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THE ROLE OF MENTAL HEALTH PROFESSIONALS IN THE CRIMINAL PROCESS: THE CASE FOR INFORMED SPECULATION

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Our understanding of the subject addressed in this article derives substantially from Browning Hoffman, our collaborator and teacher. Were we confident that we had faithfully presented Browning's own ideas, we would list him as joint author. In lieu of this, we acknowledge our profound indebtedness to him and our hope that this modest effort would earn his praise.

We also would like to express our thanks to our colleagues John Calvin Jeffries, Jr., Graham C. Lilly, Stephen Saltzburg, Elizabeth S. Scott, Gary Melton, Ph.D., and C. Robert Showalter, M.D., all of whom offered helpful comments on early drafts of this article.

PARTICIPATION by psychiatrists, psychologists, and other mental health professionals in the criminal process is currently the target of considerable criticism in the legal literature. Although the attack has focused mainly on the clinician's supposed inability to assess either an offender's dangerousness to society or his "amenability" to treatment and rehabilitation, the critics have also called into question the forensic expert's ability to diagnose mental dysfunction and to reconstruct its supposed effects on past behavior.

In some measure, this attack is incidental to more sweeping ideological challenges to prevailing conceptions of criminal responsibility and punishment. Many critics of the insanity defense assert that the law ought to be indifferent to most claims of abnormal

psychological functioning; and critics of the utilitarian ideology of sentencing would abandon the ethic of individualization and link punishment primarily to the characteristics of the offending conduct. Obviously, if subjectivism and individualization were purged from the criminal law, there would be no place for mental health professionals in the courtroom.

Much of the critical commentary, however, is focused more specifically on the clinical methodology of the mental health professions. Some critics take the position that even if differences among offenders in psychological functioning were to remain legally significant, the mental health professional should not be permitted to offer opinions as an expert witness. The essence of the claim is that reconstructive and predictive issues can be decided by laymen on the basis of common experience, and that the "expert" has so little "knowledge" reaching beyond everyday experience that his participation in the adjudication is highly misleading and should be circumscribed severely.

This article gives our perspective—derived in large part from our experiences at the University of Virginia's Forensic Psychiatry Clinic, which has performed more than 250 multidisciplinary evaluations of criminal defendants since 1974[1]—on this controversy. Unlike the typical "court clinic,"[2] Virginia's Forensic Psychiatry Clinic operates as an independent agency, exercising complete control over case selection. Referrals, which come primarily from defense attorneys, are screened by the Clinic staff[3] to determine whether the evaluation will be pedagogically valuable for the law students, psychology and psychiatry residents, and community mental health professionals who participate in the evaluation. Each evaluation consists of an extensive background investigation, a social history, psychological testing and one or more psychiatric

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[1] The Clinic was established in 1969, under the auspices of the University of Virginia's Department of Psychiatry, to expose psychiatric residents to occasional forensic experience. Over the past decade, the Clinic's original two-member staff has increased fourfold and its service and training functions have been expanded and diversified. Today it is a core component of the University's Institute of Law, Psychiatry and Public Policy, which sponsors and promotes interdisciplinary research and collaborative professional training of lawyers and behavioral scientists.

[2] *See generally* R. SLOVENKO, PSYCHIATRY AND LAW 127-40 (1973).

[3] The Clinic staff consists of two psychiatrists, one psychologist, one psychiatric social worker and three attorneys.

interviews observed by all staff and trainees.[4] The Clinic's evaluation is shaped during several case conferences featuring active interchange between the clinicians and law-trained personnel.

Our experiences at the Forensic Psychiatry Clinic have persuaded us that, with a few major exceptions, the law should not significantly curtail the participation of mental health professionals in the criminal process. We readily acknowledge the imprecision of the clinician's tools and his limited knowledge of the range of variables influencing human behavior. However, we believe the interest of the law in the perspectives of the mental health professions has been marked less by a faith in the scientific basis of the disciplines than by considerations of fairness and a vision of humane, enlightened justice. From this perspective, the well-trained clinician has much to offer.

For reasons that we will summarize in Part I, we believe the substantive law will, and should, remain fundamentally unchanged. Despite the speculative and uncertain nature of the inquiry, the law will, and should, continue to ask questions about a defendant's psychological functioning and its relationship to his behavior. Having made this assumption—and assertion—we examine, in Part II, the skeptics' claims that mental health professionals should not be permitted to offer opinions as expert witnesses. We argue that this categorical exclusion would be self-defeating and highly unfair to the defendant, and is not supportable on either substantive or evidentiary grounds. We illustrate these general propositions in a variety of substantive contexts.

As noted, however, we ourselves are skeptical about the reliability of forensic evaluation and the soundness of the testimony offered by mental health professionals. We believe the appropriate and necessary response to this problem is to improve the quality of forensic evaluation, not to bar the experts from the courtroom. Toward this end, Part III discusses the shortcomings of current evaluation procedures and makes proposals for improvement, based in large part upon our experience at the Forensic Psychiatry Clinic.

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[4] *See* notes 258-62 *infra* and accompanying text.

I. Individualization in Crime and Punishment: The Assault of the Skeptics

A. The Reach of Skepticism

The challenge to subjectivism has been most pronounced in connection with the predictive inquiries characteristic of sentencing and parole systems. Retributivists, of course, see individualized predictions of potential recidivism or rehabilitation as morally irrelevant to the task of distributing punishment.[5] Many utilitarians, however, disturbed by the lack of empirical confirmation of the reliability of predictive inquiries, have become retributivists in practice.[6] Doubting the justifications for sentence disparity among offenders similarly situated with respect to offense and prior record,

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[5] For a lukewarm endorsement of retribution as a first principle of punishment by one of the modern reformers, see A. von Hirsch, Doing Justice 6 (1976).

[6] *See, e.g.*, Twentieth Century Fund Task Force on Criminal Sentencing, Fair and Certain Punishment 75-77 [hereinafter cited as Fair and Certain Punishment]; Perlman & Stebbins, *Implementing an Equitable Sentencing System: The Uniform Law Commissioners' Model Sentencing and Corrections Act*, 65 Va. L. Rev. 1175 (1979).

The underlying basis for this skepticism is the lack of empirical support for the belief that the behavior of *individual* offenders can be predicted with a significant degree of accuracy. Even the most confident clinical researchers acknowledge the imprecise relationship between their diagnostic and explanatory skills and the prediction of criminal behavior, especially violent behavior. *See, e.g.*, Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 Crime & Delinquency 371, 384 (1972). A fundamental problem in predicting individual behavior is the potent influence of environmental and situational factors that neither can be predicted nor controlled with substantial confidence. *See generally* Monahan, *The Prediction of Violence* in Violence and Criminal Justice 15 (D. Chappell & J. Monahan eds. 1975); Monahan, *The Prediction of Violent Criminal Behavior: A Methodological Critique and Prospectus* in National Academy of Sciences, Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates 244-69 (1978) [hereinafted cited as Deterrence and Incapacitation].

At best, the state of the art within the behavioral sciences permits only gross probability estimates based on statistical experience tables (which may include objectively defined "clinical" variables but usually do not); unfortunately, the methodology for doing even this is most primitive when the specific unit of analysis is assaultive behavior or other serious offenses rather than the likelihood of criminal recidivism in general. *See, e.g.*, Wenk, Robison & Smith, *Can Violence be Predicted?*, 18 Crime & Delinquency 393 (1972) (finding no operationally practical prediction procedure); Johnson, *The Role of Penal Quarantine in Reducing Violent Crime*, 24 Crime & Delinquency 465, 469-85 (1978). With respect to criminal recidivism in general, see D. Gottfredson, C. Cosgrove, L. Wilkins, J. Wallerstein & C. Rauh, Classification for Parole Decision Policy (1978) (published by National Institute of Law Enforcement and Criminal Justice) [hereinafter cited as Parole Policy].

For a general discussion of clinical and statistical prediction, see D. Glaser, The Effectiveness of a Prison and Parole System 289-92 (1964).

these reformers mistrust sentencing variations as based mainly on hunch or influenced easily by bias and prejudice. Utilitarian critics also question the net crime-reducing effects of prevailing sentencing and parole practices. Finding no empirical proof that individualized decisions, in the aggregate, achieve optimum rehabilitative, incapacitative, and intimidative effects, these critics further argue that the unpredictability of individualized sentencing and parole decisions undermines general deterrence.[7]

The contemporary assault on subjectivism in the criminal law has not been limited, however, to the field of sentencing and parole. Many critics also question the various doctrines in the substantive law[8] that accord significance to claims of abnormal psychological functioning at the time of an offense. "Moral skeptics" deny that there is any categorical difference between "normal" individuals and the "mentally ill" with regard to ability to control behavior by conscious direction. If the law posits free will for normals, they contend, no empirically verified basis exists for selectively embracing a deterministic premise for those offenders regarded as psychologically abnormal.[9] The moral skeptics are joined

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[7] *See* FAIR AND CERTAIN PUNISHMENT, *supra* note 6, at 3-9; N. MORRIS, THE FUTURE OF IMPRISONMENT 30-31 (1974); A. VON HIRSCH, *supra* note 5, at 61-66; Perlman & Stebbins, *supra* note 6, at 1180-81.

[8] The trend, over the last century, has been toward increased subjectivism in the substantive criminal law. Loosened criteria for the insanity defense, widening doctrines of mitigating mental abnormality in homicide prosecutions, and less rigid approaches to the manslaughter formulation are the most obvious examples. Equally significant, however, is the trend, epitomized by the Model Penal Code, toward defining mens rea and the associated doctrines of mistake and intoxication in increasingly subjective terms. *See* MODEL PENAL CODE §§ 2.04, .08 (Proposed Official Draft, 1962). These trends have widened significantly the participation of mental health professionals in the guilt-determination phase of the criminal process.

[9] *See, e.g.*, T. SZASZ, LAW, LIBERTY AND PSYCHIATRY 123-38 (1963); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 640-45 (1978). *Cf.* Livermore & Meehl, *The Virtues of* M'Naghten, 51 MINN. L. REV. 789, 789-800 (1967) (finding determinism speculative and destructive to the postulates of the criminal law).

In its extreme form, the skeptical position argues that there is no such thing as mental disorder, only disturbances of behavioral functioning that may compromise the person's ability to cope successfully with the environment. *See, e.g.*, T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961). A thorough response to the Szasz position appears in Moore, *Some Myths About "Mental Illness,"* 32 ARCHIVES GEN. PSYCH. 1483 (1975).

Whether people who behave abnormally can ever be said to "have" a diagnosable mental disorder, the moral skeptic argues that if the law attempts to characterize aberrant behavior as either freely willed or determined, it should do so without respect to whether the defen-

by the "method skeptics," who argue that even if psychological aberration can in fact compromise a person's ability to direct his behavior, the available tools for measuring volitional impairment are too primitive for the law's purposes.[10] Absent a proven organic etiology, method skeptics feel that hypothesized clinical functional disorders have not been demonstrated with sufficient clarity to provide a scientific base for the important legal and moral distinctions drawn by the criminal law or for reliable decisions in individual cases. The method skeptics tend to be especially troubled by the inadequacies and abuses of psychiatric participation in adjudications of insanity claims.[11]

The indeterminacy of an inquiry, however, is not always a persuasive reason for refusing to undertake it, and a serious objection to individualized clinical inquiries into mental aberration would reach well beyond the insanity defense. Most clearly, the skeptics' arguments would appear to deny either exculpatory or mitigating significance to any claim that psychological forces impaired a de-

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dant could be said to be mentally ill. Given the moral imprecision of such an inquiry, the "moral skeptic" is usually led to the conclusion that it should not be undertaken at all. Under this view, the insanity defense would be abolished, as would other doctrines based on the assumption that the mentally disordered have a diminished ability to control their behavior. *See* Morse, *supra*, at 640-45.

The contemporary revival of proportionality as the touchstone of sentencing policy, *see, e.g.*, FAIR AND CERTAIN PUNISHMENT, *supra* note 6; Perlman & Stebbins, *supra* note 6, would ordinarily imply that claims of relative blameworthiness attributable to psychological dysfunction should be accorded substantial weight in grading and sentencing decisions. Extreme skepticism about the empirical basis for presumed relationships between mental disorder and criminal behavior, however, may lead to the conclusion that all persons should be held accountable, on equal terms, for their offenses, and that the effort to calibrate the responsibility of the mentally ill accordingly should he abandoned.

[10] *See, e.g.*, Morris, *Psychiatry and the Dangerous Criminal*, 41 S. CAL. L. REV. 514, 533 (1968).

[11] Other arguments are sometimes appended to this basic proposition. Liberals argue that the doubts about the empirical basis for the insanity defense raise questions about the legitimacy of the double deprivations and stigmatizations visited upon the "criminally insane." *See, e.g.*, Burt, *Of Mad Dogs and Scientists: The Perils of the "Criminally Insane,"* 23 U. PA. L. REV. 258, 280-85 (1974); Morris, *supra* note 10, at 524-25. Conservatives argue that because the defense is so imprecise and speculative, it merely opens a loophole for the guilty, a loophole which surely should be closed if the moral necessity of the defense is in doubt. *See, e.g.*, STAFF OF SENATE COMM. ON THE JUDICIARY, 93D CONG., 2D SESS., REPORT ON CRIMINAL JUSTICE CODIFICATION, REVISION AND REFORM ACT 102-04 (Comm. Print 1974); NEW YORK STATE DEP'T OF MENTAL HYGIENE, THE INSANITY DEFENSE IN NEW YORK 7-9, 131-40 (1978) [hereinafter cited as NEW YORK INSANITY DEFENSE].

For a review of both the conservative and liberal arguments against the insanity defense, see Morris, *supra* note 10, at 524-25.

fendant's capacity to refrain from his criminal behavior; their objections would thus extend to any variant of the doctrine of diminished or partial responsibility,[12] whether in the grading of offenses or at sentencing, and also to modern reformulations of the manslaughter doctrine which ask both how acutely disturbed the offender was, and why.[13] Moreover, the doubts of the method skeptics would call into question the automatism and unconsciousness defenses, even those founded on neurological rather than psychogenic explanations,[14] as well as the evidentiary doctrines by which evidence of intoxication or psychological abnormality is admissible to negate subjectively defined mens rea elements of criminal offenses.[15] These inquiries are every bit as speculative as those required by the responsibility doctrine.

The law's tolerance for speculation and imprecision varies according to the context and consequence of the inquiry. When a defendant claims that his psychological aberration has, or ought to

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[12] *See, e.g.*, Morse, *Diminished Capacity: A Moral and Legal Conundrum*, 2 INT'L J. L. & PSYCH. 271, 296-98 (1979).

[13] *See* Morse, *supra* note 9, at 640-41 & nn.249, 254. Morse, however, distinguishes the duress defense and the traditional common-law manslaughter formulation because they excuse behavior that was directly responsive to overwhelming, objectifiable pressures of the external environment. *See id.* The Model Penal Code manslaughter formulation is more subjective, grading an intentional killing as manslaughter if it is "committed under the influence of extreme mental or emotional disturbance for which there is reasonable explanation or excuse." MODEL PENAL CODE § 210.3(1)(b) (Proposed Official Draft, 1962).

[14] Although the issue is not much discussed, the skeptics appear to be intuitively more confident about the precision of the inquiry when it concerns neurophysiological explanations for aberrant behavior rather than psychogenic ones. Thus, they might permit the defendant to offer evidence of epilepsy and trauma to negate the "voluntariness" (conscious direction) of his criminal act. These investigations, however, usually are every bit as speculative as those concerning functional mental disorder. *See* Goldstein, *Brain Research and Violent Behavior: A Summary and Evaluation of the Status of Biomedical Research on Brain and Aggressive Violent Behavior*, 30 ARCHIVES NEUROLOGY 1 (1974).

We also wonder what the abolitionists think about the traditional reach of the automatism doctrine to conditions such as somnambulism or hypnotic trance, which lack identifiable neurophysiological substrates or "causes" and which therefore may be regarded more cautiously by the method skeptics. It seems likely that claims of acute psychogenic impairments of consciousness, such as dissociative states, which are now usually offered in support of a defense of insanity, would be offered as proof of "unconsciousness" if the insanity defense were abolished.

[15] Although the skeptics usually endorse the "elements" approach as an acceptable alternative to the insanity defense, *see, e.g.*, NEW YORK INSANITY DEFENSE, *supra* note 11, at 9-10; Morse, *supra* note 9, at 642-44; Morse, *supra* note 12, at 275-88, it is important to recognize the speculative breadth of the clinical inquiry that still would be permitted under such an approach.

have, exculpatory or mitigating significance, the risk of unreliable decisionmaking is often accepted in deference to the perceived ethical imperatives of individualization. In some contexts, the inquiry may be ethically indispensable regardless of how little we know; consideration of mitigating mental abnormality in capital sentencing proceedings represents the polar case in point.[16] The law's increasing tolerance for speculation in connection with defensive claims of psychological aberration parallels a trend toward reduced specificity and precision in the definition of excuses; vagueness that would be unacceptable in the definition of offenses is often accepted in the formulation of doctrines of excuse.[17]

In contrast, the law does and should demand greater confidence in the precision and reliability of an inquiry that provides the sole predicate for criminal liability or for significantly enhanced stigmatization and punishment. This principle is reflected in the salience of conduct requirements in the substantive criminal law and in the general preference for precision in the definition of offenses. It also underlies the growing distaste for the wide range of authorized punishments now characteristic of discretionary sentencing and parole systems and explains the trend toward specification of objectively defined mitigating and aggravating circumstances.

B. The Boundaries of Legitimate Speculation: An Illustrative Case

Reconstructive inquiries regarding the degree of a person's in-

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[16] 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 humankind. . . .[I]n 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.

Woodson v. North Carolina, 428 U.S. 280, 304 (1976) (plurality opinion of Stewart, Powell, and Stevens, JJ.).

[17] The modern formulations of the manslaughter doctrine and of the defenses of insanity and duress reflect less rigidity and greater individualization than the common-law doctrines. Consequently, excusing conditions are formulated only with that degree of specificity necessary to give the jury adequate normative guidance regarding the nature of the question being asked. *See, e.g.*, MODEL PENAL CODE § 2.09 (Proposed Official Draft, 1962) (duress); *id.* § 4.01 (insanity); *id.* § 210.3(1)(b) (manslaughter provocation formula). *See generally* Fletcher, *The Individualization of Excusing Conditions*, 47 S. CAL. L. REV. 1269 (1974).

toxication due to alcohol or other psychoactive drugs, and the nature of any associated functional or behavioral impairment, are notoriously speculative and imprecise—no less so, indeed, than those pertaining to impairments allegedly attributable to intrapsychic forces.[18] Yet, whether a person was intoxicated by or under the influence of alcohol or other drugs often has considerable significance in the criminal law: (1) evidence of intoxication often has mitigating significance when offered by the defendant to reduce the grade of the offense; (2) intoxication is sometimes the predicate for an aggravated form of vehicular homicide; and (3) intoxication is the sole predicate for criminal liability under "driving-while-intoxicated" statutes. A review of the intoxication inquiry in these three contexts will illustrate the normative boundaries of permissible speculation in the criminal law, and will, we suggest, deflect the skeptics' general attack on subjectivism and clinical in-

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[18] The first problem is determining exactly *what* the defendant consumed, a problem complicated considerably when the substance is not legitimately marketed and therefore not reproducible for purposes of measurement. The *amount* consumed is of obvious importance since behavioral effects vary with dosage levels, sometimes in a complex, curvilinear fashion. It is also important to know the span of *time* during which the substance was consumed since behavioral effects vary during the course of drug action.

The second problem is reconstructing the situation during which the substance was consumed, because a person's behavioral response to a psychoactive drug is influenced not only by pharmacological variables but also by psychosocial variables such as the "set" (the user's expectations of the drug's effects) and the "setting" of use. These variables are more important at the lower ranges of the dose-response curve; with the higher doses of a substance, psychological and social factors become progressively less influential than pharmacological ones.

A third problem is individual variability. Drug effects, especially behavioral ones, differ considerably according to biological and psychological characteristics of the users even if those users have consumed the same doses over the same period of time. Again, these differences are exaggerated at lower dose levels, and the band of individual variation narrows as the dose increases. Moreover, some drugs, such as hallucinogens, appear to produce a wider range and frequency of individual variation than others. In addition, an individual's previous use of a psychoactive substance may have cumulative effects which influence acute behavioral responses.

A fourth problem is the difficulty of translating psychopharmacologic understanding regarding drug action on the central nervous system into cognitive-behavioral terms relevant to the law. Determinations regarding degree of impairment of perceptual and judgmental functions are, at best, gross probability estimates even when they are based on accurate assumptions regarding what was consumed, how much, and over what period of time.

These problems are discussed in NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, SECOND REPORT, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE 32-34, 147-65 (1973); Tinklenberg, *Drugs and Crime* in NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, DRUG USE IN AMERICA: PROBLEM IN PERSPECTIVE 242 app. (Vol. I 1973).

quiry in the doctrines of crime and punishment.

1. The "Defense" of Intoxication

It can be argued that the law should not take into account any claim by a defendant that his mental condition was impaired by the voluntary ingestion of alcohol or other psychoactive drugs. A retributivist could find the intoxicated defendant as responsible as the sober defendant, if not more so, and the utilitarian could argue that full accountability for alcohol-induced or drug-induced behavior is a necessary means of deterring people from becoming severely intoxicated or from placing themselves at risk for antisocial behavior. A few states appear to take this view, ascribing no mitigating significance to evidence of voluntary intoxication.[19]

In most jurisdictions, however, intoxication can reduce the grade of the offense. The doctrinal vehicle for weaving the defendant's claim of mitigation into the fabric of the law is usually the proposition that evidence of intoxication is admissible, on behalf of the defendant, to raise a reasonable doubt as to whether he had the specific intent, purpose, or knowledge typically required for conviction.[20] The prevailing rationale for this position is that it is unfair to adopt a subjective criterion for culpability and then foreclose the defendant from producing evidence tending to show that he did not, in fact, have the required state of mind.[21]

In a technical sense, evidence of drunkenness has mitigating significance only if the intoxication compromised the defendant's ability to perceive or assimilate legally relevant circumstances or to foresee and consciously seek prohibited results. The practical effect, however, of admitting intoxication evidence is to permit the factfinder to take into account the offender's implicit claim that his drunkenness compromised the higher cognitive functions that ordinarily can be expected to inhibit impulsive expression of anger

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[19] *See, e.g.*, TEX. PENAL CODE ANN. tit. 2, § 8.04 (Vernon 1974) (evidence of intoxication can be considered only in mitigation of penalty). *Cf.* Chittum v. Commonwealth, 211 Va. 12, 174 S.E.2d 779 (1970) (holding that intoxication instruction need not be given in case involving kidnapping and attempted rape even though such an instruction would be required in a murder prosecution).

[20] *See generally* W. LAFAVE & A. SCOTT, HANDBOOK ON CRIMINAL LAW § 45, at 341-47 (1972); MODEL PENAL CODE § 2.08 (Proposed Official Draft, 1962); R. PERKINS, CRIMINAL LAW 898-906 (2d ed. 1969).

[21] *See* MODEL PENAL CODE § 2.08, Comment (Tent. Draft No. 9, 1962).

and other emotions, and that his conduct thus was "out of character" for him. In this sense, the defense functions as a partial excuse, in the same way as conceptualized at common law.[22]

When offered by a defendant, evidence of intoxication generally is entertained, despite its speculative quality, because severely intoxicated defendants may not be as culpable—or as responsible—as sober ones. The risk of unreliable decisionmaking is accepted in deference to the perceived ethical imperatives of individualization.[23]

2. *Intoxication as a Predicate For Enhanced Punishment*

In every jurisdiction, an intoxicated person who kills while driving a vehicle is guilty, at least, of negligent homicide, a misdemeanor.[24] A few states raise the grade of a vehicular homicide to a felony, punishable typically by five years' imprisonment, simply upon proof that the defendant was driving while intoxicated.[25]

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[22] *See* Singh, *History of the Defense of Drunkenness in English Criminal Law*, 49 L. Q. REV. 528 (1933). Only by conceptualizing the problem in this way is it clear why evidence of intoxication should be inadmissible to negate general intent or recklessness under the Model Penal Code's culpability formulation. Technically, the defendant's culpability for getting drunk does not, perforce, establish the mens rea for the ensuing offense. The law simply refuses to entertain his claim of diminished responsibility for some of his drunken acts; the lines between specific and general intent crimes, or between crimes requiring knowledge and recklessness, provide convenient doctrinal tools for compromise. *See* G. FLETCHER, RETHINKING THE CRIMINAL LAW 846-52 (1978).

[23] Although the point is primarily of academic interest, a person who—without a conscious purpose to do so—consumes a psychoactive substance leading to intoxication is not responsible for his criminal conduct if "by reason of such intoxication [he] at the time of his conduct [lacked] substantial capacity either to appreciate its criminality . . . or to conform his conduct to the requirements of the law." MODEL PENAL CODE § 2.08(4)(b) (Proposed Official Draft, 1962). Under such circumstances, it would be morally obtuse to decline to entertain the defendant's claim of excuse, despite the speculative nature of the effort to ascertain the degree of his intoxication and its impact on his cognitive functioning or behavior controls.

[24] Note, *An Analysis of the Drunken Driving Statutes in the United States*, 8 VAND. L. REV. 888, 888 (1955). Evidence of intoxication may also be accorded considerable weight in determining whether the defendant was "criminally negligent" or reckless—and therefore guilty of manslaughter—or whether he was so indifferent to the value of human life as to be guilty of murder. *See* Comment, *Murder Convictions for Homicides Committed in the Course of Driving While Intoxicated*, 8 CUM. L. REV. 477 (1977); Annot., 21 A.L.R.3d 116 (1968).

[25] *See, e.g.*, GA. CODE ANN. § 68A-903(a) (Supp. 1979) (making vehicular homicide a first degree crime, punishable by imprisonment from one to five years, if the driver's ability was impaired by alcohol or drugs); N.M. STAT. ANN. § 66-8-101.B (1978) (same).

Doctrinally, the proof of intoxication establishes the aggravating element; the prosecution is not obligated to prove that the defendant was aware of and consciously disregarded the risk of death, that the defendant's conduct was "criminally negligent," or that the defendant was guilty of any equivalent enhanced culpability with respect to the death of the victim. In this sense, these statutes are subject to the same fundamental criticisms as the misdemeanor-manslaughter and felony-murder rules: the punishment may be so excessive, in relation to the defendant's culpability, that it would violate the principle of proportionality.[26]

Proportionality aside, we would argue that these statutes also are objectionable because they predicate enhanced punishment — beyond that otherwise permitted for negligent homicide, which can be proven on the basis of the defendant's conduct — solely upon proof of "intoxication." The vagueness of the aggravating element, and the speculation inherent in its proof are, under these circumstances, beyond tolerable boundaries. The defendant's alleged intoxication may be given evidentiary significance in proving his negligence or in proving any higher fault criteria, but it should not provide the sole predicate for significantly enhanced stigmatization and punishment.[27]

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[26] *See* Jeffries & Stephan, *Defenses, Presumptions, and Burden of Proof in the Criminal Law*, 88 YALE L. J. 1325, 1383-87 (1979).

Some courts have upheld murder convictions for drunken drivers on the felony-murder theory or on the indistinguishable theory that the defendant's culpability in getting behind the wheel while drunk establishes the mens rea for homicide. *See, e.g.*, Shiflet v. State, 216 Tenn. 365, 373, 392 S.W.2d 676, 680 (1965) ("[C]riminal intent necessary to sustain a conviction of murder in the second degree is supplied from an unlawful act which is malum in se, and . . . driving an automobile under the influence of an intoxicant is such an unlawful act."). *Cf.* People v. Wallace, 2 Cal. App.2d 238, 37 P.2d 1053 (Ct. App. 1931) (stating that a homicide committed by an intoxicated driver could be murder under the felony murder rule).

[27] A legislature could attempt to avoid altogether the difficulties of plumbing for the mens rea of an intoxicated mind by making it a separate criminal offense to become intoxicated and, while in a state of intoxication, to commit specified dangerous acts or to cause specified undesirable results. The law would thereby avoid any consideration of mens rea at the time of the subsequent conduct, and would also avoid the difficult inquiry regarding the precise relationship between the defendant's fault in getting drunk and his ensuing conduct. This is the general form under the German law of "dangerous intoxication," an offense punished by a sentence of five years or the maximum penalty for the ensuing criminal behavior, whichever is less. *See* STGB § 330(a)(1), *discussed in* Daly, *Intoxication and Crime: A Comparative Approach*, 27 INT'L & COMP. L. Q. 378, 388-90 (1978). Although no analogous provision exists under Anglo-American law, the vehicular homicide statutes discussed at note 25 *supra* are parallel.

3. Driving While Intoxicated

This is not to say that "intoxication" should never be an element of an offense. Every state punishes, as a misdemeanor, driving while intoxicated.[28] The fact of intoxication while driving is the essential predicate for criminal liability because such statutes usually do not require proof of any other conduct elements, such as impaired operation of the vehicle. Typically, however, imprecision in the definition of the offense and uncertainty in its proof are reduced by provisions that permit or require the factfinder to infer the ultimate fact of intoxication from proof of a specific blood alcohol content (BAC).[29] If the law makes the presumption conclusive, the offense actually proscribes driving with a specified BAC rather than driving while intoxicated. The law thus dispenses altogether with the subjective dimension of the inquiry. As long as it is permissible under the principle of proportionality for the state to punish as a misdemeanor the act of driving with a specified BAC, there is nothing objectionable about the "presumption" of intoxication.[30]

Similarly, if the state legitimately may punish driving with a specified BAC, a law that permits but does not require the factfinder to presume "intoxication" from proof of that BAC would be acceptable.[31] Under such a law, however, "intoxication" remains the ultimate criterion for liability; thus, the defendant with a high BAC must have an opportunity to disprove the presumed fact of intoxication. It would violate basic principles of fairness to deny him this opportunity, despite the speculative nature of the inquiry and the imprecision of the tools available for reconstructing the likely effect of a given BAC on perceptions, judgment, motor functions, and behavior.

