition of the volitional prong of the American Law Institute insanity test and also recommended that psychiatrists not express opinions on the ultimate issue of responsibility. After behind-the-scenes negotiations, the two organizations issued a

joint statement emphasizing their essential agreement (while maintaining their original separate positions).[26]

Other Forensic Evaluations

The process of formulating opinions on criminal responsibility, however, does not differ significantly from that applied to a wide variety of other legal questions. In addition to the other evaluations which are considered to be "forensic," such as competency to stand trial, testamentary capacity, psychic trauma, and child custody, there are many which are regularly performed by "general" psychiatrists without the criticisms that are applied to criminal responsibility evaluations by the profession itself. Most psychiatrists have been involved in involuntary civil commitment evaluations; and as a growing number of states establish a qualified right to refuse treatment, psychiatrists are providing opinions concerning their patients' competency to make treatment decisions as well. With the current emphasis on informed consent for all types of medical treatment, psychiatrists (particularly those in consultation-liaison services) are being asked to provide more opinions about the competency of medical and surgical patients to consent or refuse treatment.[27] These evaluations are usually unopposed, and less often subject to legal challenge, and are therefore less likely to expose weaknesses in the clinical reasoning involved.

As remuneration for direct care to mental patients diminishes and is distributed among a growing pool of mental health service providers, and as external evaluation and regulation of the practice of medicine in general proliferates, psychiatrists have increased their involvement as consultants to regulatory organizations such as insurance companies, workers' compensation boards, social security disability panels, and peer review organizations. The increase in malpractice suits against psychiatrists[28] has also drawn other psychiatrists into the court to provide opinions on the profession's standard of care.

In all these situations, including criminal responsibility, psychiatrists are being asked to perform clinical evaluations in order to address essentially nonclinical legal or administrative questions. Each of these evaluations requires the psychiatrist to be familiar with the nonclinical definitions and rules which apply to the evaluation in question, to address those specific external concerns explicitly in their evaluations, and to translate their clinical findings into conclusions useful to those requesting the evaluation.[29]

The criticism most often directed at psychiatric participation in the insanity defense, that we are being asked to answer questions for which our clinical training and experience do not prepare us,[21] is equally applicable to our conclusions in many of the other legal and administrative evaluations mentioned above. There we are being asked to answer equally difficult (if less publicized) social and moral questions such the degree of disability induced by a mental disorder, and the effects of that disability on a person's ability to make important personal decisions such as whether to

accept hospitalization or treatment or to whom to leave property, or a person's capacity to work or to be a parent.

Organizational Forensic Decisions

It has been demonstrated that the personal ideologies of individual psychiatrists may be the determinative factors in their opinions on criminal responsibility;[30] although few data are available, it is unlikely that those who offer opinions on these other issues are any less free of personal bias or ideology. Indeed, the profession itself has demonstrated its collective ideology in a variety of official nonclinical positions. I have already mentioned the American Psychiatric Association's call for the elimination of the volitional prong from the criteria for the insanity defense.[25] This position was based in part on the assertion that it is more difficult for clinicians to determine volitional than cognitive capacity; but there are no data to support such a conclusion, which has been challenged vigorously by Rogers.[31] It is also probable that a perception that elimination of the volitional prong would be more restrictive, and thus less troubling to the public, also entered into the deliberations, as its adoption in the *Durham* and American Institute tests of criminal responsibility was explicitly for the purpose of making the test more inclusive.[32]Other APA positions on issues of social significance which have been based largely on political considerations include the decision that egosyntonic homosexuality is not a mental disorder[21] and the exclusion of potential diagnoses such as paraphilic rapism and premenstrual syndrome from the DSM-IIIR.

