Psychiatrists and Capital Sentencing: Risks and Responsibilities in a Unique Legal Setting

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For a decade, the effort to abolish the death penalty in this country was focused on the U.S. Supreme Court. It was argued that the death penalty was inherently unconstitutional because it contravened the "evolving standards of decency which mark the progress of a maturing society," and therefore amounted to the cruel and unusual punishment proscribed by the eighth amendment to the Constitution of the United States. When the Supreme Court finally agreed to address this question in 1972, only Justices Marshall and Brennan agreed with the abolitionist position.

The Georgia statute before the Court in this 1972 case[1] classified first degree murder, rape, and armed robbery as capital crimes and left the decision whether to impose the death penalty in lieu of life imprisonment entirely to the discretion of the jury. Three members of the Supreme Court were convinced such statutes did, indeed, create a "substantial likelihood" that the death penalty would be imposed arbitrarily, and they joined with Justices Marshall and Brennan, forming a majority of five, to strike down the Georgia statute and virtually all the state statutes then in effect.

Between 1972 and 1976, 35 states reenacted the death penalty in response to the *Furman* decision. However, the states responded to the *Furman* opinion in two entirely different ways. Some states tried to minimize the risk of arbitrariness by *requiring* the imposition of the death penalty for certain crimes. These so-called mandatory statutes generally applied to certain specified types of homicides, such as those committed by a person serving a life term or those involving the killing of a police officer. The other response to *Furman* was to preserve some degree of discretion but to reduce the risk of arbitrariness through normative constraints; the usual model was a separate sentencing hearing at which the judge or jury would consider evidence offered in aggravation and mitigation and would decide whether to impose the death penalty according to specified statutory criteria, a process that was policed by appellate review.

In a series of cases decided in 1976, the Supreme Court reviewed representative statutes of each type. It upheld the statutes that had allowed, in varying degrees, consideration of mitigating circumstances and had permitted the structured exercise of discretion.[2,3,4] On the other hand, the Court invalidated the statutes that had banned sentencing discretion altogether and had prescribed death as the mandatory penalty for certain types of crimes.[5,6]

Again, there was no majority on the Court for any single point of view. However, despite the complexities of the Court's opinions, several basic propositions did clearly emerge. First, "the penalty of death is qualitatively different from a

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sentence of imprisonment, however long. 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."[7] From this premise flows the corollary proposition that the death penalty may "not be imposed under sentencing procedures that (create) a substantial risk that it (will) be inflicted in an arbitrary and capricious manner."[8]

Applying these principles, the majority of the Court upheld the capital sentencing procedures of Georgia, Florida, and Texas. In each case, the Court concluded that the statutory scheme adequately structured the exercise of discretion by requiring a separate (bifurcated) proceeding for choosing, after conviction of a capital offense, between death and life — a proceeding that approximated the carefully structured process by which guilt is determined rather than the traditionally unstructured process of sentencing.

At the same time, the Court struck down the mandatory statutes of North Carolina and Louisiana. The Court did so because it believed "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 penalty of death."[9] The Court continued that "a process that accords no significance to relevant facets of the character and record of the individual offender or the circumstances of the particular offense excludes from consideration in fixing the ultimate punishment of death the possibility of compassionate or mitigating factors stemming from the diverse frailties of human kind."[10]

By requiring the states to individualize the capital sentencing process, the Supreme Court virtually has assured routine participation by psychiatric (or other clinical) experts. Clinical evaluation and testimony will be sought by the defense, as a matter of course, in capital cases. At a minimum, the defense must try to persuade the judge and jury that the offender's homicidal behavior is only understandable in terms of some underlying psychopathology or mental abnormality and that it would be unjust therefore to execute him. Undoubtedly, the defense also would like to persuade the jury that the defendant is not beyond rehabilitation or redemption. In any event, it is clear that the defendant's case in mitigation — if there is to be one at all — will often be built primarily on a foundation of psychiatric testimony.

The indispensability of psychiatric testimony in capital cases is further assured by the restricted coverage of most capital sentencing statutes. The Supreme Court has implied that only intentional homicide can be punished by the death penalty and in most states, a person cannot be convicted of capital murder (or sentenced to death) unless the killing was "premeditated" and was not committed in the "heat of passion" upon legally adequate provocation. For this reason, these cases will lack the type of extenuating evidence concerning provocation or excuse that customarily leads to convictions of less serious forms of homicide, such as second degree murder or manslaughter. In short, most capital cases will involve homicidal behavior that defies lay understanding and sympathy.