Suppose now that under the same law a defendant refuses to submit to any chemical test that would measure BAC.[32] Here, de-

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[28] *See* Note, *supra* note 24, at 888.

[29] The specified BAC is typically .10% alcohol. *See, e.g.*, N.Y. VEH. & TRAF. LAW § 1192(2) (McKinney Supp. 1979). For an exhaustive discussion of the evidentiary issues in driving-while-intoxicated cases in one state, see King & Tipperman, *The Offense of Driving While Intoxicated: The Development of Statutory and Case Law in New York*, 3 HOFSTRA L. REV. 541 (1975).

[30] *See* Jeffries & Stephan, *supra* note 26, at 1387-93.

[31] *See id.*

[32] If he does so, a state may revoke his driver's license. *See* Bell v. Burson, 402 U.S. 535

termination of the defendant's criminal liability depends entirely on inferences about his mental condition drawn by the factfinder from descriptions of his behavior and physical condition. We surely cannot be especially confident that the inquiry will be accurate or reliable in individual cases. Nevertheless, our tolerance for speculation and imprecision in the proof of the subjective predicate for the offense may be influenced by: (1) the difficulty of framing the offense more objectively and precisely; (2) the fact that invalidation of this statute would, in effect, disable the state from regulating an area of human conduct with significant consequences for the public safety; (3) the fact that the defendant chose to forego an opportunity to create objective contemporaneous evidence of his condition, thus weakening his claim of unfairness; and (4) the relatively light character of the punishment. These considerations may convince us to tolerate vagueness in the definition of the offense and speculation in its proof;[33] if we do so, however, it would be unfair to restrict the defendant's evidence because of its speculative quality.

C. Clinical Inquiry in the Criminal Law: The Irreducible Minimum

These observations suggest, in a single evidentiary context, why the skeptics will not—and should not—succeed in purging subjectivism from the criminal law. The skeptics have systematically failed to acknowledge and clarify the normative context of their criticisms. Those who oppose predictions in sentencing typically decry all individualized assessments of amenability to rehabilitation or likelihood of recidivism, without regard either to the nature of the punishments at stake or to the possibility that the defendant himself may register a predictive clinical claim in mitigation. At the same time, sentencing reformers appear to welcome, as an integral part of the specification of mitigating and aggravating circumstances, clinical inquiries regarding an offender's psychological

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(1971).

[33] The New York Court of Appeals recently rejected vagueness challenges to the New York provisions penalizing driving while impaired by alcohol and driving while intoxicated. *See* People v. Cruz, 26 CRIM. L. REP. (BNA) 2293 (N.Y. Jan. 9, 1980) (rejecting argument that "impairment" and "intoxication" are unconstitutionally vague in any case where the driver has refused to submit to a scientific test for determining the amount of alcohol in his body).

functioning at the time of the offense.[34] Meanwhile, critics of the responsibility doctrines often assert, without clarification as to context, that claims of mental aberration should be denied legal significance because the inquiry lacks a precise and objectifiable scientific foundation.

The numerous and difficult issues of penal policy and jurisprudence implicated by the limitations of our present abilities to explain and predict human behavior, and by the ill-understood relationship between presumed mental abnormality and criminal behavior, are beyond the scope of this article. Nevertheless, for the sake of clarity in the remainder of our discussion, it seems prudent to outline briefly our views on several of the salient issues concerning the permissible boundaries of speculation for predictive and reconstructive inquiries in the criminal law.

1. Predictive Inquiries

The speculative character of clinical predictions of dangerous behavior by individual criminal offenders is well documented in the scientific literature.[35] We think it indisputable that "special track" dangerous offender laws that depend on a finding of individual dangerousness[36] are impermissible when they authorize punishment to be extended beyond either the maximum prescribed for the offense actually committed or any lesser limit derived from the

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[34] *See* note 72 *infra* and accompanying text.

[35] *See* sources cited note 6 *supra*.

[36] So-called "sex psychopath" or "dangerous sex offender" laws, which authorize extended terms or special, indeterminate commitments, are on the books of some three-fifths of the states. A general description of these statutes can be found in ABA, SENTENCING ALTERNATIVES AND PROCEDURES, Std. 2.5, Comment (m), at 100-07 (Approved Draft, 1968). For a full-scale assault on "special track" dangerous offender laws, see von Hirsch, *Prediction of Criminal Conduct and Preventive Confinement of Convicted Persons*, 21 BUFFALO L. REV. 717 (1972). *Cf.* COUNCIL OF JUDGES, NATIONAL COUNCIL ON CRIME AND DELINQUENCY, MODEL SENTENCING ACT § 5 (2d ed. 1972) (providing for special sentencing of dangerous offenders). The Act provides in part that, except for murder in the first degree (for which the sentence is life imprisonment), the court may sentence the defendant to a term of up to 30 years if the defendant is being sentenced for a felony in which he (1) inflicted or attempted to inflict bodily harm *or* seriously endangered the life of another and was previously convicted of one or more felonies *and* (2) he is suffering from a severe mental or emotional disorder indicating a "propensity toward continuing dangerous criminal activity." *Id.* Although the drafters claim that this provision would shorten most terms rather than lengthen them, *see id.*, this assertion seems naive; most sentences, even if 30 years or longer, are tempered by parole provisions that are not applicable to dangerous offenders.

principle of proportionality.[37] Harder questions are presented when predictive considerations are taken into account to choose among alternative sentences that are *within* the statutory range and are not excessive in relation to the seriousness of the offense. We think the legitimate use of predictions in such cases depends on the normative context of the decision.

The need for accuracy and reliability in the selection of sentences is at its highest in the administration of capital punishment.[38] Even if incapacitation were, in principle, a legitimate basis for choosing the death penalty over life imprisonment,[39] incorrect predictions are irreversibly unfair to "false positives,"[40] and the speculation required in such assessments of individual dangerousness is intolerable. In our opinion, those states that specify as an aggravating circumstance in capital sentencing the "probability"

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[37] *See* von Hirsch, *supra* note 36. *See generally* Dershowitz, *Preventive Confinement: A Suggested Framework for Constitutional Analysis*, 51 TEX. L. REV. 1277 (1973).

Drafters of several recent sentencing codes have authorized extended incapacitative terms for a designated class of repeat offenders without requiring a "clinical" prediction of dangerousness in each case. *See, e.g.*, NATIONAL ADVISORY COMMISSION ON CRIMINAL JUSTICE STANDARDS AND GOALS, CORRECTIONS Std. 5.3 at 155-58 (1973) (recommending extended confinement of "persistent felony offenders," "professional criminals," and "dangerous offenders," all defined on the basis of prior behavioral history); Great Britain, Powers of Criminal Courts Act 1973, c.62 § 28 (permitting extended confinement of persons convicted of crimes punishable by terms of more than two years when (a) the offender has committed three prior offenses, (b) with the most recent offense committed within the last three years, and (c) the total confinement for the offenses was at least five years).

Enhanced sentences for "persistent offenders" should not be permitted to exceed the authorized maximum for the defendant's most recent offense unless (a) the law is narrowly drafted regarding the number and type of prior offenses upon which extended terms are predicated, and (b) the incapacitative justification for such a law is firmly based on validated recidivism data demonstrating sufficiently high probability of violent recidivism among members of the statutorily defined group to warrant preventive confinement of each member of the group. For present purposes, we pass by the extraordinarily difficult ethical questions regarding what group probability is high enough to offset the offender's claim that he may be a "false positive." *See generally* Gordon, *A Critique of the Evaluation of Patuxent Institution, with Particular Attention to the Issues of Dangerousness and Recidivism*, 5 BULL. AM. ACAD. PSYCH. & L. 210 (1972); Walker, *Dangerous People*, 1 INT'L J. L. & PSYCH. 37 (1978).

[38] Woodson v. North Carolina, 428 U.S. 280, 305 (1976) (plurality opinion of Stewart, Powell, and Stevens, JJ.).

[39] Because imposition of the death penalty for incapacitative purposes violates the principle of necessity, we cannot accept this assumption as valid. *See* Bonnie, *Foreword, 1978-1979 Survey of Developments in Virginia Law: Psychiatry and the Death Penalty: Emerging Problems in Virginia*, 66 VA. L. REV. 167 (1980).

[40] "False positives" are those individuals erroneously predicted to engage in future criminal activity.

that the defendant will constitute a "continuing threat to society"[41] are asking an unnecessary and impermissible question.[42]

At the other extreme is the sentencing choice between imprisonment and such alternatives as fines and probation. Even if presumptive sentences are formulated on the basis of retributive criteria, we believe it is permissible and desirable to take predictive considerations into account in justifying departures from a presumptive sentence of total confinement. Although retributive considerations may justify imprisonment, they do not require it, and speculation that errs *against* imprisonment is tolerable.[43] Moreover, although we recognize the risk of inequity, we believe that a defendant's claim to be regarded as an individual is important enough in this context that he should not be restricted to backward-looking arguments in making his case-in-mitigation. Finally, we are convinced that sentencing judges will take predictive considerations into account even though unauthorized to do so. Although judges may be required to justify departures from a presumptive sentence of imprisonment in culpability terms, it is difficult to believe that they will not be influenced by predictive

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[41] Four states have such provisions. *See* Bonnie, *supra* note 39, at 174-75.

[42] The United States Supreme Court rejected a vagueness challenge to the Texas statute in Jurek v. Texas, 428 U.S. 262 (1976) (plurality opinion of Stewart, Powell and Stevens, JJ.). While Justice Stewart acknowledged that "[i]t is, of course, not easy to predict future behavior," he observed that predictions of future criminal conduct are frequently required in bail decisions and in sentencing and parole. *Id.* at 274-76. The Court in *Jurek* showed inadequate sensitivity to special normative problems presented by such predictions in a capital sentencing proceeding, and its decision to uphold the Texas statute has been criticized strongly by the commentators. *See, e.g.*, Black, *Due Process for Death:* Jurek v. Texas *and Companion Cases*, 26 CATH. U. L. REV. 1 (1976); Dix, *Administration of the Texas Death Penalty Statutes: Constitutional Infirmities Related to the Prediction of Dangerousness*, 55 TEX. L. REV. 1343 (1977).

[43] Those who propose presumptive sentencing typically argue that incarceration should be the sanction of last resort and should be affirmatively justified in terms of prescribed criteria. The prescribed criteria under the proposed schemes, however, would not include predictive ones. *See, e.g.*, N. MORRIS, *supra* note 7, at 59-73; A. VON HIRSCH, *supra* note 5, at 98-100, 110. *Cf.* Perlman & Stebbins, *supra* note 6, at 1196-97 (discussing inclusion of predictive criteria in Uniform Law Commissioners' Model Sentencing and Corrections Act).

Although we agree that incapacitative considerations should not be taken into account in justifying a longer sentence of incarceration than otherwise would be imposed, we do not believe it follows that a finding of little likelihood of recidivism should be irrelevant in justifying departures from a presumptive sentence of imprisonment. This distinction is especially important if the legislatures are not sympathetic with the reformers' desire to reserve incarcerative sentences for the most serious offenses.

intuitions concerning individual defendants.[44] Since these considerations may influence sentencing decisions in any event, the inquiry should be explicit and visible.

Once the decision is made to incarcerate an offender, decisions regarding length of confinement fall in an intermediate normative zone. Imprisonment is not for the offender's benefit, and a belief in the rehabilitative potential of incarceration should not be permitted to extend a term of confinement beyond that which would be chosen on other grounds.[45] This cannot be said as easily, however, for incapacitative considerations. Even the retributivists propose an enhancement of presumptive sentences, keyed to the number of previous offenses of which the offender has been convicted.[46] Although this approach typically is justified on culpability grounds, we believe an unarticulated rationale, and the only defensible one, is incapacitative.[47] If this is so, the relevant questions are: First, whether the probability of recidivism is linked empirically to the number and nature of prior convictions; and second, whether the probability is sufficiently high to justify a longer term of con-

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[44] Such intuitions would include beliefs that the defendant's offense was situational and unlikely to be repeated, or that it was linked to a psychological or psychosocial problem remediable through appropriate intervention, or that the defendant can be most efficiently intimidated through sanctions short of imprisonment.

[45] *See* N. MORRIS, *supra* note 7, at 18-19; A. VON HIRSCH, *supra* note 5, at 127-30; Perlman & Stebbins, *supra* note 6, at 1179.

[46] *See, e.g.*, NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, UNIFORM LAW COMMISSIONERS' MODEL SENTENCING AND CORRECTIONS ACT §§ 3-104, -105 (Approved Draft, 1978) (published by U.S. Department of Justice, Law Enforcement Assistance Administration) [hereinafter cited as MODEL SENTENCING ACT].

[47] The offender is said to "deserve" more severe punishment for the present offense because he has been warned previously and has thumbed his nose at the law. *See, e.g.*, A. VON HIRSCH, *supra* note 5, at 85. This rationale, however, appears suspect. Because the offender has already been punished for the previous offense, the present punishment cannot justly be viewed as additional punishment for that offense. As for the present offense, why should the individual's past behavior be any more relevant to his just punishment than his future behavior? The fundamental tenet of retribution, as a justifying purpose of punishment or as a principle for limiting the excesses of utilitarian schemes, is that the offender is being judged for his blameworthiness in committing the proscribed act. He is not being punished for what he is—for his bad character—but for what he did. That he has offended before may be relevant to his character but not to his culpability for the present offense.

Threats of enhanced punishment for second or subsequent offenses may have significant deterrent effects for the population of one-time offenders. The purpose of imposing enhanced punishment on recidivists, however, must be either (1) to make the deterrent threat credible or (2) to incapacitate offenders who have demonstrated, by their conduct, a significant risk of recidivism.

finement.[48]

In determining length of confinement, then, there is no reason in principle to restrict the inquiry to prior conduct. Predictions based on sound empirical techniques, employing only variables that are objectively measurable and verifiable, can legitimately contribute to such decisions. A statistical matrix like that used by the United States Parole Commission[49] may answer this description; we believe that purely clinical techniques of prediction do not.

2. *Reconstructive Inquiries*

a. *Mens Rea*

Our "driving while intoxicated" discussion[50] highlighted a context in which evidence of psychological aberration often figures: a defendant wishes to negate inferences about his conscious functioning that otherwise would be drawn from his conduct, when the law has made his mental state a material element of an offense, justification or excuse. The most relevant examples are encompassed within the rubric of "diminished capacity," which permits the defendant to show that because of intoxication or endogenous causes, he lacked the conscious awareness, belief, or intention required by the substantive law. As noted earlier,[51] it would violate basic notions of fairness to preclude the defendant from offering evidence relevant to diminished capacity, however primitive our understanding of mental dysfunction and of the precise effects of intoxicants. If the law chooses to define culpability in subjective terms, it cannot close the door on the defendant's effort to reconstruct his actual state of mind.[52]

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[48] For provocative analysis of the difficult ethical question posed by incapacitative reasoning, see Gordon, *supra* note 37, at 215-42; Walker, *supra* note 37, at 37-43. *See also* A. VON HIRSCH, *supra* note 5, at 24-26.

[49] *See* 28 C.F.R. § 2.20 (1979). *See generally* PAROLE POLICY, *supra* note 6; Gottfredson, Hoffman, Sigler & Wilkins, *Making Parole Policy Explicit*, 21 CRIME & DELINQUENCY 34 (1975).

[50] *See* notes 28-33 *supra* and accompanying text.

[51] *See* notes 21-23 *supra* and accompanying text.

[52] On most subjective mens rea inquiries, the prosecution bears the burden of persuading beyond a reasonable doubt. From the standpoint of the evidentiary dynamic of a criminal trial, however, the defendant who claims to have functioned abnormally at the time of the offense bears the burden of producing supporting evidence as well as a de facto burden of persuading the factfinder to credit the claim. In this sense, the issue may be little different from mens rea inquiries linked to claims of duress or self defense, on which the defendant in

b. Automatism and Unconsciousness

These "defenses" typically are said to negate the "voluntariness" dimension of the actus reus requirement;[53] the prosecution accordingly bears the ultimate burden of proof on the issue once the defendant introduces sufficient evidence to raise the defense.[54] It is true, of course, that we cannot be certain after the offense that a person has experienced an epileptic seizure, a concussion, a somnambulistic fugue state or a hysterical dissociative episode. Proof of any of these conditions depends entirely on reconstruction of the person's behavior at the time of the offense, and on his relevant history. It also is true that consciousness is itself a question of degree, and that disturbances of consciousness, regardless of cause, may be variable in relation to the cortical functions that are compromised.[55] We may even be convinced that by according exculpatory significance to such conditions, we are opening a door through which many more guilty than innocent persons will pass.

Nonetheless, we know enough to acknowledge that such conditions do occur and that they can obliterate a person's conscious awareness of and control over his behavior. There are no moral skeptics here.[56] Neither our skepticism about the methods of clinical investigation and proof nor our concerns about abuse should persuade us to ignore a universally shared moral intuition: it would be morally wrong to convict and punish a defendant for committing acts of which he was unaware and which he did not consciously choose to commit.[57]

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many jurisdictions bears the burden of persuasion.

[53] *See, e.g.*, H. PACKER, THE LIMITS OF THE CRIMINAL SANCTION 133 (1968); 1 R. ANDERSON, WHARTON'S CRIMINAL LAW AND PROCEDURE § 50 (1957).

[54] *See, e.g.*, People v. Bridgewater, 47 Cal. 2d 406, 303 P.2d 1018 (1956); State v. Mercer, 275 N.C. 108, 165 S.E.2d 328 (1969).

[55] "[O]bservation of mental processes, particularly of those occurring in states of pathology, reveals that highly significant psychic processes operate under widely varying degrees of awareness, and even in the absence of awareness." J. KOLB, MODERN CLINICAL PSYCHIATRY 21 (1973).

[56] Commentary has focused mainly on the theoretical basis for the varying dispositional consequences of automatism or unconsciousness defenses (which result in outright acquittal) and the insanity defense (which ordinarily leads to civil commitment). *See, e.g.*, Fox, *Physical Disorder, Consciousness, and Criminal Liability*, 63 COLUM. L. REV. 645 (1963). In England and Canada, the implications of the analytical distinction have been evaded by distinguishing between insane automatism and non-insane automatism. *See generally* M. SCHIFFER, MENTAL DISORDER AND THE CRIMINAL TRIAL PROCESS 83-119 (1978).

[57] *See generally* H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 90-112 (1968). Of course,

c. The Insanity Defense

The case for the insanity defense is not as clear on moral grounds. The moral skeptics dispute the propositon that persons suffering from serious mental disorders are, as a class, less able than normals to comprehend the consequences of their acts, or to control their behavior. Because a claim of insanity, unlike a claim of automatism, does not usually negate the mens rea[58] or the actus reus of the offense,[59] its abolition would not be incongruent with the culpability structure of the criminal law.[60] Moreover, the method skeptics can argue plausibly that the risk of fabrication is siguificantly greater with insanity claims than it is with automatism and unconsciousness claims.[61] Few conditions can result in unconsciousness, and the behavioral indicia of "automatic" behavior are comparatively easy to describe and document; in contrast, the "conditions" that can compromise rationality and volitional control are not easily defined, and the criminal behavior of the psychologically abnormal person may not differ superficially from that of a "normal" offender.[62]

Nevertheless, the ethical foundations of the criminal law are rooted in beliefs about human rationality, deterrability, and free

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a person with a history of automatism might he guilty of some other offense because he may have been reckless or negligent in placing himself in circumstances involving substantial, unjustified risks. *See, e.g.*, People v. Decina, 2 N.Y.2d 133, 138 N.E.2d 799, 157 N.Y.S.2d 558 (1956).

[58] Even the skeptics would permit evidence of psychological aberration to negate the cognitive mental elements of specific substantive offenses. *See* note 15 *supra*.

[59] The United States Supreme Court's decision in Robinson v. California, 370 U.S. 660 (1962), weaves together the requirement of an act and the requirement of a voluntary act. The Court untangled the *Robinson* rationale in Powell v. Texas, 392 U.S. 514 (1968), abandoning the voluntariness dimension altogether. As Justice Black recognized, a contrary holding in *Powell* could have constitutionalized the volitional thread of the insanity defense. *See id.* at 544-46 (Black, J., concurring).

[60] In about half of the states, the defendant bears the burden of proving by a preponderance of the evidence his lack of criminal responsibility. W. LAFAVE & A. SCOTT, *supra* note 20, at § 40, at 313. If the insanity defense is not constitutionally required on substantive grounds, then such procedures under which the defendant bears the burden of proof are constitutionally permissible as well. Jeffries & Stephan, *supra* note 26, at 1365-79. In contrast, the automatism defenses probably are constitutionally required because the abnormal conditions allegedly deprive the defendant of conscious control over his behavior and therefore implicate the minimum fault criteria for criminal liability. *Id.* at 1371-76.

[61] *See generally* H.L.A. HART, THE MORALITY OF THE CRIMINAL LAW 5-29 (1965); H.L.A. HART, *supra* note 57, at 32-33.

[62] *See* D. ABRAHAMSEN, THE PSYCHOLOGY OF CRIME 106 (1967).

will. These are articles of moral faith rather than scientific fact. Many commentators believe that the integrity of this system of beliefs requires symbolic affirmation of the pervasively held, but also unvalidated, intuition that mental abnormalities "exist" and can subvert a person's ability to comprehend the consequences of his acts or to control his behavior.[63] According to this view, perpetuation of the insanity defense is essential to the community's moral perceptions of the legitimacy of punishment. However uncertain the inquiry, a respect for the moral integrity of the criminal law may require us to make it. The insanity defense is likely to remain intact.[64]

d. Diminished Responsibility[65]

The proposition that a person suffering from severe mental disorder should not be regarded as fully responsible for his offense, even if he is not legally insane and even if he had the mens rea required for the offense, has had frequent ideological support but little application in the law. "Partial" or "diminished" responsibility has never been accepted as a general principle, and only in homicide cases has it had any operational significance.[66]

The concept evolved in homicide cases to permit the jury to convict mentally ill, but legally sane, defendants of second degree murder and thereby foreclose consideration of the death penalty.

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[63] *See, e.g.*, A. GOLDSTEIN, THE INSANITY DEFENSE 223-25 (1967); Bonnie, *Commentary: Criminal Responsibility* in PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS AND DEBATE 97, 100-01 (R. Bonnie ed. 1977); MODEL PENAL CODE § 4.01, Comment (Tent. Draft No. 4, 1955).

[64] Even the skeptics appear to recognize the nnfairness of convicting and punishing a defendant who lacks the mental capacity to defend himself. Thus they do not challenge the theoretical and empirical bases for the concept of incompetency to stand trial, plead guilty or waive other important rights.

[65] We use the tenn "diminished responsibility" to refer to grading (or sentencing) rules that accord independent mitigating impact to claims of volitional inpairment technically irrelevant to the mens rea elements of the substantive offenses. Diminished responsibility can be accomplished (1) through redefinition of the grading distinctions of the substantive offenses; (2) through the articulation of a general rule for grading some offenses; or (3) if presumptive sentencing is in effect, through the formulation of mitigating factors that justify or require a departure from the presumptive sentence.

[66] *See generally*, Arenella, *The Diminished Capacity and Diminished Responsibility Defenses: Two Children of A Doomed Marriage*, 77 COLUM. L. REV. 827 (1977); Dix, *Psychological Abnormality as a Factor in Grading Criminal Liability: Diminished Capacity, Diminished Responsibility, and the Like*, 62 J. CRIM. L.C. & P.S. 313 (1971).

Since the United States Supreme Court's 1976 decisions upholding capital punishment,[67] however, diminished responsibility attributable to mitigating mental abnormality has been unchained from the mens rea of homicide. Now a person convicted of capital murder is constitutionally entitled to a separate sentencing proceeding during which he may present any evidence in mitigation.[68] Virtually every state reenacting capital punishment has included among its specified mitigating circumstances two responsibility formulations derived from the Model Penal Code: whether the defendant's capacity to "appreciate the criminality . . . of his conduct or conform his conduct to the requirements of the law was significantly impaired" and whether he was suffering from "extreme mental or emotional disturbance" at the time of the offense.[69]

Apart from capital punishment,[70] it is difficult to fix the place of diminished responsibility in the fabric of the substantive law. A generic principle of grading that cuts across all offenses[71] would be difficult to implement and would introduce too much uncertainty into the law. On the other hand, acutely compromised volition, not limited by a "mental disease or defect" requirement, easily could serve as a mitigating circumstance under presumptive or otherwise structured sentencing schemes. For example, the Model Sentencing

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[67] *See* Woodson v. North Carolina, 428 U.S. 280 (1976); Jurek v. Texas, 428 U.S. 262 (1976); Gregg v. Georgia, 428 U.S. 153 (1976).

[68] Lockett v. Ohio, 438 U.S. 586 (1978).

[69] MODEL PENAL CODE § 210.6(4) (Proposed Official Draft, 1962). On the meaning of these circumstances, see Bonnie, *supra* note 39, at 183.

[70] Although the logic of their position admittedly would preclude such an inquiry, the skeptics have been exquisitely silent on the relevance of claims of mental abnormality to capital punishment. Undoubtedly even they would tolerate speculation in this context. Indeed, it would be morally repugnant, as well as unconstitutional, to condemn a person to death, no matter how heinous his deed, without hearing his claim of mental abnormality and according it some mitigating significance.

Although mitigating mental abnormality is included in the lists of mitigating circumstances in all states, a finding of such a circumstance usually does not preclude a death sentence. We believe that such a finding should have conclusive significance; in this sense, we contend that a doctrine of diminished responsibility is a morally indispensable feature of the jurisprudence of capital punishment.

[71] Although Professor Morse opposes the concept of diminished responsibility, *see* Morse, *supra* note 12, at 296-98, he argues that if the law insists on some responsibility doctrine, it should be applicable to all crimes: "[T]here should be a single category of partial responsibility, between full culpability and legal insanity, that should apply to every crime, and punishment should be a fixed percentage of the punishment of the offense formally proven." *Id.* at 295.

and Corrections Act specifies as mitigating factors findings that "substantial grounds exist tending to excuse . . . the defendant's conduct, though failing to establish a defense;" that "the defendant was suffering from a mental or physical condition that significantly reduced his culpability for the offense;" and that "the defendant because of his youth or old age lacked substantial judgment in committing the offense."[72] Thus, an inevitable consequence of the trend toward structured sentencing will be a refined effort to calibrate the responsibility of criminal defendants, including targeted inquiries into the possible explanatory effects of psychological abnormality.

D. Summary

The skeptics' argument is far too sweeping in its implications. Whether or not the insanity defense is maintained, and we believe it will be, the path of the law reflects a discernible trend toward *increased* rather than reduced subjectivism—and allied clinical inquiry—in the substantive criminal law. Similarly, the byproduct of contemporary efforts to reduce the "lawlessness" of sentencing has been an explicit focus on the motivational aspects of, and psychological explanations for, criminal behavior—a focus which will require "findings" analogous to those required at the guilt stage. In particular, we believe that notions of diminished responsibility, which have proven so difficult to integrate with the grading structure of the substantive law, are an inevitable feature of any sentencing scheme that permits any room for individualization.

Moreover, even if predictive inquiries are severely curtailed, as we believe they should be, a wholly retributivist approach is unlikely to prevail. Decisions regarding the appropriateness of incarceration in individual cases will continue to be based partly on predictive criteria, and the speculation characteristic of clinical predictions will continue to be tolerated.

Having made these assumptions about the substantive law of

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[72] NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, *supra* note 46, § 3-1.08. The Model Act was inspired by, though not wholly consistent with, retributivist ideology, and reflects considerable skepticism about clinical inquiry. Yet, notwithstanding a heroic effort by some drafters to erase clinical predictions from the sentencing process, the Model Act relies heavily on reconstructive clinical concepts in the formulation of mitigating and aggravating circumstances that can justify departures from the presumptive sentence. *See generally* Perlman & Stebbins, *supra* note 6.

crime and punishment, we now turn to a consideration of the appropriate role of mental health professionals in the adjudication of subjective issues. For this purpose, we will put aside the thorny questions raised by clinical predictions and will focus entirely on reconstructive inquiry. In so doing, we emphasize that the qualifications of expert witnesses and the permissible scope of their opinions should be determined separately in the two contexts.

II. Expert Testimony by Mental Health Professionals: The Need for Informed Speculation

An abstract commitment to the moral relevance of claims of psychological aberration may have to bend to the need for reliability and precision in the administration of the law. Rules may be shaped to approximate the universe of morally relevant individual differences, or to entertain only a small part of that universe.[73] We assume, however, that at the very least, the law will not become indifferent to a defendant's claim of abnormal psychological functioning at the time of an offense; however shadowy the inquiry, the law will continue to accord exculpatory or mitigating significance to claimed clinical abnormalities and to some psychological explanations of aberrant behavior.