On even broader social fronts, psychiatry has a long and often unfortunate history of promising solutions to major social problems, beginning with claims of cures for mental illness in the nineteenth century,[33] which were resurrected in the 1930s as a basis for the plea to convert all prisons into hospitals,[34] and again in the 1960s as one of the cornerstones of deinstitutionalization. There are no signs that attacks of professional modesty are breaking out; as recently as 1987, the Executive Vice President of the American Medical Association proclaimed at the American Psychiatric Association's annual Convocation of Fellows that psychiatry is now sufficiently knowledgeable about the causes of the problems of adolescents (including drug abuse, pregnancy, and suicide) to join with the pediatricians to solve them for our society.[35]

As has been the case with individual expert opinions regarding criminal responsibility, there has been considerable disagreement among individual psychiatrists about each of these issues. For the purpose of this discussion, it is not necessary to address the propriety or validity of such decisions and statements; they are included to demonstrate that the same application of clinical judgment to nonclinical issues required in the insanity defense is to be found throughout the practice of psychiatry and the public statements of its official organizations.

Critics have argued that to the extent that these activities embarrass the profession, they should be abandoned;[2]

as with the law, the dignity of the profession is thought to be of sufficient importance to dictate its practices. I would argue that there are two potential sources of any embarrassment derived from such activities: the quality of the reasoning involved in the opinions, and the degree of publicity attending them. Although we typically have less control than we might like over media accounts of our pronouncements, we can (and should) affect the quality of our work products; and it is here that the expertise of forensic psychiatry has the potential to inform our deliberations and to make our recommendations more effective outside our professional circles. Rather than adopting a nihilist position by abandoning difficult tasks assigned to us (and thus leaving them to others arguably even less qualified to perform them), we should improve our performances. Such an endeavor would not only decrease legitimate criticism of our participation in social arenas such as criminal courtrooms, but it would also enhance our ability to persuade courts and legislatures of the validity of our arguments.

The Growing Impact of Law on the Practice of Psychiatry

It is increasingly clear that privately practicing psychiatrists, who comprise the majority of the profession, can no longer avoid dealing with legal issues, even if they want to do so (and I believe that there are a growing number of situations in which they should not even *want* to). The duty of therapists to protect third parties from the actions of their patients introduced by the *Tarasoff* decision[36] has been the most visible and certainly the most widely discussed symbol of private psychiatry's involuntary interface with the law over the past decade;[37] but it is by no means the only, or even the major, way in which general psychiatry has lost its legal virginity. Public concern about the efficacy and the cost-effectiveness of our services has resulted in increased regulation from peer review, organizations, licensing boards, and credentials committees.[38] Perhaps the major concern of organized psychiatry at the national and state level is the inequities in third-party reimbursement between mental and other types of patients. Legal challenges from economic competitors to our hegemony over entrance to training opportunities, hospital privileges, direct reimbursement, and perhaps even prescription of medications, have also become increasingly successful over the past decade.

In response to what many still perceive to be legal assaults on psychiatry,[39] we can continue to cry "rape"; or we can learn not only to protect ourselves from inappropriate intrusions, but also to become proactive in our increasing involvement with external regulatory bodies, in hopes of helping to shape the process and the procedures with which we must deal.

The Forensic Approach

A forensic psychiatrist's approach to issues with both clinical and legal aspects differs in several respects from that of a general clinical psychiatrist. In performing evaluations for the courts or for other social agencies, where those being eval-

uated often have obvious motives for simulation or dissimulation, it is necessary for a psychiatrist to be more skeptical than in a private evaluation for treatment.[1] Because of their contact with the legal system, forensic psychiatrists are more conscious of the need for external corroboration of statements made by patients under evaluation, and for longitudinal historical information. Those who treat forensic patients develop experience in recognizing and dealing with the significant differences between such patients and those in general psychiatric populations. They become expert in dealing with specific diagnostic groups not usually found in psychiatric populations, either in university training hospitals or in private psychiatric hospitals, such as sex offenders,[40] whose behavior is of significant interest to society. They also learn how to deal with differences in style between the two populations; because of their contacts with lawyers and the courts, forensic patients tend to take on many of the operational characteristics of general criminal populations, particularly the development of adversarial relationships with their treaters and reliance on grievances and lawsuits as major techniques in dealing with those in authority.[41]