This article deals with the two major substantive issues in capital sentencing statutes that may involve psychiatric evaluation and testimony as part of the sentencing process. The first is an expanded concept of mitigating mental abnormality or diminished responsibility that goes well beyond the traditional parameters of "mental disease or defect" as used in tests of insanity or criminal responsibility. The second is the issue of dangerousness — the "probability" or "likelihood" that a defendant "will constitute a continuing serious threat to society"[11] — which several state statutes explicitly recognize as an "aggravating" factor in a death penalty proceeding and which is never far beneath the surface in any capital sentencing case.

The increased breadth and scope of psychiatric input at the sentencing phase allows the clinician to develop a careful and considered formulation of the defendant's personality functioning, both developmentally and in relation to the crimes committed. Yet it also allows for the unfortunate venturing into a more speculative level of opinion formation either in connection with mitigating mental abnormality or prediction of future behavior that may not reach a threshold of either clinical or legal significance.

The task of psychiatric evaluation of a defendant charged with or convicted of a capital crime is obviously different from the evaluation of other homicide defendants. The stakes are higher, and the case will be played in a different moral key. Indeed, strongly held moral beliefs about the death penalty, and about one's own ethical obligations, will lead many clinicians to forego participaton in capital cases altogether. However, those who choose to participate will do so in a unique legal context.

Mitigating Mental Abnormality

The United States Supreme Court in *Lockett v. Ohio* (1978) held that "the Eighth and Fourteenth Amendments require that the sentencer. . . not be precluded from considering, as a *mitigating factor,* any aspect of a defendant's character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death."[12] The Court reaffirmed this position in *Eddings v. Oklahoma* (1982) in which the death sentence of a sixteen year old was overturned, because the trial judge "refused, as a matter of law, to consider in mitigation the circumstances of the petitioner's unhappy upbringing and emotional disturbance. . ."[13]

Lockett and *Eddings* require the courts to admit into evidence, and to consider, any claim raised by the defendant in mitigation. As a result, it is clear that virtually any clinical findings, and expert opinions based on these findings, may be offered in mitigation.

This is not to say, however, that clinical testimony is not subject to *any* "tests" or criteria of legal significance. Capital sentencing proceedings are different from ordinary sentencing proceedings in most states by virtue of the legislative effort to specify mitigating circumstances to guide the exercise of discretion by the trier of fact. Three fourths of the legislatures that have reenacted the death penalty have defined a threshold of significance for mitigating mental abnormality; these criteria focus on whether the capital crime was committed while the defendant

was "under the influence of extreme mental or emotional disturbance"[14] or on whether at the time of the commission of the capital crime "the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law was significantly impaired."[15] In most of these states the substantive inquiry is not restricted to behavioral impairments arising out of "mental disease or defects," which has been the traditional limiting factor in the legal tests for insanity.

There is a key substantive difference between the legal concept of exculpatory mental abnormality (nonresponsibility) and mitigating mental abnormality (diminished responsibility). In the adjudication of claims of legal insanity the clinician traditionally has been asked to relate mental abnormality to the various narrowly defined legal criteria that, if met, would excuse the defendant's conduct. The presence of an *exculpatory* mental abnormality would, therefore, erase the moral basis for ascribing guilt. A *mitigating* mental abnormality does not absolve the defendant but may serve to ameliorate or temper what would otherwise stand as a harsher sentence.

The threshold of mitigating mental abnormality can be illustrated by the following cases.

> Mr. G was a twenty-two-year-old single male who was convicted of the rape-murder of a sixteen-year-old girl and, some hours later, the girl's mother. Mr. G was renting a room from the elder victim. His exposure in the boarding house to sexual promiscuity and drug and alcohol abuse (particularly that of the victims) appeared to reactivate numerous intrapsychic conflicts about similar behavior by his mother and sister that he believed had occurred in his own home while he lived there. On the night of the rape and murders, he recalls being "high on alcohol, pot and Dilaudid." Michelle, the daughter, began to tease him sexually but would not consent to intercourse. Mr. G then raped her and simultaneously strangled her. Several hours later he returned to the scene and stabbed Michelle's mother to death. He then fled to another state and turned himself in to local police authorities, confessing fully the criminal acts he committed.
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> Mr. G's psychiatric history revealed a life-long pattern of aloofness and inability to develop interpersonal relationships. He experienced serious adjustment problems at school and was the object of frequent physical abuse by his mother because "I couldn't get through to him." He developed some relationship with a stepfather from age 10 until age 14, when the stepfather died. Two suicide attempts followed shortly after the stepfather's death. Drug abuse became a central feature of his life at about this time. He could not hold a job, "drifted" from place to place, and reported becoming "increasingly more tense."