It would seem to follow that the law, through its rules of evidence, should permit testimony by qualified mental health professionals in the adjudicatory process to assist the factfinder to evaluate the veracity and significance of claims of aberrational mental functioning. An honest and realistic appraisal of this assistance would not lead us to expect scientific precision or certainty; nevertheless, it seems sensible to hear relevant opinions from those whose professional training and experience involve appraisal of the psychological dimensions of aberrant behavior. Although the law probably has been inadequately sensitive to the imperfect scientific foundation of the clinical specialities, the demonstrable trend

[73] The "mental disease or defect" requirement, *see* notes 146-55 *infra* and accompanying text, represents a rough, but convenient, approximation of the threshold of intuited moral significance in the assignment of criminal responsibility. However, if conceptions of psychological abnormality approximated by the mental disease or defect label were regarded as insufficiently precise to permit consistent and morally accurate decisions, the boundaries of the exception could be limited to conditions with demonstrable links to organic pathology. Thus, method skepticism could lead to a tightly restrictive exculpatory doctrine, even if one's moral views did not.

for the past century has been both to enhance the subjectivism of the criminal law and to permit clinicians to offer opinion testimony on a widening array of issues.

Some commentators have questioned the soundness of these developments.[74] They have argued that the proven expertise of mental health professionals is so limited that their opinions are entitled to no more weight than those of laymen. Moreover, they fear that the utility of clinical opinion is far outweighed by the likelihood that it will mislead or confuse the factfinder: if the law persists in asking questions about abnormal psychological functioning, the critics argue, it should rely for its answers on the common sense and experience of Everyman.

Professor Stephen Morse has advocated this exclusionary position most forcefully and thoughtfully,[75] and it seems appropriate to state his views in some detail. As he is frank to admit, Morse's argument for evidentiary exclusion derives from his skepticism about the subjective inquiries of the substantive law.[76] He sees "little persuasive scientific evidence that crazy people should be treated differently from noncrazy people,"[77] but he concedes:

> [S]ociety will probably continue to consider craziness a special factor for some time. Craziness will probably continue to be a focus of legal decisionmaking when it seems related to legally relevant behavior, and the law is likely to turn to mental health experts for assistance in explaining and dealing with it. Crazy people simply appear too different to be treated like everyone else. . . .[78]

Having assumed that the law will continue to ask what he re-

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[74] *See, e.g.*, J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (2d ed. 1975); Bartholomew & Milte, *The Reliability and Validity of Psychiatry Diagnoses in Courts of Law*, 50 AUSTL. L.J. 450 (1976); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974); Morse, *supra* note 9; Comment, *The Psychologist as Expert Witness: Science in the Courtroom*, 38 MD. L. REV. 539 (1979).

[75] *See* Morse, *supra* note 9.

[76] *See id.* at 604-15. Although Morse would abolish the insanity defense, he would not purge the law of inquiries about aberrant psychological functioning if such inquiries are relevant to the mental elements of prescribed offenses. *See id.* at 640-45.

[77] *Id.* at 627. Morse uses the term "crazy people" to refer to people whose aberrant behavior deviates significantly and inexplicably from society's shared set of rules and expectations of behavior, and leads an observer to assume there is something "wrong" with the actor. *See id.* at 543-54.

[78] *Id.* at 601.

gards as unnecessary questions, Morse argues that "mental health experts should play a much more limited role in mental health law decisions than present practice permits."[79] He contends that testifying experts should not express opinions on supposedly factual questions that are "often conflated with ultimate legal questions"[80] requiring social and moral value judgments.[81] Most significantly, he contends that experts should offer only testimony grounded on "firm scientific evidence."[82] As he correctly observes, "very little mental health knowledge"[83] meets this standard, because virtually all diagnostic, psychodynamic, and developmental concepts rest on empirically unverified foundations.

Morse takes a crucial further step when he asserts that, despite the general professional acceptance of these concepts and the comparative ignorance of the factfinder, the "categories and theories of mental health science are at present too imprecise and speculative to help clarify legal questions."[84] Thus, Morse would exclude any testimony about diagnoses because, in the absence of organic symptoms, present diagnostic concepts are not highly reliable or descriptively precise.[85] He would exclude any inferences or opinions regarding the explanations or causes of an individual's past behavior, and any projections of his likely behavior in the future.[86] With respect to reconstructive inquiries, he would limit expert testimony to "hard and methodologically reliable probability data bearing on the difficulty of the actor's choice . . . when it is available."[87] Conversely, Morse would forbid expert speculation in individual cases: "If there are no reasonable probability data, experts should not be allowed to offer either theoretical views about why the actor behaved as he did or opinions concerning the difficulty of the actor's choice."[88]

Morse leaves the clinical expert only a descriptive role: "Mental health experts should be limited to testifying about behavior they

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[79] *Id.*
[80] *Id.* at 602.
[81] *Id.* at 602-03.
[82] *Id.* at 601.
[83] *Id.*
[84] *Id.* at 604.
[85] *Id.* at 604-11.
[86] *Id.*
[87] *Id.* at 617.
[88] *Id.* at 617-18.

observe. . . ."[89] The clinician's skill in observing behavior justifies this role: "Because experts interact with all types of crazy persons far more often than laypersons, they may be especially sensitive to or inquire about behavior that would go unnoticed by laypersons."[90] Such behavioral reportage can aid the factfinder, provided that experts do not "superfluously and prejudicially report conclusions about illness, abnormality, or craziness."[91] Morse would permit expert observations of behavior to include descriptions of a defendant's "reasoning and control processes,"[92] which might inform the factfinder's ultimate judgment regarding the relationship between the defendant's condition and his offense. By these terms Morse apparently refers to characteristics such as impulsiveness or suspiciousness.

Finally, Morse recommends that courts focus upon the qualifications of individual witnesses to testify on particular issues. He would not permit courts to assume expertise on the basis of degree, license or certification alone.[93] In light of Morse's recommendations concerning the permissible scope of expert testimony,[94] the focus of the envisaged qualifying inquiry is relatively clear: if the testimony is to be observational and descriptive, "extensive clinical experience with crazy persons" is essential;[95] if the testimony concerns "probability" or predictive assessments, any person with "hard probability data"[96] or possessing "data relevant to the specific prediction in issue"[97] would qualify.

A. The Limits of Expertise

We disagree with Professor Morse's sweeping proposal to exclude clinical opinion testimony. Before we detail our objections, however, we will acknowledge and discuss our agreement with him regarding the proper scope of expert testimony and the necessary qualifications for experts.

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[89] *Id.* at 601.
[90] *Id.* at 611.
[91] *Id.* at 615.
[92] *Id.* at 616.
[93] *Id.* at 622-23.
[94] *See* notes 75-92 *supra* and accompanying text.
[95] Morse, *supra* note 9, at 622.
[96] *Id.* at 623-24.
[97] *Id.* at 624.

1. Testimony on the Ultimate Issue

As we discuss more fully below,[98] we think that the common proscriptions of expert testimony on "ultimate issues" erects an artificial barrier to relevant expert opinion, often depriving the factfinder of the most useful information the clinician can offer. Accordingly, we favor such reforms as Federal Rule of Evidence 704, which provides that "testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact."[99]

In some contexts, however, the ultimate issue to be decided is a normative as well as an empirical question. As Professor Morse correctly notes, whether a defendant's capacity to control his behavior has been so impaired by abnormal psychological processes that he should receive special legal treatment is frequently a social and moral question.[100] Concepts such as "insanity" or "substantial incapacity," voluntariness, "mental disease or defect," "extreme mental or emotional disturbance," and competence all require value judgments, and expert witnesses should not be permitted to express opinions in these terms. Recent rulings to the contrary[101] are doubly objectionable: the jury may be led, incorrectly, to infer that the "ultimate" questions to be resolved are scientific rather than moral, and experts are permitted to express opinions on questions which, properly understood, are beyond clinical expertise.

In contrast, as we will argue below,[102] testimony regarding the nature and relative severity of a defendant's psychological dysfunction, and informed estimates of what a defendant may have known, perceived, or intended at a particular time, lie within the expertise of mental health professionals. The factfinder, if alerted to the limitations of the expert's knowledge and methodology, can

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[98] *See* notes 143-54 *infra* and accompanying text.

[99] FED. R. EVID. 704.

[100] *See* Morse, *supra* note 9, at 554-60.

[101] *See, e.g.*, United States v. Hearst, 563 F.2d 133 (9th Cir. 1977) (permitting testimony that defendant acted "of her own free will"); United States v. Burks, 547 F.2d 968 (6th Cir. 1976) (permitting testimony that defendant suffered from a "mental illness" that made him "suhstantially incapable of conforming his conduct" to the requirements of the law); Atkinson v. State, 391 N.E.2d 1170 (Ind. Ct. App. 1979) (permitting testimony that defendant was not "legally insane"); State v. Jenson, 251 N.W.2d 182 (N.D. 1977) (permitting testimony that defendant had the "substantial capacity" to appreciate the criminality of his act).

[102] *See* notes 124-98 *infra* and accompanying text.

profit from such testimony.

2. *Qualifications of Expert Witnesses*

We subscribe to a "functional" approach to witness qualifications, and share Professor Morse's distaste for the law's undue emphasis on a prospective expert's formal training and licensing. The inquiry should focus much more on the witness's relevant experience and, we would add, on the adequacy of the witness's evaluation procedure.

Many clinicians have no business in the courtroom. Their training in clinical methods of inquiry and treatment encourages them to err in the direction of diagnosing illness, invites many of them to speculate wildly about unconscious determinants of behavior, and frequently discourages systematic theoretical inquiry. Many clinicians are not sensitive to the limitations of their own disciplines; if they are not researchers, they focus on what they think they know rather than on what they do not know. More important, many clinicians are entirely untrained in, and insensitive to, the purposes and limitations of the legal process.

These are serious problems, and we think they merit immediate attention by the courts and by the mental health professions. Of course, if the scope of expert testimony were restricted as drastically as Morse proposes, many of these inadequacies would become immaterial. Morse's exclusionary approach is not likely to be adopted, however, and we do not think it should be. We are convinced that those who seek to improve the quality and utility of forensic testimony should focus their immediate efforts on the formulation of guidelines to help trial judges assess the qualifications and evaluative techniques of prospective expert witnesses.

Although we do not propose to draft detailed guidelines here, we believe that the primary qualifications are appropriate *forensic* training[103] and experience.[104] The qualified expert, whatever his

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[103] A clinician who is offered as an expert obviously must possess a basic foundation in the behavioral sciences. A psychiatrist should be at least "board-eligible" and a psychologist should have a Ph.D. in clinical psychology. A psychiatric social worker with a masters degree in social work, a masters level psychologist and a masters level psychiatric nurse will ordinarily have sufficient clinical-behavioral training to be helpful in some legal contexts, such as competency assessments, so long as other qualifications are established. For descriptions of these disciplines and other mental health professionals, see F. MILLER, R. DAWSON, G. DIX & R. PARNAS, THE MENTAL HEALTH PROCESS 23-26 (2d ed. 1976).

discipline,[105] must have a firm understanding of the relevant sub-

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Beyond these core requirements, it is important that each professional who testifies have at least some knowledge about *forensic* issues as well. The Group for Advancement of Psychiatry has stated: "[T]he psychiatrist must have some elementary familiarity with the criminal process in order to conduct a meaningful examination." GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, 8 MISUSE OF PSYCHIATRY IN THE CRIMINAL COURTS: COMPETENCY TO STAND TRIAL 894 (1974). *See also Report of the Task Force on the Role of Psychology in the Criminal Justice System*, 33 AM. PSYCHOLOGIST 1099, 1105 (1978) *("Psychologists who work in the criminal justice system, as elsewhere, have an ethical obligation to educate themselves in the concepts and operation of the system in which they work.")*. The need to provide mental health professionals with appropriate legal training, however, is only just beginning to be recognized by educational institutions. While a 1973 survey of 83 university medical centers indicated that 90% of these schools have some type of ongoing law and psychiatry program and an additional 6% were soon to initiate such a program, the authors of the survey found that very few postgraduate or post-residency fellows were being trained, that most courses used informal notes and case materials rather than a standard text, and that little field work was required. They also found that "[f]orensic psychiatry is still seen as a highly specialized area which, in many schools, does not warrant much teaching time or exposure, and is offered primarily as an elective." Sadoff, Thrasher & Gottlieb, *Survey of Teaching Programs in Law and Psychiatry*, 2 BULL. AM. ACAD. PSYCH. & L. 67, 71 (1974).

Basic courses on the use of clinical findings by the legal system should be mandatory for training in psychiatry, clinical psychology, and social work. In addition, forensic rotations in residency programs, special forensic fellowships, and speciality in-service training programs need to be developed. At least six institutions now offer post-residency fellowship programs in psychiatry. *Id.* at 69. The University of Virginia's Institute for Law, Psychiatry and Public Policy, for example, offers a one-year fellowship program designed to expose participants to 12 semester hours of academic courses in the criminal and civil law, and to field work in evaluating criminal defendants and patients who have been civilly committed. The Institute also directs a training program for mental health professionals in Virginia, which requires participation in eight forensic evaluations and covers the following topics in 24 hours of didactic presentation: an overview of the legal system, forensic evaluation techniques and report writing, competency to stand trial, mental state at the time of the offense, dispositional issues, confidentiality, domestic relations, juvenile courts, and expert testimony. The Institute of Psychiatry, Law and Behavioral Science established at the University of Southern California and the Center for Forensic Psychiatry at Michigan offer similar programs.

[104] Educational credentials alone are not enough. As Morse suggests, the law should require a showing of the mental health professional's ability to apply his training. The cases permitting clinical psychologists to testify, for example, have stressed that experience in a clinical setting should be the most important consideration in determining who is an expert. In Jenkins v. United States, 307 F.2d 637 (D.C. Cir. 1962) (en banc), the court stated that "[t]he critical factor in respect to admissibility is the actual experience of the witness and the probable probative value of his opinion." *Id.* at 646. *See also* United States v. Testa, 404 F. Supp. 1259, 1273 (E.D. Pa. 1975).

[105] Traditionally, the courts have permitted only psychiatrists to testify concerning (1) the defendant's competency to stand trial, (2) his mental state at the time of the offense, or (3) dispositional issues. We believe that the professional qualifications necessary to qualify as an expert should depend upon the subject matter of the proffered opinion.

For most competency evaluations, for example, the principal skill required is the ability to interview, observe, and report behavior. A skilled interviewer, even without clinical training, could probably assess a person's capacity to communicate, to understand the legal conse-

stantive law and of the differences between the thresholds of

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quences of his decisions, to interact with another person, and to make rational decisions. *See, e.g.*, Roesch & Golding, *Treatment and Disposition of Defendants Found Incompetent to Stand Trial: A Review and a Proposal*, 2 INT'L J. L. & PSYCH. 349, 365-66 (1979); Rosenberg & McGarry, *Competency for Trial: The Making of an Expert*, 128 AM. J. PSYCH. 1092, 1095 (1972). The courts, however, continue to bar experienced psychiatric social workers from testifying on competency issues, despite their ability to provide the information necessary in most competency cases. *See* People v. Walker, 84 Mich. App. 700, 270 N.W.2d 498 (1978); People v. Parney, 74 Mich. App. 173, 253 N.W.2d 698 (1977). Of course, psychologists generally also should be qualified to testify about competency. *See* People v. Pennington, 66 Cal. 2d 508, 426 P.2d 942, 58 Cal. Rptr. 374 (1967); People v. Crawford, 66 Mich. App. 581, 239 N.W.2d 670 (1976). Although some have suggested that because of the relatively simple nature of a competency examination, it is not necessary for mental health professionals to make such assessments, *see* R. SLOVENKO, *supra* note 2, at 95, we cannot agree. Even if the layman can recognize in the defendant signs of cognitive disturbance, professional training or experience often may be required both to elicit more detailed information and to determine whether some therapeutic intervention would be helpful in improving cognitive functioning. *See* State v. Hayes, 118 N.H. 508, 389 A.2d 1379 (1978).

With respect to assessing the defendant's mental state at the time of the offense, the courts have begun to permit clinical psychologists to testify. *See, e.g.*, People v. Davis, 62 Cal. 2d 791, 402 P.2d 142, 44 Cal. Rptr. 454 (1965) (reversible error to bar clinical psychologist from testifying on issue of insanity on ground that psychologist had no medical training). The primary objection to qualifying psychologists as experts is that they do not possess sufficient training to recognize the range of symptoms associated with the various somatic conditions which, infrequently, can have explanatory significance in connection with a reconstructive forensic evaluation. *See generally* Shah & Roth, *Biological and Psychophysiological Factors in Criminality* in HANDBOOK OF CRIMINOLOGY 101 (D. Glaser ed. 1974). This is a legitimate concern, of course, and it should be taken into account in shaping a forensic evaluation procedure to assure that relevant symptoms do not go unnoticed or unexplored. However, when somatic conditions are not at issue, an experienced clinical psychologist who is otherwise qualified and who has conducted a thorough evaluation should be permitted to testify as an expert witness. *See* Amicus Brief of American Psychological Association, Jenkins v. United States, 307 F.2d 637 (D.C. Cir. 1962) (en banc), *reprinted in* READINGS IN LAW AND PSYCHIATRY at 155-59 (rev. ed. R. Allen, E. Ferster & J. Rubin 1975); Comment, *supra* note 74, at 550 n.52.

To the extent that clinical expertise can elucidate predictive issues, it would seem that hoth psychiatrists and psychologists (as well as other social scientists) can be of assistance to the courts, provided they demonstrate some knowledge of the burgeoning literature on the prediction of dangerousness. For an explication of the types of literature with which the clinician performing a predictive assessment should be familiar, see Dix, *The Death Penalty, "Dangerousness," Psychiatric Testimony, and Professional Ethics*, 5 AM. J. CRIM. L. 151, 175 (1977).

Finally, we do not believe that general medical practitioners, even those who have had some contact with psychiatric problems, should be allowed to express opinions about reconstructive or predictive issues unless, by virtue of their previous treatment of the defendant in question, they can significantly add to the factfinder's appreciation of his mental processes. Cases permitting such testimony, *see, e.g., In re* Springer, 252 Iowa 1220, 110 N.W.2d 380 (1961); Holt v. State, 84 Okla. Crim. 283, 181 P.2d 573 (1947), fail to recognize the difference between the physician who has dabbled in psychiatric practice and the trained psychiatrist or clinical psychologist.

clinical and legal significance; otherwise, his testimony is likely to be misdirected, confusing, and perhaps legally erroneous. Moreover, as a clinician with the necessary forensic training will know, the expert should not offer testimony on a person's mental condition unless he has performed a thorough, personal[106] evaluation of the subject, targeted at the precise questions on which the expert will be called to testify.[107]

Some of these prescriptions easily can be applied by adequately trained trial judges. Thus, the judge can ascertain whether the witness possesses the necessary educational and experiential credentials,[108] has interviewed the subject personally, and has addressed questions specified in advance by the referring party. Because the reliability and usefulness of an otherwise qualified expert's testimony depends largely on the quality of his evaluation procedure, courts also should pay special attention to this subject. Ideally, courts should make this assessment *before* qualifying the witness, rather than leaving the matter to direct and cross-examination; most attorneys and judges, however, are not now sufficiently informed about psychological concepts and techniques to assess the adequacy of forensic evaluations. Thus, for the present we believe the legal system will have to depend primarily on the mental

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[106] Observing the defendant in the courtroom, reading his statements about the offense, or listening to the evidence do not provide a sufficient basis for an informed expert opinion under any circumstances, even if the question is phrased as a hypothetical. *See* note 204 *infra*.

[107] The clinician should not be permitted to testify on an issue unless he has conducted his evaluation with that specific issue in mind. A competency evaluation is a relatively simple inquiry, which rarely involves more than a two-hour interview and usually requires only one hour. *See* note 90 *supra*. A reconstructive or predictive assessment, on the other hand, will often require several hours or perhaps days of testing and interviewing. *See* notes 258-73 *infra* and accompanying text. A predictive determination normally will require greater concentration on the nature of previous offenses than will a reconstructive evaluation; it will also necessitate consultation of different types of clinical literature. *See generally* Dix, *supra* note 105, at 175.

Thus, for example, a clinician who has performed only a competency evaluation should not be permitted to testify about an individual's mental state at the time of the offense, *see* United States v. Walker, 537 F.2d 1192, 1195 (4th Cir. 1976), or his dangerousness, *see* Smith v. Estelle, 602 F.2d 694, 699 n.7 (5th Cir. 1979). Before admitting clinical testimony, the trial judge should ascertain precisely what questions the expert was asked to address and whether he tailored his evaluation procedures to answer those questions.

[108] *See* notes 103-04 *supra*. *See also* Jenkins v. United States, 307 F.2d 637, 649-50 (D.C. Cir. 1962) (en banc) (Burger, J., concurring) (presenting check-list of questions designed to obtain information relevant to the expert qualifications of psychologists).

health professions themselves to formulate ethical guidelines for conducting forensic evaluations and participating in the judicial process. In Part III of this article, we hope to contribute to the developing process of self-regulation[109] within the fields of forensic social work, psychology, and psychiatry. Ultimately, this may be the most promising avenue for increasing the utility of clinical testimony and for preventing unqualified witnesses from testifying as experts in the criminal process.

B. Opinion Testimony By Mental Health Professionals: Three Substantive Contexts

We concede that the central etiological theories and conceptual categories of the clinical behavioral disciplines have not been scientifically validated, and that few clinical opinions can be stated with a high degree of certainty. At best, opinions about psychological processes—beyond merely descriptive observations—are clinical probability judgments rooted in theoretical constructs that are more or less widely shared among mental health professionals.

According to the weight of authority, however, the fact that opinion testimony is uncertain does not by itself justify exclusion, as long as the evidence rises above mere conjecture or speculation.[110] If it has any tendency to prove a fact, and is otherwise qualified as expert opinion, the evidence is admissible unless some overriding reason requires exclusion.[111] The rationale for this posi-

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[109] The recently established American Board of Forensic Psychiatry and American Board of Forensic Psychology have established certification procedures within their respective fields. In addition, the American Academy of Psychiatry and Law has established a Task Force on Ethical Issues in Forensic Psychiatry and the American Psychological Association has appointed a Task Force on Psychology and Criminal Justice, whose report appears at 33 AM. PSYCHOLOGIST 1099 (1978).

[110] *See* Ladd, *Expert Testimony*, 5 VAND. L. REV. 414, 419 n.20 (1952). We argue that clinical testimony by a qualified clinician is based on education and experience rather than pure guesswork and is thus more than "mere conjecture or speculation." Because debate over what is or is not speculation is really an argument over semantics, one commentator has suggested specifically that the courts not apply a "rule of certainty" to relevant qualified expert testimony. *See* note 115 *infra*.

[111] Federal Rule of Evidence 401 states the general principle by defining relevant evidence as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." FED. R. EVID. 401. This rule is tempered by rule 403, which states: "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or

tion is that many observations, both scientific and lay, can be expressed only in terms of "probabilities" or "possibilities"; to deny the factfinder such evidence on this ground alone might deplete seriously the amount of information available.[112]

Although Professor Morse acknowledges this general evidentiary principle,[113] he asserts that "an exception should be made for mental health professionals, primarily because their expertise is limited on most issues and their unrestricted testimony tends to obscure the moral and social nature of the questions being asked."[114] We do not think the case for an exception can be made. Particularly when the defendant determines whether expert testimony by mental health professionals will be introduced—typically the case in the reconstructive inquiries of the criminal law—the opinions of qualified witnesses within their sphere of specialized knowledge should be freely admitted.

A defendant's past psychological functioning cannot be reconstructed with scientific precision.[115] The truth will remain very much in the shadows whether or not mental health professionals

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by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." FED. R. EVID. 403. *See generally* Trautman, *Logical or Legal Relevancy—A Conflict in Theory,* 5 VAND. L. REV. 385 (1952).

[112] The Advisory Committee's note to rule 401 states that "[a]ny more stringent requirement [than that imposed by the rule] is unworkable and unrealistic." FED. R. EVID. 401, Advis. Comm. Note.

[113] *See* Morse, *supra* note 9, at 626.

[114] *Id.*

[115] Although the phrase "reasonable medical certainty" describes the rule governing admissibility of expert testimony in many jurisdictions, the phrase is essentially meaningless. After analyzing the three possible bases for the "certainty rule"—preventing usurpation of the jury's role, assuring sufficiency of the evidence, and avoiding speculation—Professor Martin concludes that "either the basis itself or its application through this admissibility rule is in all cases unsatisfactory." Martin, *The Uncertain Rule of Certainty: An Analysis and Proposal for a Federal Evidence Rule,* 20 WAYNE L. REV. 781, 808 (1974). Martin points out that the differing backgrounds and orientations of legal and medical professionals make it unlikely that they mean the same thing when they speak of "reasonable medical certainty." *Id.* at 804-05. He also correctly notes that most experts do not make specific quantitative determinations regarding their certainty in a particular opinion, often because it is impossible to do so. *Id.* at 806. Professor Martin concludes that degree of certainty should not be a determinant of admissibility, and that gross speculation will be excluded on other grounds, *e.g.,* because the evidence "cannot assist the trier, it is not relevant and wastes time, and it cannot be supported by facts." *Id.* at 808-09. Although Professor Martin's arguments are addressed to application of the rule in the tort context, we believe they make sense in the criminal context as well. *See also* Markus, *Semantics of Traumatic Causation,* 12 CLEV.-MAR. L. REV. 233 (1963); Note, *Admissibility of Expert Medical Testimony in Pennsylvania: The Semantic Trap,* 31 U. PITT. L. REV. 150 (1969); note 121 *infra.*

are permitted to offer their opinions. In formulating an evidentiary test, then, we should begin by comparing the knowledge of mental health professionals not with the knowledge of physicists about the laws of motion, but with that of laymen about psychological aberration and criminal behavior. We should ask whether the observations, intuitions, and hypotheses of clinicians offer a useful and acceptable supplement to those of Everyman.

Morse insists that inferences concerning the nature, extent, and consequences of mental dysfunction are within the range of lay experience and common sense.[116] To some extent this is correct; the factfinder is competent to draw such inferences in the absence of expert testimony,[117] and need not yield to such testimony even when undisputed.[118] Moreover, lay witnesses sometimes may ex-

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[116] *See* Morse, *supra* note 9, at 618.

[117] *See, e.g.*, Hunter v. State, 335 So. 2d 194 (Ala. Crim. App. 1976); Alexander v. State, 358 So. 2d 379 (Miss. 1978); State v. Peel, 23 Mont. 358, 59 P. 169 (1899). A number of jurisdictions, by holding that laypersons may testify as to their opinion of the defendant's insanity, implicitly hold that nonexpert opinion alone may form the basis of a reconstructive defense. *See* note 119 *infra*. *See generally* M. SHIFFER, *supra* note 56.

[118] It is generally accepted that an opinion of an expert, even if uncontradicted, need not be accepted by the jury as long as there is some evidence to support a contrary conclusion. *See, e.g.*, United States v. Julian, 440 F.2d 779 (9th Cir. 1971); White v. State, 346 So. 2d 22 (Ala. Crim. App. 1977); People v. Drew, 22 Cal. 3d 333, 583 P.2d 1318, 149 Cal. Rptr. 275 (1978); State v. Blair, 531 S.W.2d 755 (Mo. Ct. App. 1975); State v. Sarinske, 91 Wis. 2d 14, 280 N.W.2d 725 (1979). This same concept has also been expressed as a requirement that a "jury may not arhitrarily disregard expert testimony . . . ." United States v. Fortune, 513 F.2d 883 (5th Cir. 1975). Of course, in jurisdictions where the government bears the burden of proving the defendant's "sanity" beyond a reasonable doubt, a jury cannot find the defendant sane, even if they find the defendant's expert unbelievable, unless the government has presented some evidence from which sanity can be inferred. *See* Christian v. State, 351 So. 2d 623 (Ala. 1977); People v. Ware, 187 Colo. 28, 528 P.2d 224 (1974).

There appear to be three primary grounds for upholding a verdict contrary to undisputed expert opinion. Most commonly, lay testimony is said to be permissibly credited over that of the experts. *See, e.g.*, United States v. Mota, 598 F.2d 995 (5th Cir. 1979) (person who knew defendant and saw him on day in question testified he acted normally while expert had only spoken to the defendant once); United States v. Coleman, 501 F.2d 342 (10th Cir. 1974) (airline employees and acquaintances of defendant testified to how he "coldly and rationally" planned and carried out the hijacking); White v. State, 346 So. 2d 22 (Ala. Crim. App. 1977) (medical assistant at jail saw defendant every day since homicide and he described defendant's behavior and concluded it was normal); Burr v. State, 267 Ind. 75, 367 N.E.2d 1085 (1977) (arresting officers described defendant's bizarre behavior as "putting them on" while he gave lucid answers to questions and understood the situation); Commonwealth v. Tyson, 485 Pa. 344, 402 A.2d 995 (1979) (police testified that defendant tried to hide his gun at arrest and five hours after shooting he gave police a coherent confession stating that he knew what he did was wrong). *But see* State v. Overton, 114 Ariz. 553, 562 P.2d 726 (1977) (lay testimony that defendant acted normally before and after shooting insufficient because

press opinions on a defendant's mental condition.[119] Nevertheless, we stress the incremental nature of the modern test: we must ask whether "specialized knowledge will assist the trier of fact,"[120] not whether the factfinder can manage when left to his own devices.[121]

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it didn't address whether defendant knew that what he was doing was wrong).

The expert's conclusion can also be disregarded if the jury finds the supporting facts to be untrue. *See* United States v. Shakelford, 494 F.2d 67 (9th Cir.), *cert. denied*, 417 U.S. 934 (1974) (jury disbelieved defendant had experienced prior hallucinations and bizarre conduct).

A jury is also free to disbelieve the expert's opinion because of distrust of the basis of that opinion or the "demeanor" or "unpersuasiveness" of the expert. *See* United States v. Fortune, 513 F.2d 883 (5th Cir. 1975); Walker v. Butterworth, 457 F. Supp. 1233 (D. Mass. 1978) (first expert saw defendant for only two hours eighteen months before the offense; second expert never saw defendant until five months after offense).