The Value of Research

Psychiatrists, particularly those with psychoanalytic training, have traditionally approached clinical questions phenomenonologically, often basing their opinions largely on their personal clinical experience alone, rather than seeking corroboration from sources other than the patient.[42] For example, despite the voluminous research demonstrating the inaccuracy of clinical predictions of future dangerousness,[43] not only do certain notorious psychiatrists confidently continue to proclaim that they are capable of predicting long-term future dangerousness,[44] but the majority of clinicians responding to a questionnaire survey after the California *Tarasoff*[36] duty to protect case indicated that they believed that they could reliably predict such behavior in their patients.[45] These claims have been widely cited in subsequent court decisions.[36,46]

Long-term treatment experience with forensic patients can provide the opportunity to accumulate the research data necessary to address a variety of questions of legitimate interest to society.[47] Most prominent among these questions, of course, is the issue of dangerousness, which has received considerable attention over the past two decades. There have been a number of studies concerning prediction of future dangerousness,[43] and also research, both biological and sociological, on the causes[48] and treatment/management[49] of such behavior. Such research depends, of course, on access to populations of presumably dangerous patients, and more practical information is clearly necessary.

Other questions of direct relevance to both psychiatry and law include the capabilities of patients to give informed consent to various medical and psychiatric procedures;[50] the efficacy of psychotropic medication when administered involuntarily;[51] the indications for,

efficacy of, and risks of treatment with newer antiaggression medications;[52] and the effects of various judicial procedures on staff[53] and patients.[54]

The "Selling" of Psychiatric Knowledge

Once such data are available, it is still necessary to convince judicial and legislative professionals of their relevancy.[55] Courts have frequently ignored the established facts when they have not supported the policy the judges have wished to further with their decisions,[56] and published court decisions in areas such as the right to refuse treatment[57] and the duty to warn[58] have badly misinterpreted available clinical data. One major reason why psychiatry has not been able to be more persuasive in court is its persistent tendency to refuse to acknowledge both the validity of opposing positions and legal reality, and to be willing to support compromise positions. At least partially as a result, courts have rejected official psychiatric positions on a variety of issues, including the right to refuse treatment,[59] the duty to warn,[60] and admission privileges to hospitals and psychoanalytic institutes for psychologists.[61]

Until recently, organized psychiatry followed the path of organized medicine in general in its response to legal issues affecting its practices—it ignored courts and legislatures as long as possible, and only recently has it adopted a proactive posture in dealing with the many complex issues which affect its practice and its patients. Just as the American Medical Association opposed the inevitable socialization of medical practice, the American Psychiatric Association refused to participate, even when invited, in early court and legislative decisions involving mental health practices, arguing that courts should stay out of our territory.[62] The American Psychiatric Association has since recognized the reality that such decisions will continue to be made with or without input from practitioners, and has established the Council on Psychiatry and Law to discuss and formulate position statements on legal issues which impact on clinical practice, and the Judicial Commission to react quickly to developing cases by providing amicus briefs to federal and state courts to inform them both of our positions and the relevant data behind the positions.

District branches of the APA have begun to follow suit: my recent survey of presidents of district branches (41/52 responding) revealed that 11 have psychiatry and law committees, 35 (including all with psychiatry and law committees) have legislative committees, and only six have neither (five because they reported they had too few members). Psychiatry and law committees provide consultation and proactive analysis of potential issues to branch executive committees, consultation and testimony to legislatures (including drafting legislation), prepare amicus briefs (often with assistance from the APA Judicial Commission), and provide education and consultation to individual members. Those branches without psychiatry and law committees obtain these services chiefly through executive, legislative, or

ethics committees, and through their state medical societies.

Forensic psychiatrists have had somewhat more success in working with legislatures than with courts. It may be that legislators are more used to dealing with interest groups than are judges, and are more likely to consult with those practitioners that their bills are likely to affect. It is also probable that the give-and-take characteristic of the development of legislation is more congenial to clinicians than the more absolute positions often taken in briefs and arguments in court. For whatever reasons, in areas such as the duty to warn,[37] sexual abuse by psychotherapists,[63] malpractice reform,[64] and reforms in civil commitment,[65] clinical input has increasingly had the effect of convincing legislators to modify bills in recognition of the legitimate concerns of the clinicians who must live with the results of their implementation.