Mr. G demonstrated a clearly definable psychiatric syndrome (in this case a schizotypal personality disorder) that may have had significant relationship to the criminal act even though he was not "legally insane" under Virginia law and even though his cognitive functioning was not impaired in a way that would "negate" the element of premeditation as defined in Virginia. In this case the diagnosis of schizotypal personality suggests a pattern of regressive behavior carried out in an attempt to relieve very high levels of tension and anxiety generated by a long history of developmental insults, which may reach the level of legal significance suggested by either of the mitigating circumstances quoted earlier.

In addition, a pattern of drug use that included some level of drug intoxication at the time of the criminal acts was thought to serve as an additional disinhibiting factor. This man's drug abuse could be clearly linked to the underlying schizotypal personality disorder in that the drugs were used as a method to relieve mounting levels of anxiety and tension.

In contrast, the following case illustrated a series of clinical observations unrelated to the mitigating circumstances specified in the statute. Instead, these merely pointed toward a psychological "interpretation" of the conduct; it was concluded that the criminal act was carried out as a brief demonstration of power and supremacy in an otherwise passive, often sullen and discontented individual who had a life-long history of chronically maladaptive relationships and poor social adjustment.

> Mr. J was a twenty-two-year-old male who was evaluated psychiatrically following his conviction for murder in the course of armed robbery.
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> Mr. J and his brother lived in a substandard apartment complex and had, over the period of several months, become more agitated and frustrated with their landlord. On the day of the crime they took a bus to the office of the landlord, ostensibly for the purpose of paying the monthly rent. For reasons that still remain unclear, Mr. J and his brother transmuted this visit to the landlord's office into an armed robbery. Mr. J, the more aggressive of the two brothers, shot the landlord with a .22 calibre pistol and removed all the cash and checks from the office. He and his brother had planned an early exit from the state but were apprehended before this flight could be effected.
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> During psychiatric evaluation, Mr. J remained somewhat detached, sullen, and withdrawn. He revealed a history of criminal behavior, including a series of earlier acquisitive property crimes. His affect remained cool, calculated, and almost detached with the exception of the time he spent talking about his younger brother, his accomplice in crime, who he felt was a much better person than himself and for whom he seemed to assume a basic sense of responsibility.

These brief case histories illustrate two different types of clinical evaluation that may be relevant and informative to the trier of fact in capital sentencing proceedings. The case of Mr. G illustrates a clearly defined type of clinical opinion focusing on the defendant's mental condition at the time of an offense. The criteria of diminished responsibility require a clinically significant level of mental dysfunction not of sufficient intensity to establish an insanity defense but bearing directly on the defendant's cognitive, affective, or volitional functioning at the time of the offense. The clinical evaluation in such cases would be used to establish the underlying pathology as well as the specific elements of compromised mental functioning that were impaired at the time the criminal act was carried out.

Of course, the judge or jury must ultimately determine the relevance and significance of data or opinion offered in support of a claim of diminished responsibility. Whether an emotional disturbance was "extreme" or whether the defendant's volitional impairment was "significant" is for the judge or jury — not the expert — to decide. While the threshold of moral significance is lower in capital sentencing than in adjudication of "legal insanity," there *is* a moral threshold; and

the clinician should leave matters of moral judgment to the trier of fact.

The clinical observations in Mr. J's case have no direct bearing on the legal criteria of diminished responsibility and are best characterized as descriptive and interpretive. Because they offer few insights outside the ken of the ordinary layman, they are on the periphery of specialized psychiatric expertise. This is not to say, however, that they are either irrelevant or inadmissible. A capital defendant is entitled to put his character and personality before the judge or jury and to offer whatever evidence he believes will encourage leniency. From this perspective, clinical insights derived from a survey of the individual's personality development and functioning may help the fact finder understand the place of the criminal act in the defendant's life. Although much of the information and observations available in cases such as Mr. J's would be apparent to a layperson, the forensic clinician can interpret these facts and observations as elements of a more basic developmental history from which certain behavioral patterns may be seen to evolve.