[119] Lay witnesses generally are allowed to testify as to their opinions about the defendant's sanity, as long as they state the facts from which they formulated their opinions. *See, e.g.*, United States v. Milne, 487 F.2d 1232 (5th Cir. 1973), *cert. denied*, 419 U.S. 1123 (1975); United States v. Pickett, 470 F.2d 1255 (D.C. Cir. 1972); State v. Lapham, 135 Vt. 393, 377 A.2d 249 (1977). *But see* Gregory v. State, 40 Md. App. 297, 391 A.2d 437 (1978) (no layperson is competent to render an opinion as to sanity). The general foundation requirements for lay opinions on sanity require "ample opportunity" to observe defendant's conduct, close observation by the witness, and proximity in time between the observations and the offense. *See* People v. Wright, 58 Mich. App. 735, 228 N.W.2d 807 (1975); Commonwealth v. Knight, 469 Pa. 57, 364 A.2d 902 (1976).

[120] FED. R. EVID. 702. As Professor Ladd puts it:

> There is no more certain test for determining when experts may be used than the common sense inquiry whether the untrained layman would be qualified to determine intelligently and to the best possible degree the particular issue without enlightenment from those having a specialized understanding of the subject involved in a dispute.

Ladd, *supra* note 110, at 418.

As to whether mental health professionals possess "specialized knowledge or understanding," it is obvious that there is a body of knowledge, not generally accessible to laypersons, that is the special province of those trained to be psychiatrists, psychologists, and social workers. This knowledge can be used both to explain and to treat behavioral aberrations. Although there may be no uniform theory upon which all mental health professionals rely, *see* C. HALL & G. LINDZEY, THEORIES OF PERSONALITY (1970), the various theories are applied daily; the professional literature reflects years of experimentation and close observation by behavioral scientists. Moreover, the courts have permitted "expert" testimony based on other concepts that are not empirically verified or universally recognized. *See, e.g.*, United States v. Oaxaca, 569 F.2d 518 (9th Cir. 1978) (testimony of criminologist that three of four hairs retrieved from red ski mask were "similar" to defendant's was not objectionable as imprecise because "expert" underwent "searching cross-examination"); United States v. Barletta, 565 F.2d 985 (8th Cir. 1977) (FBI agent qualified as an expert on the "ways and language of bookmakers" and was permitted to testify that, based on intercepted conversation between defendant and another, it was his opinion that the defendant was a member of a crime organization); United States v. Jackson, 425 F.2d 574 (D.C. Cir. 1970) ("expert" testimony regarding modus operandi of pickpockets permitted).

[121] The critics of forensic psychiatry and psychology typically assume or assert that the admissibility of such testimony should be determined according to the criteria which govern

Of course, otherwise admissible opinion testimony offered by a

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so-called "scientific" evidence. Such an approach would supplement the criteria for expert testimony (specialized training or knowledge and incremental assistance to the lay fact-finder) by adding a requirement that the scientific principles upon which the expert relies in administering and interpreting the test be generally accepted by the relevant scientific community. Advocates of this approach sometimes analogize to the cases excluding polygraph evidence. In Frye v. United States, 293 F. 1013 (D.C. Cir. 1923), the court held that the theory upon which the polygraph is based had not crossed "the line between the experimental and the demonstrable stages," *id.* at 1014, and that such evidence should not be admitted until the underlying scientific principles have become "sufficiently established to have gained general acceptance in the particular field in which it belongs." *Id.* The critics of mental health testimony rarely fail to point out that opinions about truthfulness based on polygraph interpretation by a skilled expert are correct at least 80% of the time whereas clinical agreement on a psychiatric diagnosis is generally much lower. *See, e.g.*, J. ZISKIN, *supra* note 74, at 3-6; Ennis & Litwack, *supra* note 74, at 737.

The *Frye* test has been severely criticized because of the difficulty in determining whether a given scientific method has gained "scientific acceptance." Some courts accordingly have modified the test, implicitly if not explicitly. *See* United States v. Williams, 583 F.2d 1194 (2d Cir. 1978), *cert. denied*, 439 U.S. 1117 (1979); United States v. Baller, 519 F.2d 463 (4th Cir.), *cert. denied*, 423 U.S. 1019 (1975). Most commentators have argued for the rejection of the test. McCormick is especially critical: " 'General scientific acceptance' is a proper condition for taking judicial notice of scientific facts, but not a criterion for the admissibility of scientific evidence. Any relevant conclusions which are supported by a qualified expert witness should be received unless there are other reasons for exclusion." MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE § 203, at 490-91 (2d ed. E. Cleary 1972) [hereinafter cited as MCCORMICK]. He cites with approval several cases in which evidence based on disputed scientific principles was admitted and the jury was permitted to weigh for itself whether to accept or reject the experts' conclusions. *Id.* at 490 n.33. Others have echoed McCormick's view. *See, e.g.*, R. LEMPERT & S. SALTZBURG, A MODERN APPROACH TO EVIDENCE 935 (1977); 2 J. WIGMORE, EVIDENCE § 662, at 904-05 (J. Chadbourn rev. 1979); Boyce, *Judicial Recognition of Scientific Evidence in Criminal Cases*, 8 UTAH L. REV. 313 (1963-64); Martin, *supra* note 115.

Even if the courts should insist that the validity and reliability of scientific tests be generally acknowledged as a precondition for admissibility, the reasons for doing so do not apply to reconstructive testimony by mental health professionals. The courts' main concern seems to be that laymen will be unduly impressed by the trappings of science and will give undue weight to the test results, *see* Strong, *Questions Affecting the Admissibility of Scientific Evidence*, 1970 U. ILL. L.F. 1, 12-13, and that cross-examination and cautionary instructions will not have adequate corrective effects. However well-founded these concerns are with respect to toxicology, neutron activation analysis, or the polygraph, which draw their convincing force from principles of the physical sciences and mathematics, we think the concerns have little applicability to the testimony of psychiatrists and psychologists. We think laymen are naturally skeptical about the scientific nature of psychiatric and psychological expertise, especially when it is offered in exculpation or mitigation of criminal liability. Although our opinion is based only on casual empiricism from courtroom experience and surveys of appellate opinions, we feel the risk of "expert dominance" is grossly exaggerated. Moreover, the corrective value of skilled cross-examination is much more dependable when the witness is relying entirely on his own observations (including psychological test instruments) and clinical wisdom than when he reports the results of a test which is said to speak

qualified expert still may be excluded if its probative value is outweighed by the likelihood that it will cause undue delay, confuse the issues, mislead the jury, or unduly prejudice one of the parties in the case.[122] Ordinarily the balancing of benefits and risks is made on a case-by-case basis. Critics of forensic psychiatry typically argue, however, that the risk of misleading the jury, and thereby prejudicing one of the parties, is so substantial that only a categorical exclusion of such mental health testimony is an adequate response. In the context of the reconstructive inquiries of the criminal law, we do not agree.

The imprecision of an expert's concepts, and the possible shortcomings of his evaluative techniques, may be explored through direct examination and cross-examination, and in arguments by counsel concerning the weight of his testimony. The court can confine the expert to his sphere of specialized knowledge, and exclude opinions on ultimate issues involving moral judgments.[123] Cautionary instructions also are available. Even if the defense has offered the only psychiatric testimony, the natural skepticism of the jurors, coupled with the safeguards already mentioned, should virtually eliminate the danger of the jury abdicating its factfinding role.

We believe that wholesale exclusion of expert opinion testimony from reconstructive inquiries would unduly prejudice the interests of defendants and enhance the natural advantage enjoyed by the prosecution on such issues, contrary to the fundamental concepts of fairness governing the criminal process. Detailed discussion of such testimony in three substantive contexts will help to illustrate our assertions, and to underscore our differences with Professor Morse.

1. The Usefulness of Diagnoses

The substantive criminal law typically ascribes exculpatory or mitigating significance to reconstructive clinical formulations only if the defendant's claimed aberrations were attributable to a "mental disease or defect." Because the law thereby endorses a "medical model" of abnormal psychological functioning, courts

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for itself.

[122] *See* FED. R. EVID. 403.

[123] *See* notes 98-102 *supra* and accompanying text. *See generally* M. SCHIFFER, *supra* note 56, at 211-13.

have generally considered the presence of a diagnosable mental illness to be a matter of some evidentiary importance.[124] Professor Morse is highly critical of the law's reliance on diagnostic concepts, and of its willingness to depend on experts to define "normality."[125] He would forbid expert testimony "about whether an actor suffers from a mental disorder or even about whether the actor is normal,"[126] fearing that diagnostic labels might induce the factfinder to make unwarranted assumptions about the nature and severity of the defendant's condition.[127] He points to the relative unreliability of clinical diagnoses,[128] and emphasizes that the determination of whether a defendant's abnormality is severe enough to be considered a "mental disease or defect" is a value judgment that should be reserved to the factfinder.[129]

We do not think that these concerns justify exclusion of such testimony. Admittedly, serious prejudice may result if the factfinder accords any evidence undue significance on an issue central to the outcome of a case. Thus, critics of forensic psychiatry point out that many courts refuse to admit opinions based on poly-

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[124] *See* A. GOLDSTEIN, *supra* note 63, at 48. A "mental disease or defect" requirement may apply to reconstructive formulations offered under diminished capacity doctrines, as well as to explanatory formulations under "responsibility" doctrines such as insanity or diminished responsibility. *See, e.g.*, MODEL PENAL CODE § 4.01 (Proposed Official Draft, 1962). It is important to note the different implications of the requirement in these very different contexts. While we recognize its legitimacy as a normative threshold in responsibility-based "defenses," *see* notes 98-101 *supra* and accompanying text, we regard it as arguably unconstitutional when applied to prevent a defendant from offering clinical testimony bearing on mens rea. *See* notes 21-23, 50-52 *supra* and accompanying text.

[125] *See* Morse, *supra* note 9, at 604-15.

[126] *Id.* at 604.

[127] *See id.* at 611.

[128] *See id.* at 606-11.

According to an extensive review of the literature conducted in 1967, the rate of reliability was approximately 60% or less for "specific" diagnostic categories and between 64% and 85% for broader "general" categories. *See* Zubin, *Classification of the Behavior Disorders*, 18 ANN. REV. PSYCH. 373, 382-83 (1967). *See also* Pasamanick, Dinitz & Lefton, *Psychiatric Orientation and its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 AM. J. PSYCH. 127 (1959). It should be noted that recent studies, using more refined interview techniques and more precise diagnostic criteria, have yielded considerably better results.

Diaguostic reliability studies measure the consistency with which different professionals agree on a diagnosis for a given patient; validity measures the accuracy of these diagnoses. *See generally* Beck, *Reliability of Psychiatric Diagnosis: 1, A Critique of Systematic Studies*, 119 AM. J. PSYCH. 210 (1962). Because the validity of a diagnosis is dependent on demonstrated reliability, these studies also furnish an indirect measurement of how well clinicians diagnose in an absolute sense.

[129] *See* Morse, *supra* note 9, at 604-06; notes 98-102 *supra* and accompanying text.

graph testing, despite their reputed 80% reliability:[130] the risk of undue reliance and of consequent prejudice on a key issue—a party's truthfulness—is simply too great.[131] The analogy between reconstructive formulations employing diagnostic concepts and polygraph testing is inapt, however. For one thing, the "mental disease or defect" inquiry—in which diagnostic concepts are most probative—represents only a threshold question; the *pivotal* determination under the various reconstructive tests relates to the actual effects of a person's condition on his cognitive or emotional processes at the time of the offense. Moreover, the risk of unfairness to the defendant is minimized by the fact that, under constitutionally correct procedures,[132] the prosecution cannot introduce psychiatric testimony unless the defendant raises a clinically based "defense"; thus the defendant controls the introduction of psychiatric testimony.[133] Finally, although the "scientific" aura of the polygraph might lead to undue jury reliance,[134] the factfinder is unlikely to abdicate to a clinician the duty to apply the "mental disease" threshold requirement; the risk that this would happen can be minimized if the expert is required, on cross-examination, to explain the use and limitations of his diagnostic concepts, and if cautionary instructions clarify the incongruence of the diagnosis with the legal test.

Expert opinions about the comparative severity of behavioral dysfunction often rely upon diagnostic concepts; such opinions can, in some cases, yield insights that are both probative and valuable to the factfinder on the "mental disease" issue. Without the conceptual aid offered by diagnostic constructs, the factfinder will

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[130] *See* note 121 *supra*.

[131] *See* McCormick, *supra* note 121, § 207, at 506-07; J. Ziskin, *supra* note 74, at 5; Ennis & Litwack, *supra* note 74, at 736-37.

[132] *See* notes 205-19 *infra* and accompanying text.

[133] Morse's primary concern with the risk of prejudice to the defendant deriving from unreliable diagnoses is reflected in his effort to deflect the argument that "diagnoses of physical disorders are also quite unreliable." Morse, *supra* note 9, at 607 n.169. He responds: "Even so, the consequences of unreliability are considerably different. Physical diagnoses rarely lead to stigmatizing special legal treatment that deprives persons of rights or brands them as lacking in behavioral autonomy and dignity." *Id.* Obviously, Morse's main concern is with civil commitment. The normative distinction between the consequences of physical and psychological diagnoses disappears entirely when the relevant legal context is the reconstructive inquiries of the criminal law; in this setting, it is the defendant who seeks to benefit from expert testimony. Morse consistently overlooks this fact.

[134] *See* note 121 *supra*.

confront a bare description of symptoms, with only lay conceptions of illness to assist in interpretation. In many instances lay conceptions may be all the assistance needed; in others, however, the factfinder may be deprived of information helpful in determining the nature and severity of the defendant's alleged abnormality.

A case seen at the Forensic Psychiatry Clinic illustrates the potential usefulness of diagnosis in this context. Mr. G was a twenty-five-year-old man charged with capital murder for the alleged rape and murder of a seventeen-year-old woman and the subsequent murder of the rape victim's mother. The Clinic's staff found that, as a child, Mr. G. had been extremely withdrawn, hostile, and unresponsive. As his mother said, "He was always a loner and never got close to anyone." Frustrated by his silence and seeming unwillingness to respond to her, she beat him on an almost daily basis, often with a broom or a baseball bat. She admitted, "I was a child abuser, I just never thought of it that way then." Mr. G usually would respond to these beatings by whistling, in an effort to make her think she was not hurting him. Over the years, however, he stored up considerable secret anger and resentment toward her; he reported that he frequently had fantasies of revenge.

Mr. G's father died when Mr. G was two. His mother remarried a few years later, and Mr. G remembered feeling that his stepfather was the only person to whom he could relate. Unfortunately, his stepfather died when Mr. G was ten. At about this time, Mr. G began to indulge heavily in the use of alcohol and drugs. By the age of twelve he had been thrown out of school several times for use of marijuana, LSD, and glue. He had no close friends; he would often lock himself in his room, walk alone in the woods, or sit in a corner of the living room by himself for long periods of time.

According to Mr. G, during his late adolescence his mother and sister began entertaining "streams of men." He also reported that they used alcohol and drugs excessively. He said his hatred of his mother and sister increased steadily during these years; to him both were "sluts" and "junkies." According to Mr. G's mother, she had only one boyfriend in four years, and she and the daughter did not indulge heavily in intoxicants.

During his interview at the Clinic, Mr. G appeared extremely depressed and demonstrated considerable anxiety. He began the interview in a sullen, detached mood, but gradually became more communicative, revealing a thought process that was unsophistica-

ted and almost childlike. He had great difficulty in dealing with abstract concepts, but in general was able to answer questions coherently.

Consider the usefulness of this information to a jury trying to decide whether Mr. G was suffering from a "mental disease or defect." Much of this information might indicate some degree of abnormality, at least in terms of the defendant's childhood behavior and his perception of reality. Other data push in the opposite direction—Mr. G's ability to communicate in a "normal" fashion and the fact that he had supported himself for several years with no apparent problems. Beyond the impressions concerning Mr. G's "normality" obtainable from these facts alone, we believe that the factfinder could benefit still further from diagnostic opinions.

The Clinic felt that Mr. G's early emotional isolation and unresponsiveness to others, his pervasive but repressed hostility toward his mother and sister, and his autistic thought processes were indicative of a severe "schizoid personality disorder." Although his schizoid tendencies were of obscure origin, his behavioral manifestations met the accepted criteria for the diagnosis.[135] Drawing upon this diagnostic formulation, the Clinic observed:

> In an individual with a severe schizoid personality disorder, perceptions are distorted, but not to the extent that would be true in a psychotic state. Severe schizoid personality disorders sometimes merge into a state in which the individual is out of touch with reality. While many people have schizoid symptoms, those with symptoms as acute as Mr. G's comprise a very small percentage of this group.

This information reveals that while Mr. G was not psychotic, he may have been bordering on that condition; moreover, he was not

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[135] The American Psychiatric Association's Diagnostic and Statistical Manual defines "schizoid personality" as follows:

> This behavior pattern manifests shyness, over-sensitivity, seclusiveness, avoidance of close or competitive relationships, and often eccentricity. Autistic thinking without loss of capacity to recognize reality is common, as is daydreaming and the inability to express hostility and ordinary aggressive feelings. These patients react to disturbing experiences and conflicts with apparent detachment.

AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 301.2, at 42 (2d ed. 1968) [hereinafter cited as DSM-II]. *See also* Teicher, *Personality Disorders*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2181 (2d ed. A. Freedman, H. Kaplan & B. Sadock 1975) [hereinafter cited as COMPREHENSIVE PSYCHIATRY].

the "average" schizoid personality.[136] We believe a juror presented with this type of testimony could place into better perspective the type of disorder from which Mr. G suffered. This diagnostic description helps the factfinder to assess the relative severity of Mr. G's mental condition, facilitating a more informed decision on the "mental disease or defect" question.[137]

We introduced this discussion by stressing that diagnostic concepts can have probative value in connection with the assessment of normality implicit in the "mental disease or defect" inquiry. In some cases, diagnoses also may contribute to an explanatory formulation by helping the clinician to interpret observed data and to organize his thinking about the subject's behavior. In Mr. G's case, for instance, the Clinic learned that he had known his eventual victims for some time, and had regarded them as "sluts." Based in part on the assumption that severely schizoid individuals often confuse reality and fantasy, the Clinic hypothesized that sometime before the offense Mr. G began to project his hatred for his mother and sister onto his victims, who were roughly the same ages. The Clinic observed in its report that the mother-victim was the primary object of hatred and disgust; Mr. G invested her with all of the evil qualities he perceived in his mother. As he said, "I felt she deserved to die. She didn't love her daughter; she didn't care what

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[136] Regarding variations in functioning among adults diagnosed as schizoid, see Winokur & Crowe, *Personality Disorders*, in 2 COMPREHENSIVE PSYCHIATRY, *supra* note 135, at 1283.

[137] The operational meaning of the "mental disease or defect" concept and the threshold of legal significance of a claim of abnormality depend on the context and consequence of the inquiry. In Mr. G's case, for example, the trial court determined that "the nature of his mental instability was not sufficient to prove insanity," reflecting the high threshold generally required for claims of exculpatory mental abnormality. In Virginia, as in many jurisdictions, proof of a psychosis may be necessary to establish a mental disease. *See generally* A. GOLDSTEIN, *supra* note 63, at 47-48.

However, Mr. G. was convicted of capital murder. In the context of a capital sentencing proceeding, the threshold of significance for a claim of mitigating mental abnormality is undoubtedly lower, if there is one at all. If Mr. G had heen tried in Indiana, for example, the clinical evidence would have been introduced to establish that his "capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was substantially impaired as a result of a mental disease or defect or of intoxication." IND. CODE ANN. § 35-50-2-9(c)(6) (Burns 1975). Even though this langnage is virtually identical to the Model Penal Code insanity defense formulation, its legal meaning obviously would differ in the context of a capital sentencing proceeding. In Virginia, the significance of Mr. G's claim of mitigating psychological dysfunction that "significantly impaired" his cognitive or volitional capacity does not depend on whether it is attributable to a mental disease or defect. *See* VA. CODE ANN. § 19.2-264.4(B)(iv) (Supp. 1979).

she was like." These words could be applied to the relationship between his mother and himself.

The Clinic expanded upon this inferential diagnostic material in assessing Mr. G's mental state at the time of the offense. Mr. G. had assaulted the younger woman, who had encouraged his sexual advances on several prior occasions, when she rejected his attempt at intercourse. He began slapping her around, raped her, and finally choked her to death. He then left the house, but returned moments later to kill the mother as well, because "she was the one who made (the daughter) the way she was."

Using the schizoid personality construct, the Clinic noted that although such individuals have difficulty expressing their hostility directly, they may eventually act out aggression in a highly symbolic and regressive manner.[138] Especially when the schizoid symptoms are severe, this symbolic act can take the form of impulsive antisocial behavior.[139] The Clinic hypothesized that Mr. G., in order to revenge himself against his mother, first created a surrogate for her and then impulsively killed the surrogate and her daughter when "they" (in his mind the former was responsible for the actions of the latter) rejected him.

We do not wish to exaggerate the usefulness of diagnoses, either as tools for assessing "normality" or vehicles for explaining behavior. The diagnosis of schizoid personality in Mr. G's case was only one of several factors contributing to a conclusion about the severity of his dysfunction and his mental state at the time of the offense. In many cases, especially those not involving acute, severe disorder, it is likely that diagnoses will provide little or no help, because their overinclusiveness will fail to differentiate the subject

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[138] For a description of "projective identification," see Kernberg, *Melanie Klein*, in 1 COMPREHENSIVE PSYCHIATRY, *supra* note 135, at 641, 644.

[139] In a study of 153 "sudden murderers"—persons who, without any previous involvement in serious aggressive antisocial acts, suddenly and intentionally kill (or attempt to kill) another human being—Weiss and his colleagues arrived at the following conclusion:

> In general, the sudden murderers demonstrated certain qualities of the schizoid personality (emotional coldness and isolatedness, difficulty in forming close relationships with other persons, and difficulty in *directly* expressing hostility), and certain qualities of the passive-aggressive personality (inefficiency, feelings of helplessness, and persistent reaction to frustration with resentment).

Weiss, Lamberti & Blackman, *The Sudden Murderer, A Comparative Analysis*, 2 ARCHIVES GEN. PSYCH. 669, 675 (1960) (emphasis added). *See also* Heston, *The Genetics of Schizophrenic and Schizoid Disease*, 167 SCI. 249, 251 (1970).

from the general population.[140] Moreover, diagnoses can serve as a cover for tautological thinking: Mr. A has symptoms *X* and *Y*, therefore he has *Z* diagnosis; Mr. A has *Z* diagnosis, therefore he must have had (during the offense) of will have (in the future) *X'* and *Y'* symptoms. Diagnoses cannot substitute for individualized behavioral assessment focused on the issue and time in question.[141]

Nevertheless, in some cases diagnoses can contribute useful information to the factfinder, who must ultimately determine whether the condition exhibited by a defendant crosses the threshold of legal significance. Notwithstanding the risk of unreliability, diagnostic concepts can perform this function if they are viewed not as definitive statements, but as tools for organizing observations and comparing the subject with others.

2. *Opinions Relating to Mental Elements of Offenses*

The criminal law often defines elements of an offense or of an affirmative defense in terms of an actor's actual conscious functioning at the time of the offense—what he believed, perceived, and wished to accomplish. These questions do not concern the actor's "responsibility," nor do they require a shadowy assessment of volitional control.[142] Thus, the admissibility of expert opinion on mens rea ought to be a less troubling issue than is admissibility of expert opinion in responsibility inquiries like insanity. Our review of recent case law, however, indicates that no question is more unclear than when expert testimony will be admissible to establish a defendant's conscious state of mind at the time of his offense.

Some courts admit testimony by mental health experts only if the defendant claims legal insanity.[143] A majority, however, also

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[140] *See* Morse, *supra* note 9, at 605-06.

[141] For an elaboration of this problem in connection with diagnoses of "antisocial personality," DSM II, *supra* note 135, § 301.7, at 43, see Dix, *supra* note 105, at 177-92.

[142] Analytically, claims of diminished volitional control are, of course, entirely irrelevant to the cognitively oriented subjective mental requirements of the substantive criminal law. Many so-called diminished capacity cases in the appellate courts involve proffered testimony concerning impaired volition, which is simply irrelevant to mens rea. Yet instead of simply upholding the exclusion on relevance grounds, the appellate courts frequently make confusing statements regarding the concept of specific intent and the "defense" of diminished capacity. *See, e.g.*, United States v. Busic, 592 F.2d 13 (2d Cir. 1978); United States v. Bennett, 539 F.2d 45 (10th Cir.), *cert. denied*, 429 U.S. 925 (1976); People v. Nance, 25 Cal. App. 3d 925, 102 Cal. Rptr. 266 (1972).

[143] *See, e.g.*, State v. Briggs, 112 Ariz. 379, 542 P.2d 804 (1975); Bethea v. United States,

permit expert testimony bearing on some variety of the so-called "defense" of diminished capacity.[144] Thus, most jurisdictions admit such testimony on behalf of a murder defendant seeking to show that, by virtue of mental disease, he lacked the capacity to premeditate or deliberate.[145] A growing minority will admit expert testimony to show that the defendant had a mental disease or defect depriving him of the capacity to entertain any subjectively defined mental state—specific intent in common-law jurisdictions,[146] and purpose, knowledge, or recklessness in Model Penal Code jurisdictions.[147]

Even in those jurisdictions defining "diminished capacity" most liberally, however, careful adherence to its terms—*lack of capacity* due to *mental disease*—would admit little testimony other than that admissible in support of an insanity defense. Commentators have noted that, in order to negate intent, evidence would have to show "severe mental disability that substantially interfered with the defendant's reality testing functions."[148] Such a disorder would probably suffice to establish insanity.[149] Only in connection with

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365 A.2d 64 (D.C. 1976), *cert. denied*, 433 U.S. 911 (1977); Bradshaw v. State, 353 So. 2d 188 (Fla. Dist. Ct. App. 1977); State v. Rideau, 249 La. 1111, 193 So. 2d 264 (1966), *cert. denied*, 389 U.S. 861 (1967); Fox v. State, 73 Nev. 241, 306 P.2d 924 (1957); State v. Jackson, 32 Ohio St. 2d 203, 291 N.E.2d 432 (1972), *cert. denied*, 411 U.S. 909 (1973); Gresham v. State, 489 P.2d 1355 (Okla. Crim. App. 1971); Hughes v. State, 68 Wis. 159, 227 N.W.2d 911 (1975), *rev'd sub nom.* Hughes v. Matthews, 576 F.2d 1250 (7th Cir. 1978); Smith v. State, 564 P.2d 1194 (Wyo. 1977).

[144] *See generally* Arenella, *supra* note 66; Dix, *supra* note 66; Lewin, *Psychiatric Evidence in Criminal Cases for Purposes Other Than the Defense of Insanity*, 26 SYRACUSE L. REV. 1051 (1975); Note, *Diminished Capacity—Recent Decisions and An Analytical Approach*, 30 VAND. L. REV. 213 (1977).

[145] *See, e.g.*, State v. Gramez, 256 Iowa 134, 126 N.W.2d 285 (1964); State v. Di Paolo, 34 N.J. 279, 168 A.2d 401, *cert. denied*, 368 U.S. 880 (1961); State v. Padilla, 66 N.M. 289, 347 P.2d 312 (1959). *See generally* W. LAFAVE & A. SCOTT, *supra* note 20, §·42, at 325-32.

[146] *See, e.g.*, United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972); People v. Wetmore, 22 Cal. 3d 318, 583 P.2d 1308, 149 Cal. Rptr. 265 (1978).

[147] The Model Penal Code is significantly less restrictive than the usual common-law formulations. First, the mens rea concepts are more subjectively oriented than the common-law formulations, so evidence about the defendant's mental condition is likely to be relevant, in theory at least, in more cases; second, and more important, § 4.02(1) does not require a showing of lack of capacity to have the required state of mind. *See* MODEL PENAL CODE § 4.02(1) (Proposed Official Draft, 1962).

[148] Arenella, *supra* note 66, at 834-35.

[149] *Id.* at 835. Of course, a defendant who is legally insane still may be capable of entertaining a required mental state. *Id.* at 831-35. *See also* Dix, *supra* note 66, at 324-27; Morse, *supra* note 12, at 277.

the concepts of "deliberation" and "premeditation" is it clinically conceivable that a legally sane defendant would nonetheless lack the mental capacity to perform the requisite cognitive functions.[150]

Within these narrow boundaries, the scope of testimony often is further restricted by an inappropriately rigid application of the ultimate issue rule. It is often said that the expert may express an opinion only on whether, at the time of the offense, the defendant had the *capacity* to entertain the state of mind required by the substantive law. The witness may not state whether, in his opinion, the defendant actually did have the required state of mind,[151] because this would "invade the province of the jury."

