Charles E. Smith,[1] *M.D.*

The Art of Forensic Psychiatry: A Montage of Murder Cases

REFERENCE: Smith, C. E., "**The Art of Forensic Psychiatry: A Montage of Murder Cases,**" *Journal of Forensic Sciences*, JFSCA, Vol. 29, No. 1, Jan. 1984, pp. 209-218.

ABSTRACT: The cases of 25 attorney-referred murder defendants were analyzed to determine reasons for referral and demographic and clinical characteristics, including mental status and possible relationships between psychiatric findings and trial outcomes. The results suggest that a finding of major mental disorder may be accepted as a mitigating factor, particularly when a disposition is reached through the plea bargaining process. Meanwhile, formal adjudications of fitness for trial (competency) and criminal responsibility did not appear to be significant determinants in the outcome of these cases, even when major mental disorder was demonstrable. Instead, it appears that the forensic psychiatrist functioned most effectively in these cases as an instrument of compassion rather than as ancillary to the criminal law process. It is suggested that this can be an appropriate role for the forensic psychiatrist.

KEYWORDS: psychiatry, jurisprudence, homicide

> Although as doctors we may be less effective than legislators in the prevention of crime and the treatment of criminals, it is right to recognize the fact that we are concerned with individuals rather than with groups, and that the offenders who come under our special care are usually the most difficult and the least responsive. They are sometimes referred to us only in the last resort, and we must serve them with optimism free from exaggeration, inspired by hope, and encouraged by good will.
>
> Sir Norwood East [*1*]

Psychiatric participation in the criminal justice process remains highly controversial [*2,3*]. To offer a definitive opinion on such a debatable area may seem venturesome. However, as a practitioner who has provided services to the courts for many years, it seems desirable to make some evaluation of the impact and use of this work. Toward this end, this paper offers a self-assessment of some of my experiences in this field.

An early training experience in criminal law, followed by a variety of work experiences with lawyers, has given me a high regard for those who ably prosecute and defend criminal defendants. It is important to know that capable lawyers and doctors can enjoy mutual regard, not withstanding critical differences in their role and methodology. Such mutual regard exists when each is loyal to his own role, and neither has attempted to usurp the role or function of the other. In my opinion, the biggest problems on today's law/psychiatry horizon stem from one discipline's efforts to invade the other's domain, or to second-guess its theoretical foundation.

While experience suggests that it does take some courage to become involved in forensic

Received for publication 5 March 1983; accepted for publication 9 May 1983.
[1]Professor of psychiatry, Department of Psychiatry, School of Medicine, University of North Carolina, Chapel Hill, NC.

Copyright © 1984 by ASTM International

science matters, the rewards are seldom fulsome. It is a difficult task to distinguish illness from evil; to make the distinction without reference to personal morality is probably impossible. As with many of the issues surrounding the management of mental illness, fears and prejudices are well-entrenched, in this instance, often intensified by the ageless stigma attached to serious criminal misbehavior. Considering these circumstances, one who engages in this work may expect his self-image to be quixotic rather than heroic.

As a final caveat, I would like to stress the need to be guided by practical considerations in the provision of these services. Limitations in resources and native conservatism common to the communities where these cases occurred, have all tended to dictate a practical, middle-of-the-road, commonsense approach. We make no pretense here of having developed new and innovative approaches. Instead, the thrust has been toward useful, cost-effective interventions, consistent with the needs, interests, and resources of the communities where these cases were tried. Thus, it is hoped that the results which we report are representative of the main stream of forensic psychiatric practice.

With these theoretical considerations in mind, let us move on to examine some data bearing on the application of psychiatric assessment to murder defendants.

Methods and Materials

For purposes of this paper, a record review was made of the cases of 25 attorney-referred murder defendants seen during the years 1969 to 1982. The data tabulated in these cases included the following: demographic characteristics, reasons for referral, diagnoses, modes of killing, relationships to victims, and dispositions.

Demographic Data

The demographic data, which are summarized in Table 1, shows these defendants to be predominently young males with modest educational and employment attainments. You will note that blacks are over-represented in this series, as is the case for murder statistics nationwide. The ages in this group ranged from 15 to 61, with a median age of 26 and an average

TABLE 1—*Demographic characteristics of murder defendants.* N = *25 males.*

RACE	*N*	MARITAL STATUS	*N*
White	15	Single	9
Black	10	Married	7
		Separated	5
		Divorced	4
AGE		EMPLOYMENT	
-15	2	Unemployed	6
16-25	10	Military	2
26-35	6	Laborer	10
36-45	3	Farmer	4
46-55	2	Cook	2
56-65	2	Clerk	1
EDUCATION			
Less than 9 years	6		
9-11	9		
12	8		
More than 12 years	0		
No data	2		

age of 30. A quarter of these defendants were unemployed and slightly more than a third had broken marriages. As a whole, the group tended to be representative of lower socioeconomic levels.