While the courts are unlikely to exclude "clinical biographies" from capital sentencing trials, the testifying witnesses must be careful to recognize the substantial element of post hoc speculation often required. Courts will not ordinarily possess the clinical sophistication to determine whether an opinion rests on an accepted theoretical foundation. The law must depend on clinicians themselves to be sensitive, as a matter of professional ethics, to the limits of their expertise and to qualify their opinions accordingly.

Dangerousness

The United States Supreme Court has upheld the constitutionality of a prediction of future dangerousness as an aggravating circumstance in capital sentencing proceedings. It does not follow, however, that prediction of future behavior is a proper subject for expert testimony in this context.

The few empirical studies attempting to assess the validity of long-term clinical predictions concerning future "dangerous" behavior suggest that the accuracy of clinical predictions of long-term future dangerousness is remarkably low. In 1974 the American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual concluded that "the ability of psychiatrists or any other professionals to reliably predict future violence is unproven." In 1981 the American Psychiatric Association filed an amicus curiae brief in the matter of *Estelle v. Smith* that even more sharply questioned the predictive capabilities of psychiatrists by stating "there are no reliable criteria for psychiatric predictions of long-term future criminal behavior."[16]

In 1982 the APA filed an amicus brief in *Barefoot v. Estelle,* restating the position taken in the *Estelle v. Smith* brief that psychiatrists have little or no expertise in the prediction of future dangerousness:

> Although a likelihood of future violent behavior may be assigned to a given individual solely on the basis of statistical "base rates" and other information of an actuarial nature, psychiatric determinations in this area have little or no independent validity.[17]

This brief further states that "the prejudicial impact of assertedly 'medical' testimony far outweighs its probative value."[18]

In *Barefoot,* a majority of the Supreme Court upheld, against constitutional challenge, the admissibility of expert testimony by a psychiatrist on the issue of future dangerousness in capital sentencing proceedings. The majority opinion appears to rest, at least in part, on a belief that the processes of the adversary system will counteract inaccurate or misleading testimony by expert witnesses. Psychiatrists, however, should not accept so readily the idea of ultimate truth emerging from the discerning powers of the adversary process — most especially in a context as highly emotionally charged as the capital sentencing proceeding.

Justice White, writing the majority opinion in *Barefoot* acknowledges "there is no doubt that the psychiatric testimony increased the likelihood that [Barefoot] would be sentenced to death."[19] In his dissenting opinion in *Barefoot,* Justice Blackmun puts the point more boldly:

> In a capital case, the specious testimony of a psychiatrist, colored in the eyes of an impressionable jury by the inevitable untouchability of a medical specialist's words, equates with death itself.[20]

These are indeed sobering considerations for the psychiatrist who, as a physician, is always enjoined first to do no harm.

The examination, evaluation, and expert testimony by a psychiatrist in a capital sentencing proceeding takes place in a context already highly charged emotionally, which therefore increases the risk of misinterpretation. Moreover, juries are inclined to believe the defendant poses a continuing threat to society by the nature of inferences based on the commission of the capital crime for which he has been found guilty. Expert testimony that confirms such a lay assumption is less likely to be discounted in the face of cross-examination or rebuttal evidence than expert opinion that contradicts lay intuitions. Simply put, it is very likely to be given more weight than it deserves. In this context, it is especially important to keep expert opinion within generally accepted boundaries of expertise.

The inability to predict future dangerousness is not to be confused with the capability of psychiatrists to predict, with some degree of reliability, imminent dangerousness. Some meaningful criteria have been developed for the prediction of imminent dangerousness, although even this task cannot be accomplished at this time in a fully satisfactory manner. It is not difficult to see, however, that a false positive prediction (a prediction that violence will occur when in fact it doesn't) of imminent dangerousness in the context of a civil commitment proceeding, for example, does not have the same consequences as a false positive prediction of future dangerousness in a capital sentencing proceeding. These verdicts are fundamentally different, clinically and legally.

It is unlikely that the "future dangerousness" criterion will be removed from the capital sentencing statutes now including it. It is equally unlikely that prosecutors will stop asking psychiatrists to offer expert opinion on this subject — either in connection with hypothetical questions or, more frequently, in connection with testimony by an examiner testifying in rebuttal after clinical opinion has been offered by the defense. It therefore becomes imperative for psychiatrists to de-

velop a paradigm for effectively dealing with this issue. The following observations may inform the development of such a paradigm.