Such a restriction serves no purpose. Although, in an extreme case, a witness may be able to state confidently that the defendant lacked capacity to have the required mens rea, this is tantamount to saying that, in the witness's opinion, the defendant did not *in fact* entertain the necessary state of mind. More commonly, the witness will be unable to state any opinion about a defendant's capacity in the abstract because the functioning of most mentally ill persons is heavily dependent on environmental influences and stresses.[152] Even for a seriously disturbed person, the only issue on

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[150] *See* Dix, *supra* note 66, at 325. Even in murder prosecutions, the cognitive content of premeditation and deliberation is typically defined so restrictively that a legally sane but mentally abnormal defendant technically is guilty of first degree murder in most situations. Only if the premeditation-deliberation formula is given a qualitative dimension is the evidence of mental disorder likely to be relevant to show that the defendant lacked the required state of mind. In its famous line of "diminished capacity" cases, the California Supreme Court reformulated the concept of "malice aforethought" as well as premeditation. *See* People v. Noah, 5 Cal. 3d 469, 487 P.2d 1009, 96 Cal. Rptr. 441 (1971); People v. Conley, 64 Cal. 2d 310, 411 P.2d 911, 49 Cal. Rptr. 815 (1966); People v. Wolff, 61 Cal. 2d 795, 394 P.2d 959, 40 Cal. Rptr. 271 (1964); People v. Gorshen, 51 Cal. 2d 716, 336 P.2d 492 (1959); People v. Wells, 33 Cal. 2d 330, 202 P.2d 53, *cert. denied*, 338 U.S. 836 (1949). For analysis of the California cases, see G. Dix & M. Sharlot, Criminal Law: Cases and Materials 751-56 (2d ed. 1979); Arenella, *supra* note 66, at 836-49; Dix, *supra* note 66, at 328-32; Morse, *supra* note 12, at 275-88. *See also* W. La Fave & A. Scott, *supra* note 20, § 42, at 328-31.

[151] *See, e.g.*, People v. Loving, 258 Cal. App. 2d 84, 65 Cal. Rptr. 425 (1968); Bradshaw v. State, 353 So. 2d 188 (Fla. Dist. Ct. App. 1978); Simpson v. State, 381 N.E.2d 1229 (Ind. 1978); Koester v. Commonwealth, 449 S.W.2d 213 (Ky. 1969); Dawson v. State, 84 Nev. 260, 439 P.2d 472 (1968); Jackson v. State, 84 Nev. 203, 438 P.2d 795 (1968); Waye v. Commonwealth, 219 Va. 683, 251 S.E.2d 202 (1979); State v. Craig, 82 Wash. 2d 777, 514 P.2d 151 (1973).

[152] We have been focusing here on mental "disease"; but a similar point should be made in connection with "mental defect." If a person's mental retardation is so severe as to deprive him of the cognitive capacities relevant to mens rea, he will be incompetent to stand trial. Similarly, a person with a chronic organic brain syndrome will be incompetent to stand

which an expert can form a reasonable opinion is the probability that the defendant had the requisite state of mind on a given occasion. Far from preventing "usurpation" of the jury's function, the ultimate issue restriction as applied in this context inhibits expression of the only opinion that can meaningfully assist the jury.[153]

All of these barriers to expert testimony associated with the diminished capacity doctrine are objectionable because they exclude relevant and competent evidence proffered by a defendant to show that he did not have the state of mind required for conviction. Recent constitutional challenges to the most restrictive exclusionary rules, in jurisdictions which refuse to admit any evidence of mental disorder in the absence of an insanity plea, indicate a defendant may not be precluded from introducing relevant testimony by qualified experts to show he suffered from a mental disorder that compromised his capacity to entertain the required state of mind.[154] Although most of the cases holding that the "defense" of diminished capacity is constitutionally required have involved murder convictions, the rationale clearly extends to any offense with subjectively defined mens rea elements.

The principle of these cases also implicates both the "mental disease or defect" requirement,[155] when applied to diminished ca-

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trial as well. Almost by definition, if a person is competent to stand trial, his condition is variable, and categorical statements about his "capacity" to entertain required mental states are impossible.

[153] There is no substantial basis for believing that an expert opinion on the defendant's probable mental state at the time of the offense, however phrased, will "usurp" the jury's function. The notion that it would do so has been characterized as "empty rhetoric." 7 J. WIGMORE, *supra* note 121, § 1920, at 18. The recent trend in evidence law has been to abandon the ultimate issue restriction. For example, Federal Rule of Evidence 704 provides that "[t]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." FED. R. EVID. 704. So long as the jury is apprised that it is not bound by, and should not give undue weight to, the expert's opinions, statements about what a defendant probably perceived, believed, or intended at the time of an offense lie within the proper boundary of expertise and should be freely admitted. For a discussion of the special problems posed by expert opinion on normative legal thresholds, see notes 98-102 *supra* and accompanying text.

[154] *See, e.g.*, Hughes v. Mathews, 576 F.2d 1250 (7th Cir.), *cert. dismissed sub nom.* Israel v. Hughes, 439 U.S. 801 (1978); People v. Wetmore, 22 Cal. 3d 318, 583 P.2d 1308, 149 Cal. Rptr. 265 (1978); Commonwealth v. Walzack, 468 Pa. 210, 360 A.2d 914 (1976).

[155] Under § 4.02(1) of the Model Penal Code, there is no "capacity" requirement. *See* note 147 *supra*. However, the Code declares that evidence "that the defendant suffered from mental disease or defect" is admissible when relevant to a subjectively defined mental element, MODEL PENAL CODE § 4.02(1) (Proposed Official Draft, 1962); by negative implication, evidence that a defendant was functioning abnormally at the time of the offense is not

pacity claims, and the testimonial "capacity" limitation. In a criminal case involving subjective mens rea requirements, the prosecution usually has no direct evidence concerning the defendant's state of mind; it must rely on "common sense" inferences drawn from the defendant's conduct. This has the practical effect of shifting the burden to the defendant to demonstrate that he did not perceive, believe, expect, or intend what an ordinary person would have perceived, believed, expected, or intended under the same circumstances.[156] Restriction of clinical testimony on mens rea thus compromises the defendant's opportunity to present a defense[157] on an issue concerning which he, in reality, bears the burden of proof. The factfinder is likely to view with considerable skepticism the defendant's claim that he did not function as would a normal person under the circumstances. The defendant must establish the plausibility of his claim of abnormality. By precluding the defendant from offering relevant expert testimony, the law unduly enhances the prosecution's advantage on this issue. For this reason, we believe the only limitations on admissibility of mens rea testimony by mental health professionals should be relevance and the normal requirements for expert opinion.

Consider the case of Ms. B, charged with knowingly possessing nine stolen welfare checks.[158] The prosecution's undisputed evidence shows that six checks, made out to six different payees, were given to Ms. B by Scott, a good friend of Ms. B's boyfriend, and that she deposited the checks, which supposedly had been en-

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admissible, however relevant, if he was not suffering from a mental disease or defect. *See, e.g.*, United States v. Bright, 517 F.2d 584 (2d Cir. 1975).

[156] Formally, of course, the prosecution is constitutionally required to prove beyond a reasonable doubt each element of the offense, including subjectively defined mens rea components. *In re* Winship, 397 U.S. 358 (1970).

[157] Exclusion of relevant and competent opinion testimony on mens rea by a qualified mental health expert might be said to relieve the prosecution of its duty to prove each element of the offense beyond a reasonable doubt. *See* Hughes v. Mathews, 576 F.2d 1250, 1255 (7th Cir.), *cert. dismissed sub nom.* Israel v. Hughes, 439 U.S. 801 (1978). However, it makes more sense to regard the exclusionary rule as a violation of the defendant's right, under the 6th and 14th amendments, to present evidence in his defense. *See, e.g.*, Chambers v. Mississippi, 410 U.S. 284 (1973) (strict application of state's evidentiary rules to exclude defendant's evidence violated due process); Commonwealth v. Walzack, 468 Pa. 210, 223, 360 A.2d 914, 920-21 (1976) (due process requires admission of defendant's proffered evidence if such evidence is both relevant and competent).

[158] Ms. B's case is loosely based on the facts of United States v. Bright, 517 F.2d 584 (2d Cir. 1975).

dorsed to and by him, in her account. The evidence also shows that one check had been returned unpaid and her account charged accordingly, and that Scott made good her loss when she confronted him. She subsequently deposited three more checks. The inferences most likely to be drawn from this evidence would be that she must have "known,"[159] as would any normally suspicious person, that the checks were stolen, especially after one of the checks was returned unpaid. Defendant testifies, however, that she did not, in fact, believe the checks were stolen. She states that she believed Scott when he told her that the checks had been given him in payment for debts and rent owed to him, and that he needed her assistance because he had no bank account of his own.

A jury would not be likely to credit a claim of such gullibility: the circumstances would have been overwhelmingly suspicious to a reasonable, "normally suspicious" person. The law, however, does not define mens rea for this offense in terms of an objective standard. The relevant question is what Ms. B actually thought; if she is so abnormally gullible that she believed everything Scott said, she is innocent.

The defense proffers expert testimony by a psychiatrist to the effect that Ms. B's personality is marked by a high degree of passivity and dependency. Because she is highly dependent on others to satisfy her emotional needs, she is compliant and characteristically avoids situations of conflict that could threaten the stability of her emotional attachments. In this particular situation, her dependence on her boyfriend and desire to please him led her to want to please his good friend Scott. As is characteristic of persons sharing her personality traits, Ms. B relies on the ego defense mechanisms of "denial" and "repression" to keep anxiety-provoking thoughts out of her consciousness, in order to maintain her

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[159] Under the governing law, Ms. B. could be said to bave "known" that the checks were stolen if she was "aware of a high probability" that they were stolen or if she acted in reckless disregard of the probability that they were stolen and made a conscious effort to avoid learning the truth. For present purposes, assume that Ms. B. claimed that she was never consciously aware of any possibility that the checks were stolen. For discussion of the "reckless disregard" concept, see United States v. Jewell, 532 F.2d 697 (9th Cir.) (en banc), *cert. denied*, 426 U.S. 951 (1976); United States v. Bright, 517 F.2d 584, 586-88 (2d Cir. 1975). The reckless disregard principle is not absolute. For example, under the Model Penal Code, unconsciousness of risk due to self-induced intoxication would not be a defense to an offense requiring a showing of recklessness. *See* MODEL PENAL CODE § 2.08(2) (Proposed Official Draft, 1962).

emotional equilibrium. Doubts about Scott's honesty—and, by inference, about her boyfriend's character and relationship with her—would have generated intense anxiety and psychological conflict. Thus, she denied and repressed the doubts, which never rose to the level of consciousness.

This formulation, if believed, tends to support Ms. B's claim that she did not "knowingly" possess stolen checks. However, it does not show that she suffered from a mental disease or defect—or even a substantial behavioral abnormality—that would deprive her of the capacity to know that the checks were stolen. Instead, it draws on theories of personality and ego defense to explain the way she functions as a person, and adds some plausibility to the notion that under the described circumstances she could have been "abnormally gullible."

Let us assume that this testimony satisfies the governing evidentiary criteria for expert opinion but that it is nonetheless excluded because a claim of mental disease or defect is a prerequisite for admissibility of expert opinion testimony on mens rea. This exclusion compromises Ms. B's ability to persuade the factfinder not to draw inferences about her beliefs on the basis of what a normal person would have believed under the circumstances. Because Ms. B carries a de facto burden of proof on this issue, the exclusion of expert testimony in effect holds her to the standards of a normally suspicious person, selectively redefining the offense to apply objective standards to her and subjective standards to everyone else.[160]

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[160] Whenever culpability is defined subjectively, it should make no difference *why* the defendant did not have the required criminal state of mind. Suppose that Ms. B's boyfriend deposited the checks, and he claims in defense to the charge of knowingly possessing them that he was so intoxicated at the time Scott gave them to him that he did not pay any attention to what the checks were or where they came from. Evidence of his intoxication would be admissible to negate "knowledge." Would a rational scheme of substantive law permit a person to support and explain a claim of unusual ignorance with evidence of intoxication but not with evidence of abnormal gullibility? Perhaps the "mental disease" threshold for expert testimony on mens rea, and the allied "capacity" limitation, indicate that the law is not committed fully to subjective definitions of mens rea after all. Only then could the answer to the question posed be "yes"; that is, the law may choose to restrict the substantive significance of claims of aberrational psychological functioning to those severe mental disorders that obliterate a person's perceptual and judgmental capacities. Any claim that a defendant with the capacity for "normal" perception and judgment nonetheless failed to exercise these capacities might be regarded as immaterial; the law may choose to hold such a person to the standards of a normal person. An analogy might be drawn to the "responsibility" doctrines: there the law presumes that every defendant has the capacity for

As a matter of evidentiary policy, it still might be argued that the mental health professional's expertise is limited to his specialized knowledge of the diagnosis and treatment of mental disorder, and that nothing else he could say about a defendant's mental condition at the time of an offense would enhance lay understanding sufficiently to qualify as expert opinion. This view is difficult to support, however. The training and clinical practice of most mental health professionals extend well beyond the diaguosis and treatment of severe mental disorder. Personality assessment, ego psychology, and psychodynamic interpretation are important features of their training and practice. If proffered testimony drawing on these concepts and approaches is relevant and is presented by a qualified person, it clearly satisfies the normal criteria for opinion testimony.[161] A diagnosable mental disorder simply is not a neces-

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conscious choice and voluntary action unless any claim of impaired volitional control is attributable to severe mental abnormality. Although the threshold may be arbitrary, a categorical normative limitation is enacted in order to avoid wholesale individualization of the criminal law, and the medical model at least approximates the universe of morally relevant aberrations.

We think the analogy fails. The volitional prong of the insanity defense reflects one of the few examples of individualized excuse in the substantive doctrines of the criminal law. By establishing a threshold of severe mental abnormality, the law aims to restrict the scope of the exception and thereby preserve the valued principle of equality. In contrast, a mental disease threshold for evidence on mens rea *violates* the principle of equality precisely because it results in selective and inconsistent interpretation of the culpability elements of the substantive law: in effect, guilt is defined differently for different defendants. A categorical limitation on evidence of psychological abnormality, rooted in the medical model, selectively restricts the ability of some defendants to demonstrate that they are, in fact, innocent of having committed the offense with the required state of mind.

[161] Ohviously, not all testimony proffered as expert opinion should be admissible. In Smith v. State, 564 P.2d 1194 (Wyo. 1977), Mrs. Smith was convicted of second degree murder for killing the woman with whom her husband was having an affair. After waiting for several hours outside the motel where the liaison was occurring, the defendant, carrying her pistol, knocked on the door of her husband's room. After a heated argument with her husband, Mrs. Smith returned to her car and followed the victim's car to her home, where Mrs. Smith shot the victim. A few minutes later, Mrs. Smith called the police.

At trial, Mrs. Smith proffered the testimony of a psychologist who would have testified that she was "near hysterical," in a "total panic state," and "did not really have control of her mental faculties" on the morning of the shooting because her marriage was breaking up and her husband was having an affair. *Id.* at 1199 n.2. He also would have testified tbat she "had no intent to kill or harm" the victim. *Id.* The sole basis of his opinion was an interview with Mrs. Smith, the content of which was identical to her testimony at the trial. *Id.* at 1199.

The Wyoming Supreme Court held that this evidence was properly excluded by the trial court. We agree. The proffer did not indicate that the witness based his opinion on any insights or information not available to the jury. He was simply reacting as a thirteenth

sary or even an important element of most clinical testimony relevant and helpful to a factfinder in determining a person's mental state at the time of an offense.[162]

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juror to the defendant's claim that she was so distressed that she didn't "really" intend to kill the victim. Even if the testimony were proffered to support a claim of "extreme mental or emotional disturbance" in connection with a manslaughter instruction, we see no basis for an expert opinion in this case.

The extent of judicial confusion regarding expert testimony on mens rea is reflected in the *Smith* opinion. Although the court first announced the proper basis for the decision—that the proffer did not satisfy the generally applicable criteria for expert testimony, *see id.*—it went on to state a sweeping exclusionary principle for mental health testimony: "The state of mind of the accused is a proper subject for expert testimony when the defense is based on insanity but not when not based on such a plea." *Id.* at 1200. Moreover, it added, "A doctor who was not a witness to the crime and does not have first-hand knowledge of a defendant's state of mind at the time of the offense, may not give his opinion as to what such mental state—intention—was." *Id.* As we have tried to show, this is an unfair restriction of a defendant's opportunity to prove his innocence, and cannot be justified in terms of either evidentiary doctrines or the policies of the substantive criminal law.

[162] Assume *D*, charged with attempting to commit an act of gross indecency with another male, claims that he believed his companion was a woman. In support of his defense, *D* proffers psychiatric testimony that he has a strong aversion to homosexuality, would be highly unlikely to engage in such behavior knowingly, and probably would react violently if confronted with a homosexual advance. *See* R. v. Lupien [1970] Can. S. Ct. 263 (1969). Since *D* is proffering a clinical opinion that he probably lacked the requisite knowledge to be guilty of the offense, this case could be analyzed as a "diminished capacity" case. As such, the evidence might be excluded on the ground that *D* had no mental disease or defect—unfairly so, as we argue in the text.

Yet the case may also be analyzed as a character evidence case, possibly with different results on the admissibility question. Courts are increasingly permitting clinical testimony, whether or not based on an identifiable mental disease, when introduced as character evidence to show whether a person with particular character traits could have committed the crime in question. *See* United States v. Staggs, 553 F.2d 1073, 1075 (7th Cir. 1977) (testimony by psychologist that defendant was more likely to hurt himself than others held relevant on issue of ability to form intent to assault with a deadly weapon); O'Kon v. Roland, 247 F. Supp. 743 (S.D.N.Y. 1965) (psychiatric testimony admitted on question of tendency to, or capacity for, sexual deviation); Waine v. State, 37 Md. App. 222, 377 A.2d 509 (1977) (psychiatric testimony that the defendant was a passive person and unlikely to commit a violent act held relevant to issue of whether defendant committed murder). The Federal Rules of Evidence reflect what is apparently the law in most jurisdictions. FED. R. EVID. 404 (Advisory Comm. Note). Rules 404 and 405 permit opinion evidence of a "pertinent" trait of an accused's character if proffered for the purpose of proving that he acted in conformity with that trait. FED. R. EVID. 404, 405. Although use of psychiatric opinions on the issue of character has been criticized, *see* Falknor & Steffen, *Evidence of Character: From the "Crucible of the Community" to the "Couch of the Psychiatrist,"* 102 U. PA. L. REV. 980, 1005 (1954), a growing number of courts appear to agree with Professor Curran that "the evidence of a psychiatrist as to a person's personality traits should be more valuable to a jury's deliberations than the glowing praises of his personal friends." Curran, *Expert Psychiatric Evidence of Personality Traits*, 103 U. PA. L. REV. 999, 1004-05 (1955).

Notwithstanding our general opposition to wholesale exclusion of clinical testimony, we

These same observations should govern the admissibility of expert opinion testimony in connection with the subjective elements of affirmative defenses. Claims of self-defense provide the most recurrent examples. A defendant pleading self-defense must show that he actually believed himself in imminent danger of death or serious bodily harm; whether or not the belief also must be reasonable, the subjective inquiry is essential. In most cases involving self-defense claims, mental health professionals will have no special understanding of the defendant or of the situational dynamics, and there will be no basis for an expert opinion. As in the mens rea context, however, the propriety of such testimony should not turn on whether the witness will testify that the defendant had a mental disease or defect.[163] Rather, the criteria should be whether the expert's opinion about the defendant's probable mental state is based on specialized knowledge, and whether it will assist the jury.[164]

A recent decision by the District of Columbia Court of Appeals, *Ibn-Tamas v. United States*,[165] illustrates this point. The defendant, charged with murdering her husband, claimed that she did so in self-defense. She presented evidence that her marriage had involved cyclical periods of violence and relative harmony, and that her husband had physically abused her.[166] She testified that on the morning of the shooting, her husband hit her, threatened her with a gun, and ordered her to leave the house.[167] The evidence showed that he left the house and subsequently returned. The defendant testified that she shot her husband while attempting to escape what she feared would be a renewed attack.[168] The government presented testimony suggesting that the defendant lured her hus-

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are not sanguine about this trend. Opinions about character have no intrinsic threshold of clinical or legal significance. Such testimony verges on an assessment of whether the defendant is "good" or "bad." Only clinical testimony directly relevant to the defendant's mental state at the time of the offense should be admissible, because "[t]he business of the court is to try the case and not the man." Thompson v. Church, 1 Root 312 (Conn. 1791).

[163] *Compare* State v. Upton, 16 Wash. App. 195, 556 P.2d 239 (1979) *with* Commonwealth v. Light, 458 Pa. 328, 326 A.2d 288 (1974).

[164] *See, e.g.*, State v. Ellis, 89 N.M. 194, 548 P.2d 1212 (1976).

[165] 407 A.2d 626 (D.C. 1979).

[166] *Id.* at 629.

[167] *Id.* at 630.

[168] *Id.*

band back into the house and ambushed him.[169]

In its cross-examination of the defendant, the prosecution suggested that her account of her relationship with her husband had been exaggerated and that her claimed perception that she was in imminent danger of death when he returned was implausible. "The government also implied that the logical reaction of a woman who was truly frightened by her husband (let alone regularly brutalized by him) would have been to call the police from time to time or to leave him."[170]

The defendant proferred testimony by Dr. Lenore Walker, a clinical psychologist who had conducted a study of 110 women who had been severely beaten by their husbands. Dr. Walker also had evaluated the defendant. In her clinical study Dr. Walker found that the wives' relationships with their husbands reflected similar patterns of cyclical abuse;[171] that even though the women felt increasingly endangered, most of them failed either to tell anyone or to seek help;[172] and that husbands commonly escalated their abusiveness when their wives were pregnant. The study led Dr. Walker to identify and describe the "battered wives syndrome." On the basis of her interview with the defendant, Dr. Walker concluded that hers was a "classic case" of this syndrome.[173]

The relevance and probative value of Dr. Walker's testimony is clear. If believed, it would have tended to support the defendant's claim that she felt herself in imminent danger at the time of the shooting, and to explain her failure to seek help. Nonetheless, the trial court excluded Dr. Walker's testimony on the ground that it would have invaded the province of the jury.[174]

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[169] *Id.* at 631.

[170] *Id.* at 633-34.

[171] "[Dr. Walker's] studies revealed three consecutive phases in the relationships: 'tension building,' when there are small incidents of battering; 'acute battering incident,' when beatings are severe, and 'loving-contrite' when the husband becomes very sorry and caring." *Id.* at 634.

[172] Unless a shelter is available, these women stay with their husbands, not only because they typically lack a means of self-support, but also because they fear that if they leave they will be found and hurt even more. . . . [B]attered women are very reluctant to tell anyone that their husbands beat them. Of those studied, 60% had never done so before (Dr. Walker typically found them in hospitals), 40% had told a friend, and only 10% had called the police.

Id.

[173] *Id.*

[174] *Id.* at 635.

Because the witness had not been asked to express an opinion on the ultimate fact in issue—whether the defendant believed she was in imminent danger when she shot her husband[175]—the court of appeals concluded the basis for the trial judge's ruling must have been that the subject of the proffered expert testimony was not "beyond the ken of the average layman."[176] Despite the wide discretion generally accorded trial judges when ruling on the admissibility of expert testimony, the court ruled that the exclusion of Dr. Walker's testimony on this ground was erroneous as a matter of law.

The proper question, the court explained, is whether Dr. Walker's testimony would have provided "a relevant insight which the jury otherwise could not gain in evaluating [the defendant's] self-defense testimony about her relationship with her husband."[177] Because the proffered testimony "would have supplied an interpretation of the facts which differed from ordinary lay perception ('she could have gotten out, you know') advocated by the government,"[178] the court concluded that the evidence could not be excluded on the ground that it was within the ken of the average layman.[179]

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[175] The witness testified only that the defendant was a "classic case" of the battered wife syndrome. *Id.* at 634. Suppose she had also stated that: "Based on the defendant's descriptions of her relationship with her husband and her account of his behavior on the day of the offense, all against the backdrop of the clinical literature and the defendant's own personality functioning, it is highly likely, in my opinion, that she panicked when her husband returned, feeling herself and her fetus in imminent danger of death or grave bodily harm." Expression of this opinion would have been permissible under the Federal Rules of Evidence, *see* note 162 *supra,* and since no value judgment is involved on the subjective aspect of the test, we see no reason to exclude it.

[176] *Id.* at 633.

[177] *Id.*

[178] *Id.* at 634-35.

[179] *Id.* at 635. It remains possible of course that Dr. Walker's insight, however interesting and however different from an untutored lay perception, is not any more "expert" than a lay opinion and is therefore inherently misleading. Hers is merely another opinion, however thoughtful, and however nicely wrapped with the trappings of science.

On appeal in *Ibn-Tamas,* the government argued on the basis of the *Frye* test, *see* note 121 *supra,* endorsed by the D.C. Court of Appeals in Dyas v. United States, 376 A.2d 827 (D.C.), *cert. denied,* 434 U.S. 973 (1977), that "the 'battered woman' concept is not sufficiently developed, as a matter of commonly accepted scientific knowledge, to warrant testimony under the guise of expertise." 407 A.2d at 637. The government's argument here thus is similar to Morse's: like most of the clinical concepts used in the mental health field, including diagnostic categories, the "battered woman" concept is based on the interpretation of patterns which emerge from a composite of clinical studies. The basic clinical meth-

Ibn-Tamas, like Ms. B's case, highlights a common feature of clinical testimony on mens rea. It is proffered to provide a plausible alternative to "normal" assumptions about conscious motivation. Because laymen do not deal with abnormal behavior on a day-to-day basis, their intuitions are skewed in the direction of normal behavior, and they favor commonsense explanations for departures from the norm. Mental health professionals, on the other hand, deal constantly with abnormal behavior and are trained to consider explanations that do not proceed from commonsense analysis. Although it is possible that the intuitions and hypotheses of experts may be skewed toward pathological explanations for abnormal behavior, it cannot be said that they add nothing of value to the common sense of the layman.

3. *Insanity and Diminished Responsibility: The Problem of Explaining Behavior*

The insanity defense and the doctrine of diminished responsibility rest on the assumption that abnormal psychological functioning can, in some cases, be sufficiently "predisposing" to absolve or reduce personal responsibility. The trend toward structured sentencing increases, rather than decreases, the likelihood that additional psychological "explanations" for criminal behavior will be accorded explicit mitigating significance.[180]

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odology and the interpretive tools are the ones employed throughout the field.

Any inferences drawn by Dr. Walker about the alternative actions psychologically available to Mrs. Ibn-Tamas before and during the offense were speculations informed by the available clinical literature (in this case her own) and the concepts commonly used in the interpretation of intrapsychic and interpersonal processes. The question is where the threshold for expert opinion by mental health professionals ought to lie. Is informed speculation—"educated guesswork" was Judge Bazelon's characterization, *see* note 191 *infra*—enough? If so, analysis of abnormal behavior based on the available clinical literature and commonly used interpretive concepts must be accepted. The court so held in *Ibn-Tamas;* the test of general scientific acceptance "focuses on the general acceptance of a particular methodology in the field, not . . . on the subject matter studied. . . . [It] deals with the 'state of the art' of inquiry, not with the quantity of substantive knowledge." 407 A.2d at 638.

Because of the confused state of the record, the appellate court remanded the case for a determination of admissibility in light of the discussion in its opinion. *See id.* at 640. Because the decision regarding admissibility of expert testimony depends on a variety of factors on which the trial judge had not ruled, the appellate court contented itself with the observation that Dr. Walker's methodology was not inadequate as a matter of law. The clear implication of the opinion, however, is that the methodology *is* adequate as a matter of law.

[180] *See* note 72 *supra* and accompanying text.

In this setting the "factual" inquiry concerns the relationship, if any, between a defendant's aberrational psychological functioning and his behavior. We agree that categorizing the strength of that relationship, and evaluating it according to some externally derived moral gradient, is the responsibility of the judge or jury and not an appropriate subject for expert opinion.[181] Professor Morse's exclusionary approach to expert testimony, however, also would preclude an expert from expressing any opinion regarding why a relationship may or may not exist between the defendant's psychological functioning and his criminal behavior.[182] We think this would unnecessarily deprive the factfinder of helpful insights and would unfairly hamper the defendant's effort to present a case-in-exculpation or -mitigation.[183]

Morse refers to the famous *Gorshen*[184] case to illustrate his rationale. Gorshen shot his supervisor after a fight at work. A psychiatric witness testified that Gorshen was a chronic paranoid schizophrenic who for twenty years had experienced trances accompanied by auditory and visual hallucinations. He claimed to see and hear devils in disguise committing abnormal sexual acts,

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[181] *See* notes 98-102 *supra* and accompanying text.

[182] *See* notes 9-26 *supra* and accompanying text.

[183] Morse makes an exception for the "special case" where "an objectively identifiable physical variable such as a brain tumor is clearly causally related" to the criminal behavior even though probability data regarding the percentage of individuals with such physical conditions who behave in specific "legally relevant" ways are not available, and even though "judges and juries will overweigh the uncontrollability of physical causes." Morse, *supra* note 9, at 618 n.193. We think this exception highlights the fundamental difficulty with Morse's analysis. His distaste for the imprecision and hypothetical quality of psychological concepts, which by nature defy measurement and verification, leads him to undervalue the defendant's interests in introducing such testimony, to exaggerate the risk of expert dominance, and to overlook the wide substantive sweep of his proposals. Yet, simply because "physical" variables can be identified and measured, he exempts these from the exclusionary rule—even though many experts doubt the linkage between many organic conditions, such as epilepsy, and criminal behavior, and even though the risk of misleading the jury is substantial. Indeed, the case for excluding opinions regarding the physical variables may actually be stronger than it is for excluding opinions regarding psychological variables. As we have noted, *see* notes 110-123 *supra* and accompanying text, we do not think there is a significant risk that psychiatric testimony in exculpation or mitigation will mislead the factfinder; jury and judge behavior consistently demonstrates that they will discard a psychiatric explanation if it fails to make intuitive sense. On the other hand, our experience at the Forensic Clinic strongly suggests that factfinders are demonstrably less skeptical about organically-based explanations and are likely to give undue weight to an expert opinion about the brain.