Reasons for Referral

Table 2 shows the reasons that were given by the defendants' attorneys when they made their initial requests for psychiatric evaluation. Known histories of mental illness and bizarre and unusual characteristics of the offense charged were the most prominent reasons for referral. In almost one fourth of the cases, the defendant's behavior was thought to have been "strange," or in some way different from his usual behavior. There were five cases in which the defendant's use of alcohol or drugs was cited, and two cases in which amnesia was alleged. In this series, the recitation of indicators suggestive of underlying mental disorder favored this examiner's agreement to evaluate the defendant [*4,5*].

Diagnosis, Relationship to Victim, and Mode of Killing

In Table 3 the killer's diagnosis is charted against his relationship with his victim and his mode of killing. Nearly half of these killers were diagnosed as having schizophrenia. Half of the victims of these schizophrenic killers were unknown to their assailants, while the remaining victims were either relatives or friends.

In the three killings that were carried out by persons diagnosed as being mentally retarded, the victims were known to their assailants through ongoing relationships. This was also true of all of the four killings that were carried out by defendants who were diagnosed as having drinking problems. Finally, in those cases in which the killers were diagnosed as having neurosis, drug intoxication, or as being without mental disorder, the victims were all well-known to their assailants.

Bizarre and Brutal Murders

Slightly more than half of the murders in this series were characterized as bizarre or brutal or both by investigators and often the press. Of the thirteen cases so categorized, six of the killers were diagnosed as having schizophrenia, while one each were diagnosed as having depressive neurosis, mental retardation, alcohol intoxication, drug intoxication, and three were diagnosed as without mental disorder.

One of the schizophrenic murderers, a young, married, black male, had inflicted multiple gunshot wounds on his victim, slit her throat, mutilated her breasts, and enucleated one of her eyes. Another of the schizophrenic murders, a young white, married male, had lacerated

TABLE 2—*Reasons for referral of murder defendants,* N = *25.*

No.	Reason
7	history of mental illness and bizarre or brutal offense
4	history of mental illness
3	bizarre or brutal offense
4	unusual behavior
2	unusual behavior and bizarre or brutal offense
2	history of alcohol abuse
1	history of alcohol abuse and amnesia
1	history of alcohol abuse and bizarre offense
1	history of drug abuse and amnesia

TABLE 3—*Relationship to victim and mode of killing*, N = 25.

Diagnosis	Relative	Friend	Unknown to Defendant	Other
Schizophrenia, $N = 11$	1—bludgeoned infant son 1—shot brother 1—stabbed brother	1—shooting 1—strangling	1—vehicular 2—bludgeoning 3—shooting	...
Mental retardation, $N = 3$	1—strangled cousin	...	...	1—bludgeoned motel clerk 1—bludgeoned infant (baby sitting)
Neurosis, $N = 2$	1—burned stepfather	1—ran over girl friend	...	...
Drug abuse, $N = 1$	1—shot brother and neighbor	...	...	...
Alcohol abuse, $N = 4$	1—shot wife	1—bludgeoning 1—shooting	...	1—stabbed "pickup"
Without mental disorder, $N = 4$	1—shot wife	1—stabbing 2—shooting	...	...

his victim's neck and breasts and beat her head to a pulp with a heavy pick handle. A third young white male schizophrenic had inflicted fatal head injuries on his victim with a heavy, blunt instrument, in addition to lacerating wounds of the breasts and ano-genital areas. In each of the foregoing cases, the victims were unknown to their assailants.

A similar bizarre and brutal killing was carried out by a young, mentally retarded black male who manually choked his victim, then stabbed her in the heart, and finally, immediately after death, shot her with a shotgun and lacerated her breasts and genitals and anal area. In this instance, the victim was related to the assailant and lived nearby.

Disposition of Cases

In my judgment, it is highly significant that nearly two thirds of these cases were eventually settled in a plea bargaining process (Table 4). This finding is consistent with the longstanding practice in criminal law administration of exchanging leniency for pleas of guilty [*6*]. Furthermore, experience suggests that in the cases of mentally ill defendants, the use of plea bargaining provides an efficacious mechanism for introducing and weighing mitigating factors in a more objective, dispassionate atmosphere than is sometimes possible in an adversarial court room hearing.

An adequate report of the psychiatric examination of the defendant may suffice for plea bargaining purposes. Occasionally, the examining psychiatrist may be called into conference with the prosecuting and defense attorneys to present his report and respond to questions. In

TABLE 4—*Dispositions of murder cases*, N = 25.

Plea bargained	16	
Incompetency defenses	3	(all succeeded)
Insanity defenses	3	(all failed)
Other defenses	3	

other instances, the examining psychiatrist may present his findings in a court hearing, with cross-examination by opposing counsel.

When opposing attorneys are able to rely on the examining psychiatrist's findings as presented in a written report, the procedure is especially advantagous to the examiner, since it reduces the need for extended courtroom appearances. For instance, in this series of cases, a courtroom appearance was required in only four of the sixteen plea bargained cases.