(1) Atypical, bizarre, and sometimes dangerous (to self or others) behavior can occur as symptoms of a mental disorder. When such behaviors are identified as symptomatic of a mental disorder, diagnosis and treatment of the disorder is indicated. These clinical processes may include the interpretation of past behaviors to the patient and possibly to others. The psychiatrist's expertise in retrospective behavioral analysis and interpretation blends, sometimes almost imperceptibly, with opinion formation regarding future behavior. Predictions of future behavior by psychiatrists may be useful both in the clinical setting as well as in the larger social and community context so long as specific qualifications and limitations are attached to such predictions.

(2) The diagnosis of mental disorder, the assessment of personality development and personality dynamics, and the expected effects of psychotherapeutic intervention cannot alone form an adequate basis for the prediction of future events. A number of extrinsic or situational components function as catalysts for the precipitation of specific events. The psychiatrist should acknowledge the significance of these factors in any predictive venture and temper any predictive opinion accordingly.

(3) Psychiatrists must be cognizant of the "qualitative difference" between a prison sentence and the sentence of death. This "qualitative difference" is clearly reflected in the complexity and exhaustiveness of the legal process in the capital sentencing context, and should also affect the process of forensic assessment and opinion formation and the shape of expert testimony. Specifically, the critical need for reliability in psychiatric testimony in the capital sentencing proceeding should preclude any prediction of long-term future dangerousness. In light of the questionable reliability of such predictions, they should be offered only in contexts that provide safeguards for opinion revision that may be warranted as a result of future observation and evaluation of the individual. Obviously a capital sentencing proceeding is not such a context.

(4) A number of actuarial schema have been developed for predicting future dangerousness. In many situations prediction of future dangerousness may be more validly accomplished using actuarial data than by relying on clinical opinion. Whether such actuarial data should be admissible in a capital sentencing proceeding is a difficult issue. Although *Barefoot* implies that such evidence would be constitutionally admissible, it is doubtful that the current studies would meet the criteria for admissibility of scientific evidence ordinarily employed in the state courts.

Conclusion

The expanded parameters of psychiatric testimony in capital cases calls attention to the risks associated with such a broadened role. The imperfections of forensic evaluation and the fortuities of the adversary system, which continue to engender debate in the context of the insanity defense, are exacerbated in the context of a capital sentencing proceeding — where the stakes are disturbingly

high and where the law invites opinion that may so easily stray from accepted boundaries of expertise.

Psychiatrists who choose to participate in these proceedings must be sensitive to the limits of their understanding and to the special burdens they bear in this unique legal setting.

References

1. Furman v. Georgia, 408 U.S. 238 (1972)
2. Jurek v. Texas 428, U.S. 262 (1976)
3. Proffitt v. Florida, 428 U.S. 242 (1976)
4. Gregg v. Georgia, 428 U.S. 153 (1976)
5. Roberts v. Louisiana, 428 U.S. 325 (1976)
6. Woodson v. North Carolina, 428 U.S. 280 (1976)
7. Woodson v. North Carolina, 428 U.S. 280, 305 (1976) (opinion by Stewart, Powell and Stevens, J.J.)
8. Gregg v. Georgia, 428 U.S. 153 (1976) (opinion by Stewart, Powell and Stevens, J.J.)
9. Woodson v. North Carolina, 428 U.S. 280 (1976) (opinion by Stewart, Powell and Stevens, J.J.)
10. *Id*
11. Jurek v. Texas, 428 U.S. 262 (1976)
12. Lockett v. Ohio, 438 U.S. 586 (1978)
13. Eddings v. Oklahoma, 455 U.S. 104 (1982)
14. Va. Code § 19.2-264.4 (B) (1950)
15. *Id*
16. American Psychiatric Association Brief for Amicus Curiae, Estelle v. Smith, 451 U.S. 454 (1981)
17. American Psychiatric Association Brief for Amicus Curiae, Barefoot v. Estelle, _____ U.S. _____, 103 S.Ct. 3383 (1983)
18. *Id*
19. Barefoot v. Estelle, _____ U.S. _____, 103 S.Ct. 3383 (1983)
20. *Id*

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