[184] People v. Gorshen, 51 Cal. 2d 716, 336 P.2d 492 (1959).

sometimes upon Gorshen himself. These experiences had intensified during the months before the crime.[185]

On the day of the shooting, Gorshen had been drinking at work. His supervisor told him to go home, and a fight ensued. He then went home, obtained a pistol, returned, and shot the victim. According to the psychiatrist, Gorshen said, "All I was thinking about all of this time is to shoot O'Leary. I forgot about my family, I forgot about God's laws and human's laws and everything else. The only thing was to get that guy, get that guy, get that guy, like a hammer in the head."[186]

The expert witness explained that during the period of the offense Gorshen was driven by an obsessive murderous rage aroused by the stress of the beating and by what he perceived as challenges to his manhood. Psychologically, this rage reflected a desperate attempt to ward off imminent and total disintegration of his personality:

> The strength of the obsession is proportioned not to the reality of danger but to the danger of the insanity. . . . [F]or this man to go insane means to be permanently in the world of these visions and under the influence of the devil. . . . [A]n individual in this state of crisis will do anything to avoid the threatened insanity . . . .[187]

Professor Morse questions the highly speculative quality of this formulation, pointing out that no "hard data" support the hypothesis "that the killing was the inexorable or nearly inexorable result of threatened ego-disintegration,"[188] and that probably very few persons with such fears kill, although there are no data available.[189] Of course, both of these points could have been made very effectively by skillful cross-examination. Skillful redirect examination in response might have brought out the psychodynamic concepts from which this formulation was derived, perhaps with descriptions from the clinical literature of the characteristics of violent behavior committed by individuals with comparable paranoid thought patterns.

Morse characterizes the *Gorshen* expert's testimony as "really a

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[185] *Id.* at 722, 336 P.2d at 495.
[186] *Id.* at 723, 336 P.2d at 496.
[187] *Id.* at 722, 336 P.2d at 496 (quoting expert witness).
[188] Morse, *supra* note 9, at 618-19.
[189] *See id.* at 619.

moral guess and not a scientific fact."[190] Although explanatory clinical formulations by careful forensic specialists are hardly "scientific facts," they do represent something more than idiosyncratic "guesses." Such witnesses offer "informed speculation,"[191] essentially in the following form:

> I cannot assure you that this is what happened, and I cannot measure for you the impact that these intrapsychic variables had on the defendant's behavior under the circumstances which existed at the time of the offense. Nonetheless, based on our operating theories of psychology, which we employ in our everyday clinical practice, and on my own study of the relevant literature concerning this type of psychological functioning and this type of criminal behavior, I think the following explanation(s) are possible (or probable).

These explanatory formulations can assist the factfinder, who must speculate in any event, by identifying "clinically reasonable" possibilities that otherwise may not occur to him. Appropriately instructed, the jury will know that these explanations are only possibilities and will not be misled.[192]

Expert opinion can offer valuable assistance not only by suggesting explanations for puzzling behavior, but also by gathering and marshalling information that otherwise might appear random or of questionable significance. The expert may suggest a conceptual framework that, if accepted by the factfinder, can serve as an organizational and interpretational tool that neither the factfinder nor counsel could have supplied. A case evaluated by the Forensic Psychiatry Clinic may prove instructive. Mr. Z was a twenty-three-year-old artist who had committed six attempted rapes over a period of six years. He had been apprehended during the course of the sixth crime. Mr. Z's attorney was chiefly interested in an assessment of Mr. Z's mental state at the time of these offenses.

Mr. Z was able to recall in detail each of his offenses. He stated

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[190] *Id.*

[191] *See* Bazelon, *A Jurist's View of Psychiatry*, 3 J. PSYCH. & L. 175, 181 (1975) ("The 'educated guess' that psychiatrists provide—and it is only an educated guess—is only as good as the *investigation*, the *facts*, and the *reasoning* that underlie it.").

[192] The *Gorshen* trial judge stated that "up till the time that [the defense expert] testified in this case, there was no explanation of why this crime was committed. . . . [He is] the first person that has any reasonable explanation. Whether it's correct or not, I don't know." 51 Cal. 2d at 725, 336 P.2d at 497.

that before each assault he had felt a powerful "impulse," though he had trouble describing its exact nature.[193] He selected his victims entirely at random, entering their homes through unlocked front doors. He always became "scared" after entering these homes, but could not make himself leave. During the course of the assault itself, he would be "horrified" at what he was doing, but felt he could not stop. He never actually raped his victims. He explained that he had been too "scared and angry with myself" to do so. On two occasions he apologized to his victim after the assault.

During his interviews at the Clinic, Mr. Z did not evidence any overt signs of "craziness." He appeared to be an intelligent, articulate young adult. The single most noticeable behavioral fact was his constant reference to the hopelessness of his situation. He mentioned thinking of suicide several times. When this line of inquiry was pursued, he reported having had such thoughts for a number of years. He had "hated" himself for as long as he could remember and felt he had very little to offer others. Descriptions of Mr. Z from his friends and excerpts from his journals indicated that he had isolated himself socially, neglected his work, and suffered long periods of depression.

By investigating Mr. Z's family history, the Clinic staff compiled additional relevant material. It appeared that Mr. Z's father had been extremely demanding of his son, constantly implying that Mr. Z had failed to meet his perfectionist standards. In addition, the father, who had devoted his life to his responsibilities as a hard-driving executive, admitted that on several occasions he had overreacted to trivial disciplinary infractions by Mr. Z. At these times he would "choke" his son by holding him in the air by his neck. Asked about these incidents, Mr. Z recalled that he had been terrified of his father during these rages. He recounted having nightmares of his father's face "exploding" due to some unexplained transgression on Mr. Z's part.

It also became apparent from talking to Mr. Z's family that his parents' sexual relations had been extremely strained. Mr. Z's mother abhorred sex and would rarely consent to engage in intercourse with her husband. On those occasions when he persisted, she would submit unwillingly, calling him "pig," "bastard," and

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[193] As he put it, "there was a feeling of real power and hate and anger . . . I was really excited sexually. You know, I just felt . . . there is a word, I can't think of it."

other epithets. As a small boy Mr. Z witnessed many of these episodes from an adjacent room and became extremely disturbed by his parents' actions.

Under Professor Morse's scheme, which admits into evidence only behavioral observations and probability data, the foregoing material would constitute all of the information available to the factfinder in reaching a conclusion about Mr. Z's "normality" and the psychological explanation for his offense.[194] In determining whether additional expert input might assist the factfinder, it is interesting to examine the inferences drawn from these facts by the Clinic staff.

The Clinic concluded that, largely due to his father's harsh treatment and his mother's neglect, Mr. Z had suffered from chronic depression throughout his adolescent years and had developed abnormally low self-esteem. Based on this perception of Mr. Z's symptomatology, the Clinic made the following observations:

> One of the characteristics of chronic depression in young adults is the unconscious desire to create situations and experiences which will perpetuate one's depression and masochistically confirm the low self-image that is inextricably bound up with such a depression. . . . Many of Z's acts in the past years can be seen as subliminal attempts at denigrating his worth as an individual; this urge toward self-degradation was aimed at symbolically repeating the debasement Z was subjected to at the hands of his parents, most significantly his father.

Applying this analysis of Mr. Z to his actions during the attempted rapes, the Clinic stated:

> Given Z's psychosexual development, the result of Z's drive toward self-degradation was his preoccupation with sexual aggression. Seeing his parents virtually do battle each time they had intercourse led Z, on an unconscious level, to equate sex with violence and degradation. The attempted rapes can be seen as an impulsive acting out of an unconscious desire to prove himself a "bad" person.

Several levels of inference are at work here, each building on the preceding stage. The reasoning progresses from reported or observed facts and symptoms, to an explanation for these symptoms,

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[194] In Mr. Z's case, the case for mitigation was made at sentencing after pleas of guilty to several of the charges.

to an hypothesis, based on the staff's theoretical and practical knowledge of human behavior, of how Mr. Z's psychological dysfunction might have affected his behavior and ultimately the specific conduct involved in his offense.

The Clinic's formulation of Mr. Z's behavior, while admittedly unverifiable in the scientific sense, offers informed speculation based on concepts of intrapsychic functioning generally accepted by clinicians who subscribe to the theoretical premises of psychodynamic psychology. It might help the factfinder to understand what otherwise might appear to be inexplicable acts. If believed, it might be regarded as probative and helpful on the issue of the defendant's ability to control his conduct. Moreover, the organizing value of this testimony is apparent. Family, psychiatric, medical, and personal history are linked together into a coherent whole. If the clinician were not allowed to express any inferences or opinions concerning his observations, the factfinder would be left with fragments of data that may actually confuse rather than enlighten. Indeed, without the clinician present to indicate its significance, some of the data discussed in the Clinic's evaluation might not be considered admissible at all.[195]

The explanation for Mr. Z's behavior is not intuitively obvious.[196] We have no doubt that the motivations for his behavior would remain obscure to the untrained layman, even if the factual information were presented.[197] To the extent that the law is inter-

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[195] *See generally* A. GOLDSTEIN, *supra* note 63, at 19. Family history information, for instance, would perhaps be considered irrelevant by a court if there were no clinician to show a connection between the history and the offense. Even if considered relevant, its probative value would be lessened because no clinical opinion would be available to render it significant. In such cases, the court might decide the evidence is inadmissible because it will waste time or confuse the jury.

[196] In Mr. Z's case, the only intuitively apparent explanation for his behavior is that he was seeking sexual gratification; even though the circumstances of the offeuses may be inconsistent with this explanation, the likely tendency of the layman is to believe it unless the defendant offers a plausible alternative. Further, it seems likely that the motivations for Z's behavior would still remain obscure to the untrained layman even after the "factual" information was presented by the expert. In the absence of some alternative hypothesis or some additional insight, the factfinder is likely to see no basis for questioning Mr. Z's capacity to "control" his behavior as a normal person would.

[197] A defendant who suffered from acute psychological aberration at the time of an offense will not necessarily display to the jury the symptoms of that aberration, *e.g.*, delusions, hallucinations, disorientation, assaultive behavior, or extreme withdrawal.

> He will act and sound quite rational and will exhibit no bizarre behavior. . . . The expert . . . will have to take the jury deep into the nature of mental illness if it is to

ested in the psychological antecedents of a defendant's criminal behavior, it must give him a reasonable opportunity to offer an explanation.[198] We see no reason to doubt the factfinder's ability to assess the weight and the exculpatory or mitigating significance of any such explanation. To exclude the only available source of informed opinion would both prejudice the defendant and confuse the factfinder.

C. Summary

We do not agree with Professor Morse that "the categories and theories of mental health science are at present too imprecise and speculative to help clarify legal questions"[199] concerning a criminal defendant's psychological functioning at the time of an alleged offense. The categories and theories of laypersons about mental dysfunction and human behavior may draw heavily on "common sense," but they are also informed by superstition, fear, and popular wisdom. If relevant opinion testimony by otherwise qualified forensic specialists is based on conceptual models of description and explanation generally accepted and employed within the field, it satisfies the generally applicable criteria for expert testimony even though the subject of the opinion is not wholly outside lay experience and even though the expert's operating theories have not been scientifically verified. So long as the expert is sensitive to

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understand in a meaningful way that men who look and act like us may really be seriously diseased.

A. GOLDSTEIN, *supra* note 63, at 25-26.

[198] The law could choose to be uninterested in the explanation for Mr. Z's behavior, so long as he consciously intended to do what he did. More specifically, the law could be uninterested in any claim by Mr. Z that his capacity to exert control over his behavior was compromised by abnormal intrapsychic forces, whether or not the abnormality is appropriately characterized as a mental disease. In a jurisdiction with no insanity defense or only with the *M'Naghten* defense, Mr. Z's proffered explanation is without any conceivable exculpatory significance. But, in any jurisdiction that opens the door to claims of volitional impairment, the law has at least invited Z to proffer an explanation if it is linked to significant intrapsychic abnormality.

Whether or not it is said to be linked to severe mental disorder, Mr. Z's explanation for his behavior is of undeniable relevance in the sentencing process. Putting aside predictive considerations, a just punishment for Mr. Z may depend on whether "substantial grounds exist tending to excuse [his] criminal conduct" or on whether he "was suffering from a mental condition . . . that significantly reduced his culpability for the offense" or on whether he committed the offense "to gratify [his] desire for pleasure or excitement." *See* MODEL SENTENCING ACT, *supra* note 46, §§ 3-107, -108.

[199] Morse, *supra* note 9, at 604.

the limits of his specialized knowledge and, in particular, is not permitted to express opinions on ultimate issues involving moral judgments, his informed speculation can help clarify the alternative lines of explanation and thereby assist the factfinder to assess the plausibility and significance of the defendant's claim of mental abnormality.

Moreover, in the context of the reconstructive inquiries of the criminal law, the risk that a jury will give undue weight to such an expert opinion, notwithstanding any cautionary instructions, has been grossly exaggerated. If only the defense has offered psychiatric testimony, the natural skepticism of the jurors, and the corrective value of cross-examination, virtually eliminate the risk that the jury will abdicate its factfinding function to the experts. If each side has its own witness, expert "dominance" is not the problem, and the risk of confusion can be minimized by adequate preparation by counsel and by ordinary judicial supervision. In short, we see little disadvantage in admitting appropriately restricted opinion testimony by qualified mental health professionals.

Most important, the wholesale exclusion of such testimony would unduly restrict the defendant's opportunity to present relevant evidence in his defense, and would enhance the natural advantage enjoyed by the prosecution on reconstructive issues. In particular, a defendant's opportunity to carry his de facto burden of proving that he did not perceive, believe, expect, or intend what a normal person would have under the same circumstances—and that he therefore lacked the mens rea required for the offense—is undermined by rules which altogether exclude qualified opinion testimony or which allow such testimony only if the expert finds that the defendant's abnormal functioning was attributable to a mental disease or defect. Similarly, a defendant's opportunity to offer a plausible explanation for his behavior—and thereby to establish a meaningful case in exculpation or mitigation under the applicable responsibility doctrines—would be restricted severely and unjustifiably by rules that exclude explanatory formulations by qualified mental health professionals.

Whether it would be unfair to the public to restrict the use of clinical opinion testimony when the state seeks to establish the predicate for coercive intervention or enhanced punishment is an

altogether separate question.[200] As we observed above,[201] the imprecision of concepts such as "mental illness" and "dangerousness," and the speculative quality of the inquiry, raise serious questions of unconstitutional vagueness when they constitute the sole predicate of criminal liability, committability or significantly enhanced punishment.[202] Even if we assume that these determinations are sufficiently precise and reliable to establish a constitutional predicate for the prescribed intervention, whether commitment or punishment, it does not necessarily follow that the state should be permitted to prove its case with clinical opinion testimony, even if the knowledge of the expert is superior to that of the layman.

In the contexts of civil commitment[203] and predictive sentencing

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[200] Many of the commentators who recently have recommended the exclusion or restriction of clinical opinion testimony have been responding to the special risks associated with such testimony when it is offered on behalf of the state in civil commitment proceedings, *see, e.g.*, Ennis & Litwack, *supra* note 74; Morse, *supra* note 9, at 624-40, or in connection with predictive determinations in criminal sentencing proceedings, *see, e.g.*, N. MORRIS, *supra* note 7; A. VON HIRSCH, *supra* note 5; Perlman & Stebbins, *supra* note 6. The critics have been especially disturbed by predictions of dangerousness under capital sentencing statutes. *See, e.g.*, Bonnie, *supra* note 39; Dix, *supra* note 66.

[201] *See* notes 18-33 *supra* and accompanying text.

[202] *See* Brooks, *Notes on Defining the Dangerousness of the Mentally Ill*, in DANGEROUS BEHAVIOR, A PROBLEM IN LAW AND MENTAL HEALTH 37 (C. Frederick ed. 1978); Shah, *Dangerousness: Some Definitional, Conceptual and Public Policy Issues*, in PERSPECTIVES IN LAW AND PSYCHOLOGY (B. Sales ed. 1977).

[203] Empirical investigations of civil commitment proceedings typically find that the "hearing" consists primarily of opinion testimony by mental health professionals who ordinarily testify in conclusory language about the ultimate issues in the case. Attorneys representing the patient-respondents generally play a passive role; cross-examination of the expert is, at best, perfunctory. The judges routinely defer to clinical judgment. *See generally* Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and A Proposal*, 45 MISS. L.J. 43 (1974); Morris & Luby, *Civil Commitment in a Suburban County: An Investigation by Law Students*, 13 SANTA CLARA LAW. 518 (1973); Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 96 (1971); Note, *Constitutional Problems of Civil Commitment Procedures in New Mexico*, 6 N.M. L. REV. 113 (1975).

The United States Supreme Court has only recently begun to confront these problems. *See* Parham v. J.R., 442 U.S. 584 (1979); Addington v. Texas, 441 U.S. 418 (1979). In the Court's opinion in *Parham*, Chief Justice Burger observed:

> Although we acknowledge the fallibility of medical and psychiatric diagnosis, . . . we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that

adjudications, restriction, or even exclusion, of such testimony may be necessitated by the demonstrated tendency of clinicians to overdiagnose mental illness and overpredict recidivism and of laymen to give undue weight to expert opinions in such legal settings.

In any event, it is clear that the problems associated with the use of experts in these contexts are considerably different from those encountered when the criminal defendant offers clinical testimony in support of a claim of abnormal mental functioning at the time of the alleged offense. We emphasize, again, that our observations in this section are limited to a single substantive context—the reconstructive inquiries of the criminal process initiated by defendants who claim that their psychological abnormalities have exculpatory or mitigating significance.

Even in this context, however, we are mindful of the risks of confusion, error, and abuse which accompany clinical participation in the legal process. We have made a case against evidentiary rules of exclusion; but we have assumed, at every point along the way, that the proffered testimony is offered by a qualified forensic specialist who has performed a thorough evaluation. Like Professor Morse, we are troubled by the poor quality of much clinical testimony which seems to rely more heavily on the assertion of Aesculapian authority than on proven expertise. If clinical testimony, in the aggregate, is to enlighten rather than confuse or obstruct the administration of criminal justice, the courts will need to pay greater attention to the qualification of expert witnesses than is now ordinarily the case. In doing so, they can be much benefited by the developing efforts of the mental health professions to clarify the requirements of forensic specialization and to formulate specific methodological and ethical requirements for the forensic discipline. As a modest contribution to this effort, we will present, in Part III, several guidelines concerning the forensic evaluation process based on our experience at the Forensic Psychiatry Clinic.

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the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.

442 U.S. at 609.

In the context of "civil" commitment of persons acquitted by reason of insanity, the issues are similar to those raised in connection with "pure" civil commitment, but they are complicated hy the unresolved philosophical questions concerning the justifications for, and boundaries of, such commitments. *See* Burt, *supra* note 11.

III. Improving the Quality of the Forensic Evaluation: Some General Principles

The "ideal" forensic evaluation procedure should satisfy two aims. First, it should afford the evaluator maximum access to relevant, reliable information about the subject and his alleged antisocial behavior. Second, it should facilitate objectivity in the interpretation of this information. In this section we describe some obstacles to the attainment of these goals, and explore some methods of overcoming them. We do not purport to describe the perfect evalution procedure; much research must be carried out before more than tentative proposals can be advanced. We do hope to contribute to the dialogue between the legal and mental health professions concerning the most effective way to promote informed and reliable clinical speculations and insights.

A. The Data Collection Process

The defendant is of course the primary source of information in any forensic evaluation. Data provided by family members, witnesses, and documentary material, however, may prove equally significant. It is also imperative that the evaluator, having gained]ho]access to these sources, be adept at both gleaning sufficient information and gauging the reliability of that information. Accordingly, this section examines the data collection process from three perspectives: problems that can arise in accumulating data from the defendant, the legal implications of using "third party" sources of information, and the possible ways in which the characteristics of the evaluator can affect the information obtained.

1. The Defendant as a Data Source

The forensic clinician should never deliver an opinion about the mental condition of a criminal defendant whom the clinician has not personally interviewed. Neither the factual predicates of "hypothetical" questions, nor observation of courtroom behavior or testimony, nor review of the interview records of other clinicians can provide an adequate clinical base for formulation of an expert opinion about a person's mental condition.[204] Moreover, even a

[204] Authors of the leading texts on forensic psychiatry and psychology take for granted that the clinician will interview the subject before testifying about him. *See, e.g.*, H. David-

personal evaluation may not yield an adequate clinical base if legal and other situational factors impede unrestricted and undistorted communication.

a. Reconciling the Fifth and Sixth Amendments

The most powerful legal disincentive to full disclosure is the defendant's fear that what he says during the forensic evaluation will be used against him in court. If the legal system values a thorough forensic evaluation, it must encourage the defendant's full cooperation. Yet, in many jurisdictions, the law tends to have the opposite effect because it fails to accommodate the defendant's sixth amendment right to explore and present a defense and his fifth amendment right to remain silent.

The sixth amendment entitles a defendant to a competent forensic evaluation for the purpose of assisting him and his attorney in exploring and presenting any available defense based on psychological aberration. When the defendant is affluent, counsel can easily retain one or more private clinicians to conduct such an evaluation. It is well established that in such circumstances the defendant's utterances to the examining clinician are protected from prosecution discovery by the attorney-client privilege, until such time as the defense waives that privilege by presenting expert testimony as part of its case.[205] Although most states do not pro-

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SON, FORENSIC PSYCHIATRY 35-62 (2d ed. 1965); J. MACDONALD, PSYCHIATRY AND THE CRIMINAL 56-65 (2d ed. 1969); R. SADOFF, FORENSIC PSYCHIATRY 25-28 (1975); Pollack, *Psychiatric Consultation for the Court*, 1 BULL. AM. ACAD. PSYCH. & L. 267, 270-75 (1973). Clinicians nonetheless are often permitted to testify (traditionally in answer to a hypothetical question but also, in recent years, in response to direct questions as well) about a defendant whom they have never personally examined. *See, e.g.*, People v. Bassett, 69 Cal. 2d 122, 443 P.2d 777, 70 Cal. Rptr. 193 (1968); Stato v. Wangberg, 272 Minn. 204, 136 N.W.2d 853 (1965). Such testimony is "of doubtful worth and often of dubious ethical quality." Diamond & Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations*, 63 MICH. L. REV. 1335, 1347 (1965).

[205] *See, e.g.*, United States v. Alvarez, 519 F.2d 1036 (3d Cir. 1975); United States *ex rel.* Edney v. Smith, 425 F. Supp. 1038 (E.D.N.Y. 1976); Houston v. State, 602 P.2d 784 (Alaska 1979); People v. Lines, 13 Cal. 3d 500, 531 P.2d 793, 119 Cal. Rptr. 224 (1975); Pratt v. State, 39 Md. App. 442, 387 A.2d 779 (1978).

An unresolved question is whether the privilege is waived by a decision to present *any* clinical testimony or whether the disclosures remain protected until the defendant calls the examining expert himself. That is, can the affluent defendant "shop" until he finds a suitable clinical opinion and by asserting the attorney-client privilege prevent the state from access to experts the defendant chooses not to use? The courts are divided on this issue. In United States *ex rel.* Edney v. Smith, 425 F. Supp. 1038 (E.D.N.Y. 1976), the court ruled that upon asserting an insanity defense, the defendant waived the protection of the privilege

vide explicitly for expert assistance to the indigent defendant who contemplates a defense based on mental aberration, in practice most appear to provide access to a forensic evaluation, usually in the state forensic unit.[206] To do otherwise would vitiate the right of indigent defendants to effective assistance of counsel.[207] By per-

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as to *all* of the experts consulted; otherwise, the court felt, the defense would be able to suppress unfavorable experts while shopping around for an expert that supported its position. *Id.* at 1052. In Pratt v. State, 39 Md. App. 442, 387 A.2d 779 (1978), on the other hand, the court noted the chilling effect of such a rule on a defendant's communications with a clinician; it also felt that in almost all cases the state would have access to its own evaluations performed by state-retained clinicians: "As long as there is a sufficient number of experts available, there is no real danger, as a practical matter, of the defense using the cloak of the privilege to remove 'unfriendly' experts." *Id.* at 451, 387 A.2d at 785. *See also* United States v. Alvarez, 519 F.2d 1036, 1046-47 (3d Cir. 1975); People v. Lines, 13 Cal. 3d 500, 511-16, 531 P.2d 793, 799-802, 119 Cal. Rptr. 225, 234-36 (1975); State v. Kociolek, 23 N.J. 400, 413-15, 129 A.2d 417, 425-26 (1957). For a provocative analysis of this issue, see Saltzburg, *Privileges and Professionals: Lawyers and Psychiatrists,* 66 VA. L. REV. 597 (1980).

[206] Some states provide by statute that the indigent who gives notice of an intent to assert an insanity defense is entitled to an evaluation by court-appointed examiners. *See, e.g.,* CAL. PENAL CODE § 1027 (West Cum. Supp. 1979); MINN. STAT. ANN. § 611.21 (West Cum. Supp. 1980). Most states, however, have no such provision; instead, they merely provide for state-funded competency evaluations by a court-appointed commission or by psychiatrists in the state hospital, *see, e.g.,* VA. CODE ANN. § 19.2-169 (Repl. Vol. 1975), which, in our experience, often result in reports addressing not only the competency issue but also the issue of the defendant's mental state at the time of the offense.

[207] In United States *ex rel.* Smith v. Baldi, 344 U.S. 561 (1952), the Supreme Court, while holding that the Constitution does not require the state to provide an independent psychiatrist to assist counsel, also appeared to suggest that the indigent defendant is at least entitled to a court-ordered psychiatric examination when the issue of sanity is raised. *See id.* at 568. In addition, several cases have found a violation of the sixth amendment guarantee of effective counsel when the defense attorney failed to investigate the possibility of an insanity or diminished capacity defense. *See, e.g.,* Wood v. Zahradnick, 578 F.2d 980 (4th Cir. 1978); Brooks v. Texas, 381 F.2d 619 (5th Cir. 1967); McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972). Unless the state provides psychiatric expertise for the indigent defendant who may have a valid clinically based defense, the defense attorney therefore will not be able to fulfill his constitutional duty to represent effectively his client.

Several commentators have argued that the sixth and fourteenth amendments require that the indigent be provided with an independent forensic evaluation by a clinician of his choice. *See* Goldstein & Fine, *The Indigent Accused, the Psychiatrist and the Insanity Defense,* 110 U. PA. L. REV. 1061, 1080 (1962); Lewin, *Indigency—Informal and Formal Procedures to Provide Partisan Psychiatric Assistance to the Poor,* 52 IOWA L. REV. 458, 487 (1966); Note, *The Indigent's Right to an Adequate Defense: Expert and Investigational Assistance in Criminal Proceedings,* 55 CORNELL L. REV. 632, 637-43 (1970). Passing this question, we assume for the purpose of this article that the courts will continue to deny the indigent the right to such an independent evaluation, at least in non-capital cases. *See, e.g.,* McGarty v. O'Brien, 188 F.2d 151, 155 (1st Cir.), *cert. denied,* 341 U.S. 927 (1951). However, we believe that the case law and basic due process concepts strongly support the

mitting the prosecution to use incriminating disclosures from forensic evaluation as evidence of guilt, however, a number of states severely undercut the usefulness of evaluations provided indigent defendants.[208] In these jurisdictions, a defendant must choose between his fifth and sixth amendment rights. If he remains silent, or is cautious about the information he reveals, he may forfeit the adequate evaluation necessary to determine whether he can successfully raise a clinically based defense.

Most jurisdictions sensibly forbid the use of the defendant's disclosures on the issue of guilt, either by statute[209] or on fifth amendment grounds.[210] Yet even in these jurisdictions the defen-

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right of the indigent to at least one clinical evaluation, whether in the state unit or not, and that the results of this examination should be protected according to procedures described in the text accompanying notes 209-19 *infra*.

[208] *See, e.g.*, Hall v. State, 209 Ark. 180, 189 S.W.2d 917 (1945); People v. Ditson, 57 Cal. 2d 415, 448-49, 369 P.2d 714, 732-33, 20 Cal. Rptr. 165, 183-84 (1962); People v. Combes, 56 Cal. 2d 135, 363 P.2d 4, 14 Cal. Rptr. 4 (1961). These courts support their rulings by asserting that the defendant's statements to the clinician were "voluntary" and thus could be used on the issue of guilt; they fail to recognize that such statements are hardly voluntary when to remain silent would make it impossible for the defendant to gain expert assistance.

Several courts have found that the fifth amendment does not apply in the forensic evaluation context because the information about the person's mental condition elicited during such an evaluation is "non-testimonial" in nature. *See* United States v. Weiser, 428 F.2d 932, 936 (2d Cir. 1969); State v. Whitlow, 45 N.J. 3, 9, 210 A.2d 763, 771 (1965); Livingston v. State, 542 S.W.2d 655, 661-62 (Tex. Crim. App. 1976), *cert. denied*, 431 U.S. 933 (1977). These courts rely on cases involving the admission of incriminating physical evidence, which the United States Supreme Court has held to be unprotected by the fifth amendment privilege. *See* United States v. Dionisio, 410 U.S. 1 (1973) (voice exemplars); Gilbert v. California, 388 U.S. 263 (1967) (handwriting exemplar); Schmerber v. California, 384 U.S. 757 (1966) (blood sample); Holt v. United States, 218 U.S. 245 (1910) (defendant required to try on a blouse to show it fit him). The analogy is not a perfect one, however; the clinician relies not only on how the defendant expresses himself but also on the content of what the defendant says. *See* Smith v. Estelle, 602 F.2d 694 (5th Cir. 1979); United States v. Albright, 388 F.2d 719, 723 (4th Cir. 1968). In any event, this rationale would in no way dissolve the fifth amendment objections to the use of the defendant's statements to prove his guilt.