Developing Forensic Expertise

I am certainly not suggesting that all psychiatrists should specialize in forensics. But if the expertise available from those who do is to fall on receptive ears, it will be necessary that the level of legal sophistication of all psychiatrists be considerably higher than it is at the present. One obvious way to accomplish this goal is to provide training during medical school and residency. The most recent comprehensive survey of all U.S. medical schools from 1984/5 revealed, however, that only 22 percent had specific required courses on medicine and law, with another 20 percent offering electives and an additional 31 percent providing some information as part of other courses. Only 10 percent of the schools offered a separate course on mental health law.[66]

Although the American Board of Psychiatry and Neurology requires that psychiatric residencies provide training in forensic psychiatry, there are few current data which reveal how well this goal is being achieved.[67] The great majority of forensic psychiatrists continue to practice privately, mostly in the civil courts.[68] Although the 1978/9 NIMH survey of 293 psychiatrists who listed forensics as an area of their practice (representing only a 20% response rate) indicated that 64 percent listed teaching as among their activities, the survey did not indicate whether their teaching was in the area of forensics.[69] Improvement is clearly needed in the quality and quantity of forensic education provided in our medical schools and residencies. No one should be able to graduate from medical school without receiving specific exposure to medicine and law, and all psychiatric residents should have focussed seminars of psychiatry and law which deal with practical as well as theoretical aspects of forensics.

Despite public and professional criticism, and the general trend away from reliance on experts to resolve social dilemmas,[47] the numbers of those identifying themselves as forensic psychiatrists continues to grow. Alan Stone, despite the criticisms noted previously, has pointed out that forensic psychiatry is "one of the few growth stocks" in an otherwise stagnant psychiatric market[1]

(p. 58). Courts and other decision-making bodies are asking for even more involvement by psychiatrists. Even the Supreme Court,[70] hardly one of our more ardent supporters over the recent past, has recognized the importance of psychiatric consultation in insanity defenses beyond offering expert opinions on the defendant's mental state to the preparation of the defense case itself.[71] Civil courts are inviting psychiatrists to participate in their deliberations in ever-increasing numbers.[72]

Forensic psychiatry has responded in various ways to this demand. The most recent survey of psychiatrists indicates that 20 to 30 percent spend at least some of their time in forensic work,[69] an increase over the 5 to 10 percent reported from a 1970 survey.[8] There has been a significant increase in the number of forensic psychiatric organizations. In addition to the Psychiatry and Behavioral Sciences Section of the American Academy of Forensic Sciences, active since 1948, the American Academy of Psychiatry and the has grown over the past 20 years to its present membership of 1,295. The American College of Forensic Psychiatry and the interdisciplinary International Academy of Law and Mental Health have also been established in the past decade. The American Board of Forensic Psychiatry was established in 1976, and to date has certified 220 forensic psychiatrists; the American College of Forensic Psychiatry has also established a certification process.

Until recently, the great majority of forensic psychiatrists had to train themselves in their field; but at least 20 forensic psychiatry fellowship programs are now in operation, with new ones being developed each year; and the number of journals in forensic psychiatry has grown from the lone *Journal of Forensic Sciences* (with few articles on psychiatric topics) to at least seven at the present time, in addition to a variety of forensic journals in other mental health fields.

Conclusions

Forensic psychiatry is flourishing, despite public relations problems with its involvement in the insanity defense. In addition to its traditional role of providing direct testimony in court, the profession has taken on the tasks of presenting our expertise and viewpoints to courts and legislatures on the growing number of issues in which judicial or legislative decisions affect our practice. It is crucial that forensic psychiatry continue to develop expertise in these areas through research and education, so that its contributions will continue to be useful both to those charged with decision-making and to the profession of psychiatry as a whole. It is equally crucial that forensic psychiatrists be supported in their efforts to share their experience and expertise with their nonforensic colleagues through tenured faculty positions which provide access to students in formal training programs as well as through presentations made at meetings of general psychiatrists. As Diamond[4] points out, without such support, even those forensic psychiatrists who would prefer to work within a more traditional academic framework will be forced to continue to derive the major source of their

incomes through the same types of courtroom testimony which has led to the calls for the abolition of the insanity defense.

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