[209] *See, e.g.*, COLO. REV. STAT. § 16-8-107 (1973); ILL. ANN. STAT. ch. 38, § 104-2(d) (Smith-Hurd 1973); MASS. GEN. LAWS ANN. ch. 233, § 23B (West Cum. Supp. 1979); MO. ANN. STAT. § 552.030(6) (Vernon 1978).

[210] *See, e.g.*, Gibson v. Zahradnick, 581 F.2d 75 (4th Cir. 1978); United States v. Alvarez, 519 F.2d 1036, 1042 (3d Cir. 1975); United States v. Bennett, 460 F.2d 872, 878-80 (D.C. Cir. 1972); United States v. Williams, 456 F.2d 217, 218 (5th Cir. 1972); United States v. Bohle, 445 F.2d 54, 66-67 (7th Cir. 1971); Thornton v. Corcoran, 407 F.2d 695, 699-701 (D.C. Cir. 1969); United States v. Albright, 388 F.2d 719 (4th Cir. 1968).

At least one of these courts appears to be confused about the full impact of its approach to the fifth amendment problem. In Gibson v. Zahradnick, 581 F.2d 75 (4th Cir. 1978), the Fourth Circuit implied, although it refused to decide, that the warnings required by Miranda v. Arizona, 384 U.S. 436 (1966), before every custodial interrogation by police might

dant's constitutional interests can be jeopardized and the evaluation process hindered when, as is often the case, state employees who conduct the evaluation make their opinions available to the prosecution and the court as well as the defendant's attorney.[211] While the state may not use the defendant's disclosures to prove his guilt, the report may provide investigatory leads and reveal prejudicial collateral information. For this reason, the state evaluator's report should not be available to the prosecution until the defendant, having received the report, gives notice that he intends to present a clinically based defense. This approach affords the indigent defendant at least as much protection as that enjoyed by his wealthier counterpart, and thus facilitates the disclosure to the evaluator of "incriminating," but clinically important information.[212]

Fifth amendment concerns also have impeded the data collection process for evaluations requested by the prosecutor after the de-

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also be required before a state forensic evaluation. *See* 581 F.2d at 79 & n.1. It would seem that if the defendant's statements cannot be used on the issue of guilt, *Miranda* warnings are unnecessary. The clinician should only need to inform the defendant that the decision as to whether the contents of the report will be used in court is up to him and his attorney.

[211] In our experience in Virginia, the state examiner's report on the defendant's mental state at the time of the offense often goes automatically to the prosecution and the court, as well as the defense, even if the defense requested the evaluation. This appears to be the case in other states as well. *See, e.g.*, R.I. GEN. LAWS § 9-17-20 (1969) (specifically providing that state psychiatrist's finding must be sent to court and prosecution); Lewin, *supra* note 207, at 481 n.111.

[212] If the defendant does decide to use clinical testimony, the trial judge should not lose sight of the defendant's fifth amendment interests. When the defendant relies solely on an insanity defense (in essence admitting that he committed the act in question), the clinician should generally be permitted to present all of the clinical observations or findings upon which opinion is based. *See* note 250 *infra*. However, when in addition to raising a clinically based defense the defendant insists that the prosecution prove his guilt, the prejudicial effect of this supporting testimony may outweigh its value to the jury in deciding what weight to give the expert's opinion. There is no easy answer to this problem. The most workable solution lies in sensitive rulings on the admissibility of inculpatory statements and other potentially prejudicial data, and in appropriate cautionary instructions. In Gibson v. Zahradnick, 581 F.2d 75 (4th Cir. 1978), for example, the court held that when the clinician testifies concerning the defendant's mental state at the time of the offense, the defendant is entitled to an instruction informing the jury that such testimony is not to be considered in determining whether the defendant committed the crime. If the issues in dispute are easily divisible without significant duplication, a third alternative—bifurcation of the gnilt and insanity determinations—should also be considered. For a discussion of the advantages and disadvantages of bifurcation, see Meister, Miranda *on the Couch: An Approach to Problems of Self-Incrimination, Right to Counsel, and* Miranda *Warnings in Pre-Trial Psychiatric Examinations of Criminal Defendants*, 11 COLUM. J.L. & SOC. PROB. 403, 459-63 (1975).

fense has given notice of its intent to assert a clinically based defense. Defendants who are affluent enough to afford a private evaluation of the feasibility of such a defense often argue that a subsequent compulsory state evaluation violates their fifth amendment privilege. They further contend that, even if the state may compel such an evaluation, the defendant has the right to refuse to answer the examiner's questions without penalty, the right to the presence of counsel, and the right to *Miranda* warnings. [213] Some courts have agreed,[214] presumably requiring the prosecution to rely solely on cross-examination of the defendant's experts to prove its case or to rebut the defense. However, most courts—concluding that this approach is unfair to the prosecution—hold that the defendant must submit to an evaluation by the state, that *Miranda* warnings and counsel are not required, and that the trial court may bar expert testimony on the defendant's behalf if the defendant refuses to cooperate with the state examiner.[215]

If the defendant has decided to raise an insanity defense, and if his utterances during the state evaluation can only be used on that issue, there is no apparent reason for barring the state from obtaining its own expert consultation.[216] If the state is entitled to such a consultation, warnings and the presence of counsel are superfluous; these only serve to complicate the data collection pro-

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[213] Miranda v. Arizona, 384 U.S. 436 (1966). In *Miranda*, the Supreme Court held that in any "custodial interrogation," the accused must be warned of his right to remain silent, that any statement he does make may be used as evidence against him, and that he has the right to the presence of an attorney, either retained or appointed. *Id.* at 467-73. The Court also held that no statement of the accused is admissible unless these warnings are given and there has been a voluntary and intelligent waiver of the rights described by the Court. *Id.* at 476-77.

[214] *See, e.g.*, Johnson v. People, 172 Colo. 72, 470 P.2d 37 (1970); French v. District Court, 153 Colo. 10, 384 P.2d 268 (1963); Shepard v. Bowe, 250 Ore. 288, 442 P.2d 238 (1968).

[215] *See generally* United States v. Malcolm, 475 F.2d 420 (9th Cir. 1973); United States v. Baird, 414 F.2d 700 (2d Cir. 1969), *cert. denied*, 396 U.S. 1005 (1970); United States v. Albright, 388 F.2d 719 (4th Cir. 1968); Pope v. United States, 372 F.2d 710 (8th Cir. 1967); State v. Mulrine, 55 Del. 65, 183 A.2d 831 (1962). These courts base their holdings on alternative theories: that denying the state its own evaluation is unfair to the state, or that once the defendant decides to introduce his own expert testimony on the issue of insanity, he waives any claim of privilege.

[216] One instance in which the state would not need its own clinician is when the defendant has consulted a number of experts, one or more of whom have reached conclusions unfavorable to his case. In jurisdictions that follow the rule announced in United States *ex rel.* Edney v. Smith, 425 F. Supp. 1038 (E.D.N.Y. 1976), the prosecution would have access to these witnesses and could use them in court. *See* note 205 *supra*. *See generally* Saltzburg, *supra* note 205.

cess[217] and offer no protection of the defendant's fifth amendment interests beyond that already provided by the restriction on the use of the evaluation results. If the defense attorney must have access to such prosecution consultations to represent his client effectively,[218] means of monitoring the evaluation other than direct intervention should be provided.[219]

The defendant, whether indigent or not, should under the fifth and sixth amendments control the results of his forensic evaluation until he raises a defense based on those results. The state should be able to obtain its own evaluation for the purpose of countering such a defense, without the artificial impediments created by

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[217] The *Miranda* warnings can create an unnecessarily adversarial atmosphere in the evaluation context, and possibly inhibit full disclosure by the client. Because of the unsettled state of the law in Virginia, *see* note 210 *supra*, the Forensic Psychiatry Clinic has often found it necessary to give such warnings to clients referred by the prosecution or the court. In some of these cases, it appears that the warnings hindered communication hy leading the client to equate the evaluation with a police interrogation. The Clinic staff occasionally has also had difficulty assessing whether a client has sufficiently understood the import of the warnings. If warnings are required, it may become necessary to determine before the evaluation begins whether the defendant possesses the capacity to understand them and whether, if so, his subsequent statements are made voluntarily. See Gibson v. Zahradnick, 581 F.2d 75, 79 (4th Cir. 1978), for an interesting example of a court trying to wrestle with these problems.

Several courts have pointed out the potentially disruptive impact of having counsel present during a forensic interview. *See* United States v. Baird, 414 F.2d 700 (2d Cir. 1969); United States v. Albright, 388 F.2d 719, 726 (4th Cir. 1968) ("[Because of] the intimate and personal nature of the examination, . . . the presence of a third party, in a legal and nonmedical capacity, would severely limit the efficacy of the examination."); Commonwealth v. Stukes, 435 Pa. 535, 257 A.2d 828 (1969). In one prosecution-referred case seen by the Forensic Psychiatry Clinic, the defendant's attorneys forbade the clinicians to ask any questions about the offense, the year preceding it, and the year following it. They also examined every question on the Minnesota Multiphasic Personality Inventory (a personality test containing over 500 questions) to determine which ones should not be answered by the defendant because of possible incriminatory effect. Of course, the resulting interview and psychological testing provided little data upon which a clinical opinion regarding mental state at the time of the offense could be based.

[218] Several courts have held that the defendant is entitled to have counsel present during the forensic evaluation on sixth as well as fifth amendment grounds. *See, e.g.*, Houston v. State, 602 P.2d 784 (Alaska 1979); Lee v. County Court of Erie County, 27 N.Y.2d 432, 267 N.E.2d 452, *cert. denied*, 404 U.S. 823 (1971); Shepard v. Bowe, 250 Or. 288, 442 P.2d 238 (1968).

[219] While the defendant may have a right to have his counsel observe the evaluation, *see* note 213 *supra*, the attorney need not be present in the interview room itself to monitor the interview. He could observe the interview through a one-way mirror or he could tape the interview. *See* Thornton v. Corcoran, 407 F.2d 695 (D.C. Cir. 1969). Both of these techniques would allow the attorney to render effective assistance without intervening directly in the delicate relationship between the clinician and the defendant.

warnings or the presence of counsel. These principles protect both the defendant's and the state's interests, and enhance the forensic clinician's ability to perform a thorough and effective evaluation.

b. Contextual Variables and Credibility Assessments

Research suggests that subjects participating in clinical interviews or testing may behave and respond differently depending upon the setting of the evaluation. The subject matter of the interview,[220] the race, sex, and attitudes of the interviewer,[221] and even the location and appearance[222] of the interview room can have an impact on the conscious and unconscious determinants of subject behavior and communication, the data upon which the clinician depends.[223]

The unique nature of the forensic evaluation can accentuate the distorting influence of these variables. While the "therapeutic" interview typically results from voluntary arrangements between

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[220] *See* S. SARASON, THE CLINICAL INTERACTION 36 (1954); T. SHAFFER, LEGAL INTERVIEWING AND COUNSELING 63-84 (1976).

[221] *See generally* Allon, *Sex, Race, Socioeconomic Status, Social Mobility, and Process-Reactive Rating of Schizophrenics,* 153 J. NERV. & MENTAL DISEASE 343 (1971); Barnard, *Interaction Effects Among Certain Experimenter and Subject Characteristics on a Projective Test,* 32 J. CONSULTING & CLINICAL PSYCH. 514 (1968); Dickes, Simons & Weisfogel, *Difficulties in Diagnosis Introduced by Unconscious Factors Present in the Interviewer,* 44 PSYCH. Q. 55 (1970); Masling, *Role-Related Behavior of the Subject and Psychologist: Its Effects upon Pyschological Data,* 14 NEB. SYMPOSIUM ON MOTIVATION 67 (1966); Milner & Moses, *Effects of Administrator's Gender on Sexual Content and Productivity in the Rorschach,* 30 J. CLINICAL PSYCH. 159 (1974). Professor Masling notes that even the presence or absence of a mustache on the examiner may affect the subject's behavior, specifically the manner in which the subject draws a male figure (a typical method used by psychologists to learn about the subject). *See* Masling, *supra,* at 79.

[222] *See* Katz, Gudeman & Sanborn, *Characterizing Differences in Psychopathology Among Ethnic Groups: A Preliminary Report on Hawaii-Japanese and Mainland-American Schizophrenics,* in W. CAUDIL & T. LIN, MENTAL HEALTH RESEARCH IN ASIA AND THE PACIFIC 148-63 (1972) (study of Japanese-American schizophrenics indicated that their behavior changed radically when discharged from the hospital into the community). *See also* S. SARASON, *supra* note 220, at 52 (children test optimally when test is administered during school hours with other children; a child who is singled out "is in no mood to do the best of which he is capable").

[223] Of course, observing the defendant's reaction to various contextual elements can also *help* the clinician understand the defendant's behavioral patterns. The client's response to particular types of questions *(e.g.,* withdrawal and sullenness when asked about parents or siblings), his attitudes toward interviewers of a particular race or sex, or his behavior in a given setting (*e.g.,* "showing off" in front of a large group of observers) may all provide the experienced clinician with clues to his personality.

therapist and patient, with the specific goal of helping the patient, the forensic evaluation is an instrument of the legal system. Therapy, if it occurs, is a tangential consideration. Few forensic clients would seek assistance were they not involved in the criminal justice system; most are cajoled into participating by their lawyers, or forced to do so by the prosecution or the court.[224] As a result, the forensic clinician must overcome not only the usual contextual hurdles confronting the therapist; he often must contend with a subject who lacks motivation to assist the clinician in his endeavor.

The significance of this problem is heightened by the fact that the forensic clinician, to a much greater extent than the therapist, must try to ascertain whether the subject's story is fabricated, unconsciously distorted, or honestly reported. Clinicians and the courts frequently fail to recognize that a critical feature of virtually every reconstructive evaluation is this need to assess the reliability of the subject's account of his experiences and behavior.[225] In the recurring scenario of the defendant who claims amnesia, for example, the clinician inevitably must decide whether the defendant's inability to remember is faked, unconsciously induced through repression, or due to some organic dysfunction or dissociative state[226] at the time of the offense.[227] The professional's reconstruction of

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[224] Many clients seen by the Forensic Psychiatry Clinic are initially indifferent or hostile to the concerns of the clinician, even when the evaluation results are clearly protected by the attorney-client privilege. This attitude stems from a variety of factors, including resentment at being thrust into such a situation, concern about divulging intimate details, distrust of "shrinks," fear of being labelled "crazy," or simply a feeling that the entire process is pointless or "silly." Some clients are quite willing to talk, but only in an effort to manipulate the evaluator into believing that they possess certain traits or acted a certain way in the past. Other clinicians have reported similar experiences. *See, e.g.*, J. MACDONALD, *supra* note 204, at 59.

Although the private therapist also may encounter unmotivated patients, it is unlikely that the lack of motivation will be of the same magnitude in a relationship presumably sought by the subject in order to obtain treatment and comfort.

[225] H. DAVIDSON, FORENSIC PSYCHIATRY 38-39 (2d ed. 1965).

[226] A dissociative state is a neurotic disorder which can result in trance-like behavior, feelings of unreality, multiple personalities, or hysteria. An individual who is experiencing such a state has difficulty screening incoming observations, and processing and storing information. An acute dissociative reaction can lead to short-term violent behavior. It is generally thought to be the result of anxiety produced by the repression of undesired impulses. *See generally* 1 COMPREHENSIVE PSYCHIATRY, *supra* note 135, at 855-89 (1967).

[227] From 30-40% of the 250 clients evaluated by the Forensic Psychiatry Clinic in the last six years have claimed some impairment of their ability to remember a given period of time. Usually this period includes the time of the alleged offense.

the offense will depend significantly upon the explanation he chooses.[228]

The forensic clinician can employ various strategies to minimize the distorting impact of context, and to assess the reliability of the subject's communications. It is most important that he elicit from the subject information regarding his behavior in contexts other than that of the alleged offense; such information provides insight into the subject's behavioral patterns, and may be verified from other sources. If feasible, the evaluation should consist of multiple interviews, preferably separated by several days and performed by different interviewers in different settings. The combined results of these interviews probably will reflect a more accurate picture of the subject and act as a more substantial check on the consistency of his story than would the content of a single interview.[229]

Another strategy concerns the method of approaching the client. Although a considerable body of literature describes the importance of trust and rapport between interviewer and subject in facilitating communication,[230] the demands of the forensic assessment may force the clinician to abandon this approach. To ferret out information from apathetic subjects, or from subjects unable or unwilling to volunteer significant data, the forensic evaluator often must discard the therapist's traditional mode of inquiry—the

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[228] For example, if the memory of the offense is repressed, it may indicate that the event was particularly "ego-dystonic" (out of character) for the individual, which may he relevant on the issue of culpability. If the inability to remember is due to organic impairment at the time of the offense, there may be grounds for an automatism defense based on the likelihood that the defendant was "unconscious" at the time of the act. *See, e.g.*, State v. Mercer, 275 N.C. 108, 165 S.E.2d 328 (1969); Note, *Epilepsy and the Alternatives for a Criminal Defense*, 27 CASE W. RES. L. REV. 771, 782-87 (1977). A bona fide dissociative state during the time of the offense (which is quite rare in the Clinic's experience) could result in a successful insanity or automatism defense. *See* Pollard v. United States, 282 F.2d 450 (6th Cir. 1960); United States v. Westerhausen, 283 F.2d 844 (7th Cir. 1960). Of course, if the loss of memory is determined to be faked, this has implications for the clinician's final opinion as well.

[229] The Forensic Psychiatry Clinic uses this system; generally a social worker, a psychologist, and a psychiatrist have all interviewed the subject by the time the formal opinion formation process has begun. *See* notes 258-61 *infra* and accompanying text. This system is designed to capitalize upon the differing perspectives offered by those from different professional orientations.

[230] *See, e.g.*, A. BENJAMIN, THE HELPING INTERVIEW (1974); A. GARRETT, INTERVIEWING: ITS PRINCIPLES AND METHODS 9-29 (1942); S. RICHARDSON, B. DOHRENWEND & D. KLEIN, INTERVIEWING (1965); T. SHAFFER, *supra* note 220, at 64-143; H. SULLIVAN, THE PSYCHIATRIC INTERVIEW 59-112 (1954).

open-ended, "non-leading" style of questioning—and employ a more probing, confrontive technique.[231]

The clinician also has at his disposal less obvious means of accumulating information and assessing credibility. Arguably, he is more sensitive to "body language," the non-verbal cues that register sincerity or ambivalence.[232] Some psychological tests include a scale designed to reflect whether the client responded truthfully to the test questions.[233] The clinician also may resort to more potent investigative devices, such as sodium amytal, hypnosis, and the polygraph.[234] None of these tools can be relied upon to provide consistently accurate results; each presents potential for abuse.[235]

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[231] *See generally* 1 COMPREHENSIVE PSYCHIATRY, *supra* note 135, at 493. There are several different confrontive approaches, most of which can prove useful in the forensic context. Benjamin, for example, identifies approximately 30 "leads and responses" that can be used in an interview, several of which can be employed with a client who for one reason or another needs to be prodded into revealing more about himself. In ascending order of aggressiveness, they include suggestion, advice, urging (or persuasion), moralizing, and, for those who are particularly recalcitrant, disagreement, opposition and criticism, disbelief, ridicule, confrontation (through use of other evidence), rejection, threat, command, and punishment. A. BENJAMIN, *supra* note 230, at 108-54. *See also* J. RUESCH, THERAPEUTIC COMMUNICATION 188-201 (1973). Generally, the more aggressive techniques would be used only in tempered form in the forensic context, and would be reserved until after the clinician bad attempted to capitalize on any rapport that had been established.

[232] Non-verbal communication *(e.g.*, facial expression, gaze, gestures and bodily movement, posture, clothes, and "non-verbal" vocalizations) can inform the experienced observer about various aspects of an individual's personality. *See generally* M. ARGYLE, BODILY COMMUNICATION (1975); R. BIRDWHISTELL, KINESICS AND CONTENT (1970).

[233] The Minnesota Multiphasic Personality Inventory (MMPI), for instance, is a personality test utilizing three so-called validity scales. These scales "represent checks on carelessness, misunderstanding, malingering, and the operation of special response sets and test-taking attitudes." A. ANASTASI, PSYCHOLOGICAL TESTING 498 (4th ed. 1976).

[234] Sodium amytal, commonly known as "truth serum," actually only relaxes psychological defense mechanisms that prevent the individual from consciously remembering certain events; this allows the denied or repressed material to surface. Under the influence of sodium amytal, individuals may reveal thoughts and memories that, for various psychological reasons, they could not previously express. *See generally* Mann, *The Use of Sodium Amobarbital in Psychiatry*, 65 OHIO ST. MED. J. 700 (1969). An individual who is placed under hypnosis similarly may reveal repressed memories. Schneck, *Hypnosis in Psychiatry*, in HYPNOSIS IN MODERN MEDICINE 143-44 (2d ed. 1959). The polygraph, or "lie-detector," measures various physiological aspects such as blood pressure, pulse rate, respiration, psychogalvanic skin reflexes, and muscular activity, which theoretically enable the experienced interrogator to detect signs of fear and thus indicate when the subject is lying. F. INBAU & J. REID, LIE DETECTION AND CRIMINAL INTERROGATION 99-106 (3d ed. 1953).

[235] An individual's body language is linked closely to sex, cultural background, and other variables, which may be unfamiliar to or misinterpreted by an examiner. In addition, because it is difficult to determine whether a particular non-verbal sign is intended to be communicative, it is relatively easy to be deceived by "body" signals. *See* M. ARGYLE, *supra*

The clinician should use them in conjunction with one another[236] and with his own careful assessment of the individual's personality. Under such circumstances, these tools can assist the clinician in delving into the defendant's personality and can provide support for a variety of clinical judgments.[237]

The clinician's extended exposure to the defendant in a setting arguably more conducive than the courtroom to open communication, and his access to the wide array of techniques described above, enhances his ability to test his hypotheses about the defendant's motivations and credibility. Of course, assessment of the veracity of witnesses lies at the heart of the jury's function; accordingly, the clinician should explain to the factfinder the extent to which the clinician's conclusions are dependent on what the defendant has told him.[238] The clinician should be able to explain why

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note 232, at 5-12.

The validity scales on the MMPI may indicate carelessness or misunderstanding, rather than malingering. *See* note 233 *supra*. Even if malingering is strongly suggested, this does not, of course, indicate that the subject will lie about matters that are not tested.

There are several problems associated with the use of narcoanalysis. Because an individual who is under the influence of sodium amytal is highly suggestible, examiners must avoid leading questions. *See* J. MACDONALD, *supra* note 204, at 115. Second, although the technique can be helpful in interrogating persons who are inclined to tell the truth, a person who intends to deceive probably will be able to continue the deception whether drugged, *see* R. SADOFF, *supra* note 204, at 66, or under hypnosis, *see id.* at 64. Finally, the subject may be prone to substitute his fantasies for what actually occurred, due to amytal's tendency to promote temporary regression to less mature levels. *See id.* at 65-66. *See generally* Gall, *The Case Against Narcointerrogation*, 7 J. FOR. SCI. 29 (1962).

Studies on the validity of polygraph results vary, but most indicate that experienced polygraph operators can determine truth or deception over 90% of the time. *See* F. INBAU & J. REID, *supra* note 234, at 111-12; Horvath & Reid, *The Reliability of Polygraph Examiner Diagnosis of Truth and Deception*, 62 J. CRIM. L.C. & P.S. 276 (1971). An inexperienced operator achieves a much lower success rate. *See* F. INBAU & J. REID, *supra* note 234, at 112.

[236] Sadoff, for instance, reports that he often asks a defendant who claims amnesia to submit to a polygraph test. Only if that test indicates that the defendant is telling the truth about his inability to remember will an amytal interview be conducted. *See* R. SADOFF, *supra* note 204, at 29.

[237] *See* notes 231-34 *supra* and accompanying text. Various authors have reported successful use of these devices. *See, e.g.*, R. SADOFF, *supra* note 204, at 29; Dession, Freedman, Donnelly & Redlich, *Drug-Induced Revelation and Criminal Investigation*, 62 YALE L.J. 315 (1953); Lynch, *Detection of Deception: Its Application to Forensic Psychiatry*, 7 BULL. AM. ACAD. PSYCH. & L. 239 (1979) (use of the polygraph); Zonana, *Hypnosis, Sodium Amytal, and Confessions*, 7 BULL. AM. ACAD. PSYCH. & L. 18 (1978). Of course, none of these techniques should be used without the defendant's consent.

[238] One article has suggested showing a videotape of the forensic interview to the factfinder. *See* McGill & Thrasher, *Videotapes: The Reel Thing of the Future*, TRIAL, May 1975, at 43. Although this would enable the jury to form its own assessment of the defen-

he believes or disbelieves the defendant and to offer corroborating evidence in support of his opinion.[239] He must expose to the factfinder the nature of the credibility assessment that is implicit in his judgment so that the factfinder will realize it must decide not only whether it believes the clinician, but also whether it believes the defendant.

2. *Obtaining Data From Sources Other Than the Defendant*

It is impossible to base a reliable reconstructive or predictive opinion solely on an interview with the subject.[240] The thorough forensic clinician seeks out additional information on the alleged offense and data on the subject's previous antisocial behavior, together with general "historical" information on the defendant, relevant medical and psychiatric history, and pertinent information in the clinical and criminological literature. To verify what the defendant tells him about these subjects and to obtain information

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dant's credibility, such a tactic may run afoul of the defendant's fifth amendment right. *See* note 212 *supra*. Showing a tape may also prove tremendously tedious to the factfinder because many interviews take several hours. Further, a videotape cannot impart to the viewer all the data that might inform a credibility assessment *(e.g.,* the results of an amytal interview, documentary material, discussion with third parties). Despite these problems, however, the videotaped interview may be a feasible method of reducing any distortion in the clinician's report. Some courts have permitted audiotapes of the interview to be presented to the jury. *See generally* People v. Cartier, 51 Cal. 2d 590, 335 P.2d 114, 5 Cal. Rptr. 573 (1960); People v. Cruz, 264 Cal. App. 2d 350, 70 Cal. Rptr. 603 (1968).

[239] The clinician's efforts to offer corroborating evidence may encounter resistance in some courts. The vast majority of courts, for example, do not permit polygraph results to be admitted in evidence unless both parties stipulate to its admissibility before the test is administered. *See generally* Annot., 43 A.L.R. FED. 68 (1979). The courts are split as to whether an expert opinion based on amytal results should be admitted. *Compare* People v. Modesto, 59 Cal. 2d 722, 382 P.2d 33, 31 Cal. Rptr. 225 (1963) (allowing expert testimony); People v. Myers, 355 Ill. 2d 311, 220 N.E.2d 297 (1966) (same); *and* People v. Jones, 42 Cal. 2d 219, 266 P.2d 38 (1954) (same) *with* People v. Busch, 56 Cal. 2d 868, 366 P.2d 314, 16 Cal. Rptr. 898 (1961) (excluding expert opinion); *and* State v. Simnott, 24 N.J. 408, 132 A.2d 298 (1957) (same). Of those courts admitting expert opinion on amytal tests, many do not permit the clinician to reveal the content of the defendant's statements made while under amytal. *See* Annot., 41 A.L.R.3d 1369 (1972). We believe that an opinion based on data obtained from these techniques, as well as the data itself, should be admissible when the technique is used by an experienced clinician to confirm hypotheses based on other data and not as an independent basis for an otherwise unsupported hypothesis, and with the stipulations concerning cross-examination and cautionary instructions outlined in Part II. *See also* Lemmon v. Denver & Rio Grande W. R.R., 9 Utah 2d 915, 341 P.2d 215 (1959); MCCORMICK, *supra* note 121, § 207, at 507. The one exception to this rule might involve the admission of polygraph results, given their possibly prejudicial impact. *See* note 121 *supra*.

[240] *See* R. SADOFF, *supra* note 204, at 19; Pollack, *supra* note 204, at 274.

unknown to the defendant, the clinician must consult, and rely upon, sources other than the defendant.

The legal implications of this reliance on third-party sources have not been resolved completely. If the law is skeptical about the clinician's ability to gather reliable information and to assess its weight in formulating his clinical opinions, then it legitimately might limit the clinician's role to first-hand observations. Conversely, a decision to admit opinion testimony based on third-party information must be predicated on the view that the qualified forensic expert can be trusted to sift information for reliability and significance before reaching his opinion.

Under the common law, much of the information on wliich the forensic clinician relies was inadmissible hearsay.[241] Any expert opinion "based upon information from third persons out of court" was held inadmissible.[242] Given the clinician's heavy dependence upon such data, this rule functioned, at least in theory,[243] "to re-

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[241] The hearsay rule limits the in-court use of out-of-court statements for the purpose of proving the truth of those statements, based on the rationale that such declarations cannot be subjected to cross-examination and thus their validity cannot be sufficiently tested. G. LILLY, INTRODUCTION TO THE LAW OF EVIDENCE § 49, at 157 (1978). Under traditional hearsay doctrine, statements by family members and acquaintances about the subject of a forensic evaluation are not admissible as evidence unless repeated in court by the declarants themselves. *See* State v. Gevrez, 61 Ariz. 296, 148 P.2d 829 (1944); Ingles v. People, 90 Colo. 51, 6 P.2d 455 (1931); People v. Keough, 276 N.Y. 141, 11 N.E.2d 570 (1937). Similarly, hospital records and reports by professionals associated with the testifying clinician (*e.g.*, other psychiatrists, psychologists, or social workers) are excluded unless the authors of those records reiterate in court the opinions contained therein. *See* United States v. Bohle, 445 F.2d 54 (7th Cir. 1971); People v. Schneider, 39 Mich. App. 342, 197 N.W.2d 539 (1972). School records, military records, and even treaties may also be excluded on hearsay grounds. *See* S. SALTZBURG & K. REDDEN, FEDERAL RULES OF EVIDENCE MANUAL 531, 535 (2d ed. 1977).

The clear trend, however, has been to admit both statements of family members and institutional records under exceptions to the hearsay rule. *See* FED. R. EVID. 804(b)(4)(B) (when declarant is "unavailable," his statements about the subject's personal or family history are not excluded by the hearsay rule if the declarant is related by blood or "intimately associated" with the subject); *id.* 803(6) (records of a "regularly conducted . . . activity" containing any data in any form, including opinions and diagnoses, not excluded by the hearsay rule).

[242] 20 AM. JUR. *Evidence* § 866.5 (Cum. Supp. 1964). *See also* Diamond & Louisell, *supra* note 204, at 1351-52.

[243] According to Dr. Diamond, because of the difficulty in abiding by the restrictive common-law rule, courts in which he testified ignored the rule altogether and let him testify about opinions based on hearsay information. *See* Diamond & Louisell, *supra* note 204, at 1352. Other courts have circumvented the rule through the legal fiction that the information underlying the expert's opinion is "data" not relied upon for its truth and therefore the expert may base his opinion on it even if the information is otherwise inadmissible. *See*

ject medical testimony almost in its entirety."[244] Over the last two decades, however, the trend has been to relax this restrictive approach. Federal Rule of Evidence 703 now provides that the facts or data upon which an expert bases an opinion or inference need not be admissible in evidence "if of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject."[245] Because the hearsay described above typically is relied upon by clinicians attempting to formulate an opinion about an individual's past or present mental state—and in fact is crucial to such an undertaking—an expert opinion based on these sources would generally be admissible under the Federal Rules of Evidence.[246]

Some commentators have argued against this liberalization of the expert opinion rule, at least as it applies to testimony by mental health professionals. Professor Morse, for example, contends that "little is at stake if a *treating* professional relies on sources other than his own observations in forming opinions."[247] Thus, he argues, the fact that a clinician engaging in *therapy* typically relies on this data does not attest to sufficient trustworthiness for *forensic* purposes. We believe, however, that the experienced forensic clinician is able to assess the accuracy of the information that he uses to form his conclusion. As Professors Diamond and Louisell point out:

> The psychiatrist is perfectly aware of the fact that the clinical history obtained from the patient is distorted and self-serving. He knows that the information provided by family and friends may have relatively little validity and that the psychobiological test report, or the nurses' notes or the consultation reports of other physicians are not the whole story of the case. The psychiatrist is especially trained to assimilate information from a wide variety of sources, to evaluate each fact, to discount some, to emphasize others, and to ignore still others. He then makes his own personal observations of his patient, puts everything together, and arrives at

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generally McCORMICK, *supra* note 121, § 15, at 35 n.2.

[244] 3 J. WIGMORE, *supra* note 121, § 687, at 3.

[245] FED. R. EVID. 703.

[246] *See* S. SALTZBURG & K. REDDEN, *supra* note 241, at 425, 427.

[247] Morse, *supra* note 9, at 615 n.187. *See also* Note, *Hearsay Bases of Psychiatric Opinion Testimony: A Critique of Federal Rule of Evidence 703*, 51 S. CAL. L. REV. 129, 154-58 (1977).

> a conclusion. This is the clinical method—the procedure by which all doctors diagnose and heal the sick.[248]

Of course, forensic clinicians constantly must remind themselves of the pivotal role that third-party information can play in the opinion-formation process. They should familiarize themselves with the concerns underlying the evidentiary principles of relevance and hearsay, and should conduct their data-collection and opinion-formation processes accordingly. They should not hesitate to force delays in the legal process in order to procure information that they feel is essential to corroborate their data and support their conclusions; and they should refuse to offer an opinion unless this information is forthcoming.[249] The courts, in turn, should not be fearful of admitting probative opinions based on data collected by experienced, conscientious clinicians.[250]

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[248] Diamond & Louisell, *supra* note 204, at 1353.

[249] Ideally, much information, including medical, psychiatric, and criminal records and a good deal of offense-related and historical data, could he acquired through the attorney or court referring the case. As the staff at the Forensic Psychiatry Clinic has repeatedly found, however, the referring party cannot be counted upon to obtain information. Attorneys especially are unreliable; they may consciously or unconsciously edit information out of a desire to withhold damaging information or because they are unable to recognize facts relevant to the clinical inquiry. All too often, however, attorneys are simply apathetic. Many defense attorneys are court-appointed; they may feel they have discharged their obligation to their client by sending him to be evaluated. For these reasons, the Clinic frequently finds itself performing the attorney's job.

The Clinic has taken some steps to rectify this situation. In its letter accepting a referral, the Clinic emphasizes that it expects the referral source to assist in obtaining information and provides a two page description of the information desired. In an effort to deter the referral source from neglecting its information-gathering responsibilities, the letter also warns that the psychiatric interview will not be conducted if necessary information has not been obtained. Even after the psychiatric interview, the Clinic will withhold its final report if the relevant information has not been received.

[250] Assuming the clinician does testify, it is a separate question whether he should be permitted to reveal the bases of the testimony. One might wish to preclude such testimony as allowing technically inadmissible or prejudicial information into the courtroom under the guise of an expert opinion. Our view, however, is that the clinician must be permitted to inform the factfinder about the informational underpinnings of his findings, even when such testimony would not normally be admissible. The factfinder must be given the opportunity to make an informed judgment about the weight to be given the expert opinion; this is possible only by admitting the expert's explanation. To prevent such testimony would increase the danger of insulating the clinician from scrutiny and misleading the factfinder with conclusory statements; as we note in Part II, cross-examination can be relied upon to expose the unreliability of the professional's informational base.

Furthermore, of course, the court possesses the authority to exclude any underlying data it considers unduly prejudicial. For example, the court might refuse to let the expert testify

3. The Clinician as a Data Collector

The "experienced" clinician also must be sensitive to the distorting influence that he himself can have on the data collected. Here we wish to describe briefly the impact that the clinician's own idiosyncracies can have on the information gathering process, and to suggest some methods of diminishing this impact.

Probably the most prominent evaluator-produced impediment to reliable information gathering is the influence of personal bias on the nature and type of data the clinician observes and considers significant. The evaluator's value system, cultural background, gender, and personal insecurities[251] all can affect his ability to be an objective collector of data. Of particular significance are studies indicating that clinicians tend to diagnose more pathology, and to find a poorer prognosis, when the subject is from a lower-class background, even when differential prevalence data are taken into account.[252]

The other major source of distortion is the professional orientation and training of the evaluator. A person trained in psychoanalytic theory, for example, may be attuned to different symptoms

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about a previously unreported crime discovered through a third party; or it might exclude a report, by a relation of the individual whom the defendant allegedly killed, that the defendant had threatened the victim on several occasions just prior to the victim's death. In such cases, the prejudice to the defendant of such hearsay evidence may outweigh its probative value. If the clinician felt that this information was essential to his opinion, the declarants could be brought to court; if not, the clinician would have to decide whether he could ethically deliver an opinion, given his inability to explain it fully.

[251] *See generally* Boverman, Boverman, Clarkson, Rosenkrantz & Vogel, *Sex-Role Stereotypes and Clinical Judgments of Mental Health*, 34 J. CONSULTING & CLINICAL PSYCH. 1 (1970); Carkhutt & Pierce, *Differential Effects of Therapist Race and Social Class Upon Patient Depth of Self-Exploration in the Initial Clinical Interview*, 31 J. CONSULTING & CLINICAL PSYCH. 632 (1967); Dickes, Simons & Weisfogel, *Difficulties in Diagnosis Introduced by Unconscious Factors Present in the Interviewer*, 44 PSYCHIATRIC Q. 55 (1970); Gross, Herbert, Knatterud & Donner, *The Effect of Race and Sex on the Variation of Diagnosis and Disposition in a Psychiatric Emergency Room*, 148 J. NERV. & MENTAL DISEASE 638 (1969); Haan & Livson, *Sex Differences in the Eyes of Expert Personality Assessors: Blind Spots?*, 37 J. PERSONALITY ASSESSMENT 486 (1973); Katz, Cole & Lowery, *Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience, and Ethnic Background on Diagnostic Decisions*, 125 AM. J. PSYCH. 937 (1969); Milner & Moses, *Sexual Responsivity as a Function of Test Administrator's Gender*, 38 J. CONSULTING & CLINICAL PSYCH. 515 (1972).

[252] *See, e.g.*, Lee & Temerlin, *Social Class, Diagnosis and Prognosis for Psychotherapy*, in 7 PSYCHOTHERAPY: THEORY, RESEARCH & PRACTICE 181 (1970). For an extensive list of studies on this matter, see Ennis & Litwack, *supra* note 74, at 725.

and may interpret the same symptoms differently than a behaviorist. One leading study has concluded: "Clinicians . . . may be selectively perceiving only those characteristics and attributes of their patients which are relevant to their own pre-conceived system of thought. As a consequence, they may be overlooking other patient characteristics which would be considered crucial by colleagues who are otherwise committed."[253]

There are several possible means of minimizing the influence of personal prejudice and professional orientation. Psychoanalysts, for example, are required as part of their training to undergo psychoanalysis themselves to reach a better understanding of their unconscious conflicts and the effects of countertransference.[254] One hopes that greater sensitivity to the fact that education, class, culture, and personality affect objectivity can decrease their impact.

Evaluator distortion can be neutralized further by the interjection of additional observers into the interview process. The interview is the product of the interaction between the interviewer and the subject. As Professor Jeans states: "Complete objectivity can only be regained by treating observer and observed as parts of a single system."[255] Independent observers, via a one-way mirror or video camera, can monitor the dynamics of this "single system." When the data garnered through the interview are assessed and interpreted, the observers' participation can add differing perspectives and can reduce the effects of at least the more obvious individual biases.

These observers can also fulfill the indispensable function of providing feedback. Without some indication as to how he interacts with interview subjects and affects the flow of information from them, an interviewer will probably find little cause to alter his interview "style," even if it is seriously deficient. Without the opportunity to test his opinions against those of other observers,

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[253] Pasamanick, Dinitz & Lefton, *Psychiatric Orientation and Its Relation to Diagnosis and Treatment in a Mental Hospital*, 116 AM. J. PSYCH. 127, 131 (1959). *See also* Copeland, Kelleher, Gourlay & Smith, *Influence of Psychiatric Training, Medical Qualification and Paramedical Training on the Rating of Abnormal Behavior*, 5 PSYCHOLOGICAL MED. 89 (1975). For further commentary on the effects of evaluator bias and context on the accuracy of information garnered in the clinical setting, see Comment, *The Psychologist as Expert Witness: Science in the Courtroom?*, 38 MD. L. REV. 539, 582-88 (1979).

[254] *See generally* Racker, *The Meanings and Uses of Countertransference*, 26 PSYCHOANALYTIC Q. 303 (1957).

[255] J. JEANS, PHYSICS AND PHILOSOPHY 143 (1945).

he will rarely see how he may be permitting external factors to influence his decisions.[256]

A fourth means of minimizing the discrepancies in the data base in a given case is the exchange of key clinical information by the defendant and the prosecution once the defendant decides to go forward with a clinically-based defense. It has been suggested that this procedure would greatly reduce the differences in clinical opinion that result from unequal access to data.[257]

B. Assuring Reliability in Opinion Formation

The law and the mental health professions both must contend with the influences of personal predilections and ideologies upon their decisionmaking processes. The legal system attempts to minimize bias and subjectivity through the structure of its factfinding and law-applying processes. It assumes that more accurate decisions will be reached through use of adversarial procedures—which permit testing of witness' assertions—and refinement of the substantive law—which provides normative constraints and guidance. Similarly, forensic clinicians should aim to structure their decisionmaking processes and develop their evaluative criteria so as to reduce error and promote consistency in the formulation of clinical opinions.

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[256] Another source of such feedback data is the subject himself. After the interview, the subject can provide valuable information about his attitude toward the interviewer and the content of the interview. Additionally, any follow-up information that can be obtained concerning what others have observed about the client or what the client has done since the evaluation will increase the clinician's opportunity to assess the reliability of his data collection process.

A final means of monitoring the evaluator is through audio-visual taping of the clinical interaction. A verbatim record of each interview can aid in the discovery of misperceptions and misinterpretations.

[257] Professor Watson suggests that once counsel has ascertained that the accused has a strong psychiatric defense, counsel should request the court to order a joint psychiatric examination by the defense and the state's experts. "Although different theories of interpretation may be utilized by the experts . . . , this procedure eliminates the 'vast' discrepancies that seem to exist between various observers. These discrepancies are far more likely to be related to trial tactics used by counsel than to differences in the psychiatric data." Watson, *On the Preparation and Use of Expert Psychiatric Testimony: Some Suggestions in an Ongoing Controversy*, 6 BULL. AM. ACAD. PSYCH. & L. 226, 231-33 (1978).

1. Structuring Decisionmaking Procedures

Many of the techniques discussed in the last section—involvement of several professionals of varying persuasions, feedback from other sources, and constant self-analysis—should be considered in devising decisionmaking procedures. The goal should be a methodology that permits objective consideration of all reasonable and conceivable hypotheses. A brief description of the opinion-formation process generally followed at the Forensic Psychiatry Clinic may be instructive.

The centerpiece of the opinion-formation process at the Clinic is a structural clinical interview. Several weeks of data collection, involving a social history interview,[258] a family evaluation,[259] psychological testing,[260] and the accumulation of documentary and research material precede this interview. On the day of the interview, a staff conference is held in order to consult the material compiled by the social worker, the psychologist, and other staff members. The participants identify and explore the range of working hypotheses about the case, and decide what data should be obtained during the interview to exclude or refine these hypotheses. An additional function of this pre-interview conference is the selection of

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[258] The client is generally interviewed in the privacy of the social worker's office by the Forensic Psychiatry Clinic's chief social worker and the law student assigned to the case. The social worker is interested in historical information helpful to the Clinic staff in formulating competing clinical hypotheses about the defendant's personality and his behavior; the law student may add questions in this regard, but generally concentrates on the details of the client's offense. The social worker also tries at this stage to arrive at some preliminary clinical impressions about the defendant.

[259] In many cases, especially those involving juveniles or young adults, an important stage in the Clinic's information gathering process is a face-to-face meeting with members of the defendant's immediate family. This "family evaluation" is designed not only to accumulate specific information about the defendant but also to learn more about the dynamics of the family unit. Such observations can prove helpful in understanding the defendant from a "systems perspective." *See generally* R. ANDERSON & I. CARTER, HUMAN BEHAVIOR IN THE SOCIAL ENVIRONMENT: A SOCIAL SYSTEM APPROACH (1974). Family dynamics are also often relevant in fashioning dispositional alternatives, especially for juveniles.

[260] The Clinic's psychologist is responsible for selecting and administering the appropriate tests. The usefulness of these tests in the forensic context is quite limited, because none of them has been validated for legal determinations. Moreover, the tests measure only the subject's present level of functioning. Psychological tests, however, "can be helpful in corroborating the consultant's impression of the patient's mental state, psychodynamics, and personality structure." Pollock, *supra* note 204, at 273. The Clinic has found that some of these tests are valuable as a supplement to the impressions of the clinical interviewer and a means of determining the plausibility of a given theory.

interviewers,[261] based on the issues involved in the case and on the social worker's impressions of the client's probable reactions to different types of individuals.

After an initial stage designed to make the client feel comfortable and relaxed, the psychiatric interview can take several directions, depending upon the client and the issues involved. If it is clear that the defendant has committed the crime with which he is charged, and that he does not seem particularly traumatized by it, reconstructive questions will come early in the interview. On the other hand, if there is some doubt as to whether the client committed the alleged act, or if it is obvious (based on his reactions during the social history interview) that he is disturbed about his involvement in the criminal process, inquiry into the details of the offense is deferred until other data have been obtained and rapport has been developed.

During the first segment of the interview, the interviewers should elicit enough information to permit the formation of provisional opinions about the degree and type of dysfunction present in the client, both at the time of the examination and on the relevant past occasions. A second staff conference is then convened. At this conference the interviewers discuss their perceptions of the client with the rest of the Clinic staff. They relate their observations and explain why they asked particular questions or pursued certain leads. The observers make their own comments, in the process giving the interviewers feedback about interview technique and voicing their own provisional opinions. This conference often will result in a new direction or emphasis for the second segment of the interview, the primary purpose of which is to probe more deeply into the questions identified during the second staff conference. The second segment often involves direct confrontation of the client in areas in which there appear to be inconsistencies, a hint of ambivalence, or fabrication. When the interviewers determine that further questioning would not be profitable, the inter-

[261] For a number of reasons, the Clinic almost always utilizes two interviewers during the psychiatric interview. The most obvious advantage is the probability that evaluators of differing orientations and backgrounds will tend to reduce the impact of evaluator bias. In addition, while one interviewer is questioning the client, the other can be closely observing the client's reactions, undistracted by the responsibility of carrying on dialogue. Finally, if confrontation with the client becomes necessary, the Clinic has found it useful for one interviewer to remain friendly and encouraging while the other assumes a more aggressive role.

view ends.

After the psychiatric interview, a third staff conference convenes. The observers of the interview divide into two groups. These groups independently attempt to develop clinically based responses to the referral questions. The Clinic has found that separating into groups stimulates observations from those who are reticent in larger, more formal assemblages. It also provides an interesting method of gauging the effects of evaluator variance. When the groups reconvene, each presents its opinion or opinions, which are then compared and analyzed. Often the result is an interchange that provokes additional interpretations of the data accumulated, thereby increasing the likelihood that every possible factual or theoretical nuance will be considered.

Ultimately, the task of articulating the Clinic's final opinion falls on the "team" assigned to the case, which includes the social worker, psychologist, psychiatrist, and law student responsible for the case. The team first must decide whether further information is necessary and, if so, how to obtain it. Once all the available data have been secured, the team then must decide whether it has enough information upon which to base an opinion. If not, the Clinic informs the referral source that the Clinic cannot offer an opinion, and explains why it cannot. Similarly, if the data do not suggest any significant clinical findings, the report will so state. If clinical findings with possible legal significance do emerge, the Clinic must sometimes make a further decision as to whether one or more hypotheses will be offered. When alternative theories cannot be rejected definitively, the Clinic will describe each viable clinical explanation, together with the supporting data.

The case of Mr. B illustrates the process of forming and excluding hypotheses that occurs at the Clinic. Mr. B was a nineteen-year-old charged with murdering a man after breaking into his apartment. In his statement to the police he claimed to have "blacked out" during the crime, although he remembered both entering the apartment and burying the victim's body.

Several tentative hypotheses arose at the initial staff conference: that he had suffered from an epileptic seizure that prevented him from "registering" the event; that he had been in a dissociative state[262] at the time of the incident; that he had "repressed" his

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[262] For a brief description of dissociation, see note 226 *supra*.

memory of the incident; or that he was lying. The staff agreed that the composite clinical picture tended to rule out dissociation. Those who had interviewed the client beforehand favored the hypothesis that he was dissembling.

During the psychiatric interview, however, the defendant described a long history of head traumas suffered while playing sports or working. By the final conference, opinion was divided between those favoring an organic explanation for his behavior and those clinicians who believed that he was fabricating the "blackout," as well as the head traumas.

The team assigned to the case immediately contacted the referral source, Mr. B's attorney, who, together with the Clinic's law student, accumulated substantial corroboration of the head injury incidents from Mr. B's childhood acquaintances, teachers, and coaches. A neurological examination also was scheduled to test the "epilepsy" hypothesis. However, the results of these tests were negative, tending to suggest that Mr. B had no lesions on his brain and that his behavior was not explicable in terms of organic pathology.

At this point the staff decided to attempt an amytal interview, to which the client consented. After thirty minutes of rambling, disconnected statements, the client haltingly began to describe the offense in detail, including the events of the "blackout" period. He stated, as he had during the psychiatric interview, that he had merely wanted money from the victim and that the victim had surprised him while he was rummaging through the victim's dresser. He then described for the first time how the victim had advanced on him, "staring at me with his steely blue eyes and backing me into a corner. He had a look that kills." Mr. B, who had a gun in his belt, said that he drew it and fired when the man came within a few inches of his face.

Mr. B's ability to describe these events made it extremely unlikely that his supposed loss of recent memory was due to organic causes. Otherwise, he would not have registered the event at all. This fact, combined with the results of the neurological testing, excluded the theory that he had been in the throes of a seizure at the time of the offense, and left two reasonable hypotheses for the claimed amnesia and the amytal story: first, that Mr. B had repressed the anxiety-producing memories recalled under the influence of amytal; and second, that he was consciously lying about

what he remembered, and that the amytal story reflected an effort to manipulate the Clinic into believing that he killed in self-defense.

The team recalled one segment of the psychiatric interview that previously had been accorded little significance. During that interview, as well as in the social history interview, Mr. B had revealed that he was extremely afraid of his father, a veteran policeman who appeared to be a strict disciplinarian, and that Mr. B had left home to escape his father. He also had mentioned the way his father's "cold" blue eyes stared at him whenever he did something wrong; he even claimed to be distracted by the blue eyes of one of the interviewers (who was later replaced by another whose eyes were less disturbing to the defendant).

These facts suggested a possible symbolic connection between the victim and Mr. B's father. The belief that Mr. B had not consciously planned to create such an impression, together with the perception of all who had observed the psychiatric interview that Mr. B was essentially passive in nature, led the team to conclude that Mr. B's account during the amytal interview was credible. The team did not think Mr. B had lied when he described the "blackout"; rather it felt that Mr. B had repressed the memory of the offense, not only because of his repulsion toward the violent act he had committed but, on a deeper level, because of its patricidal overtones. In the Clinic's opinion, his act was more the result of a panic state and fear of the victim-"father" than a premeditated murder. The final report described in detail the psychodynamic reasons for believing the defendant's story and explained how someone of Mr. B's character could have overreacted to the threatening advances of a man such as the victim.[263]

The procedure outlined above is relatively unsophisticated compared to other methodologies that may eventually have great utility in clinical decisionmaking, such as differential diagnosis using computers[264] and group probability research. We present it here merely as an example of how a practicing clinic attempts to exer-

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[263] The report was used by the court at sentencing and the defendant received a four year sentence.

[264] *See generally* Spitzer & Endicott, *Diagno*, 18 ARCHIVES GENERAL PSYCH. 746 (1968); Spitzer & Endicott, *Diagno II: Further Developments in a Computer Program for Psychiatric Diagnosis*, 125 AM. J. PSYCH., special supp., at 12 (1969).

cise quality control over its judgments.

2. *Developing Decisionmaking Criteria*

The second component of an objective opinion-formation process is the use of uniform criteria to assess whether a phenomenon of clinical or legal significance exists. Enhanced clarity in the definition of particular clinical syndromes minimizes both inconsistencies and the influence of bias and ideology in the decisionmaking process.[265]

Research conducted in the last decade suggests that operational definitions can be developed to reduce drastically variance in the criteria used to determine the diagnosis that should be ascribed to a particular set of behaviors. Professor Spitzer and his colleagues report that in using the "Research Diagnostic Criteria" developed by his group, diagnostic reliability ratings were appreciably higher than those reported in earlier studies.[266] Of course, for legal purposes these advances are important only insofar as the law specifies a "mental disease or defect" requirement and permits the use of diagnoses in defining this phrase.[267] However, similar techniques could improve the criteria that define clinical concepts more relevant to the forensic endeavor. A good example is the development of competency screening schedules, which have demonstrated very high validity when used to assess criminal defendants' competency to stand trial.[268] Another subject of recent study that could prove

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[265] At least one study has found that in diagnosis "criterion variance" is the single greatest cause of unreliability. This study found that 5% of the disagreement between evaluators was due to the subject, 30% to differences between evaluators, and over 60% due to variations in the criteria for finding a particular diagnosis present. *See* Ward, Beck, Mendelson, Mock & Erbaugh, *The Psychiatric Nomenclature*, 7 ARCHIVES GENERAL PSYCH. 198, 199-201 (1962).

[266] *See* Spitzer, Endicott & Robins, *Clinical Criteria for Psychiatric Diagnosis and DSM-III*, 132 AM. J. PSYCH. 1187, 1191 (1975). Spitzer's group was able to obtain 80% reliability for the diagnosis of "schizophrenia," an 86% rate for the diagnosis "schizo-affective disorder, depressed type," and 93% agreement on bipolar depression. They achieved similar results for all but two of the thirteen diagnostic categories they investigated. Criteria similar to those developed by Spitzer's group have been incorporated in AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL (3d ed. 1980). Widespread use of this manual should result in a considerable increase in the reliability of psychiatric diagnoses.

[267] *See* notes 124-41 *supra* and accompanying text.

[268] Professors Lipsitt, Lelos and McGarry developed a 22 item test of sentence completion designed to elicit responses pertinent to the legal criteria for competency and to screen out persons who are clearly competent. Each completion response is scored zero, one, or two and

useful in reconstructive evaluations is the attempt to fashion criteria for determining when a claimed amnesia is organically, psychogenically, or consciously produced.[269]

The field of ego psychology[270] offers considerable promise as a body of clinical knowledge capable of contributing reliable information to the legal system's task of reconstructive forensic inquiry. Professors Bellak and Sheehy[271] have developed an "ego functions assessment" schedule (EFA), which they contend can evaluate reliably impairment of an individual's ego functioning in a number of areas, including reality testing, judgment, regulation and control of drives, thought process, and defensive functioning. With this instrument, they purport to be able to link abstract statements about these functions to observable behavior.[272] While the EFA re-

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a total test score of twenty-one indicates competence. *See* Lipsitt, Lelos & McGarry, *Competency for Trial: A Screening Instrument*, 128 AM. J. PSYCH. 105 (1971). *See also* Shatin & Brodsky, *Competency for Trial: The Competency Screening Test in an Urban Hospital Forensic Unit*, 46 MT. SINAI J. MED. 131, 133 (1979); LABORATORY OF COMMUNITY PSYCHIATRY, HARVARD MEDICAL SCHOOL, COMPETENCY TO STAND TRIAL AND MENTAL ILLNESS 32-38 (1974) (inter-rater reliability of these devices is generally well over 80%).

[269] *See* Lynch, *supra* note 237; Showalter & Scott, The Use of Sodium Amytal in Forensic Evaluations: A Reconsideration (paper presented to annual meeting of American Academy of Forensic Sciences, New Orleans, La., Feb. 23, 1980) (copy on file with the Virginia Law Review Association).

[270] *See, e.g.*, G. BLANCK & R. BLANCK, EGO PSYCHOLOGY: THEORY AND PRACTICE (1974); G. BLANCK & R. BLANCK, EGO PSYCHOLOGY II (1979).

[271] *See* Bellak & Sheehy, *The Broad Role of Ego Functions Assessment*, 133 AM. J. PSYCH. 1259 (1976).

[272] For instance, the EFA instrument breaks down the reality testing function of the ego into three components: ability to distinguish between inner and outer stimuli, accuracy of perception of external events, and accuracy of perception of internal events. These components are then further defined along a thirteen-point continuum, stretching from maximum impairment of the designated component to optimal functioning of that component. Each point along the spectrum is discretely defined. Thus, in the continuum used for assessing the ability of the individual to distinguish between inner and outer stimuli, the individual is maximally impaired (point 1) if the following symptoms are found to be present:

> Hallucinations and delusions pervade.
>
> Minimal ability to distinguish events occurring in dreams from those occurring in waking life and inability to distinguish among idea, image, and hallucination.
>
> Perceptual experience is grossly disturbed (e.g., moving things look still and vice versa).

Maximum functioning (point 13) occurs when:

> Clear awareness of whether events occurred in dreams or waking life.
>
> Correct identification of the source of cognitive and/or perceptual content as being idea or image and accurate identification of its source as internal or external. Distinction between outer and inner precepts holds up even under extreme stress.
>
> Checking one's perceptions against reality occurs with a very high degree of automaticity.

mains untested in the forensic context, Bellak and Sheehy believe that it can provide "a statistically tested tool for evaluating a defendant in a format that exposes its logic to the jury," and that it can help the clinician systematically address such legally relevant issues as degree of impulsivity and intellectual capacity.[273] Experimentation with devices of this sort can contribute to the development of standardized clinical criteria that will improve the objectivity and reliability of the forensic evaluation process.

IV. Conclusion

In this article we have attempted to make the case for continued participation by appropriately qualified mental health professionals in the adjudication of reconstructive subjective issues of the criminal law. In Part I, we outlined the reasons why imprecision and speculation is and must be tolerated in doctrines of exculpation and mitigation. In Part II, we developed the case for evidentiary rules which permit "informed speculation" by qualified clinical experts so as to enable defendants to explore and present subjective defenses and assist triers of fact to assess the plausibility and significance of such claims.

We recognize that many mental health professionals have no special training or expertise in forensic matters and are not adequately sensitive to the risks of unreliability and imprecision in the evaluation process. We believe, accordingly, that the primary focus of reform should be on improving the quality of clinical participation in the criminal process, an effort which depends primarily on collaboration between the bar and the mental health professions to define the necessary qualifications of expert witnesses and to establish criteria for acceptable evaluation procedures. We sought in Part III to contribute to this collaborative effort by outlining some general guidelines that might facilitate objectivity in forensic evaluation.

Id. at 1263-64.

The individual is first rated along each continuum to arrive at the degree of impairment for the component in question. Then the component ratings are used to gauge the degree to which the ego function at issue (here reality testing) is intact.

[273] Bellak & Sheehy, *supra* note 271, at 1260-61. Of course, this instrument measures only *present* functioning. Moreover, to achieve the high inter-rater reliability the authors report (88%), extensive training in use of the instrument is required.