In most of the plea bargained cases, the charge of first degree murder was reduced to second degree murder, while in two cases the charge was reduced to voluntary manslaughter, and in one case it was reduced to involuntary manslaughter. In all instances, defense attorneys viewed the psychiatric evaluations as helpful in achieving these results, and they and their clients generally viewed the outcomes as salutary. Defense attorneys were almost universally approving of the improved understanding of their client's behavior, which they gained through the psychiatric evaluations.

In spite of the apparently successful application of plea bargaining in many of these cases, a cautionary note is indicated. We have observed the processes of psychiatric evaluation and plea bargaining to be significantly interrelated. Thus, the physician-patient relationship formed in the evaluative process may encourage and facilitate expressions of guilt; guilt is a frequent concommitant of mental and emotional disorder, and, of course, successful plea bargaining ultimately requires an admission of some kind of guilt. Considering the ubiquitous nature of guilt, we must be on guard against exaggerated confessions of guilt, especially in the cases of certain guilt prone mentally ill defendants.

Incompetency Defenses

Defenses of incompetency for trial were made in three cases, all successfully. Note that in all three of these cases pre-trial examination at the state forensic facility had resulted in opinions that they were competent.

Two of these cases involved 15-year-old defendants, both with histories of chronic mental disorder, one with a diagnosis of schizophrenia and the other with a diagnosis of mild retardation. In both of these cases the court hearings were essentially pro forma, all parties apparently being sympathetic to an institutional placement in lieu of prosecution.

The third incompetency case involved a 55-year-old black male with a lengthy history of hospitalization for chronic schizophrenia. This man had been adjudged incompetent several years earlier when charged with garroting a female friend to death with a piece of wire. Several years later, he was returned for trial on the recommendation of the staff at the hospital where he had been treated in the interim. He was examined at the request of his lawyer, who reported that he had found him little changed from the time he was originally adjudged to be incompetent. After a lengthy hearing in which his competency was bitterly contested, the presiding judge again found this defendant to be incompetent. He was returned to the hospital, and a few years later, he was released into the custody of a brother. Shortly thereafter, he is alleged to have strangled another woman with a piece of wire, and he was subsequently slain by a law officer who was trying to return him to custody for that offense. Certainly, a result of this kind has little to recommend it, and perhaps more to be deplored.

Insanity Defenses

Contrary to popular legend, acquitals on the ground of insanity are rarely made. By the same token, murder defendants are not likely to escape extended confinement, and the threat of the death penalty looms high in those jurisdictions where it remains operative.

Thus, the insanity defense is generally reserved for the most outrageous and seemingly indefensible murder cases. Paradoxically, the strongest incentive for making the insanity defense then appears to be avoidance of the death penalty. It is often said that bad cases do not

make good law, and the three insanity defenses that were made in this series are probably representative of this aphorism.

The first of these cases involved a young white soldier who picked a girl up on a street in a town nearby the military reservation where he was stationed. They spent some time drinking and partying together. Later in the day, they drove to a little frequented lovers' lane area where an altercation ensued. The victim's body was found there with 55 stab wounds and physical evidence that she had been run over with a car, probably after death.

In the hearing on this case, psychiatric testimony was rejected under an exclusionary rule after a somewhat clumsy effort had been made to introduce the psychiatric findings through a hypothetical question. This defendant was sentenced to death, but later reprieved to a life sentence when North Carolina's death penalty statute was struck down by the U.S. Supreme Court [*7*].

The other two cases in which insanity defenses were made involved young, married men, one white, the other black, both of whom had brutally murdered and mutilated young white women whom they had accosted and taken under force to secluded spots.

Both of these defendants suffered with chronic schizophrenia. In one of these cases, the presiding judge appeared to be sympathetic with the insanity defense and the jury eventually recommended against a death sentence, apparently in deference to the compelling evidence of mental disorder. In the other case, the prosecution hotly contested the insanity defense. Nevertheless, the jury recommended against the death penalty. Ironically, this defendant died soon after in the prison mental health unit of an attack of acute necrotizing pancreatitis, apparently brought on by a generous feast of fried chicken, which his indulgent mother had brought him. Such are the vagaries of forensic psychiatry.

In our experience, the use of the insanity defense has been idiosyncratic to the extent that its basic thrust appears to have been directed toward avoidance of the death penalty. From a practical standpoint, the insanity defense is rarely viable in a jurisdiction like North Carolina where the M'Naghten Rule prevails and the burden of proof of insanity rests on the defendant. However, when it appears that an insanity defense has merit, that is when the defendant is demonstrably ill with a major mental disorder, resolution of the case through plea bargaining can be an attractive alternative. If plea bargaining is not administratively feasible, the insanity defense can provide a mechanism for introducing salient findings concerning the defendant's mental condition which can serve in mitigation during the trial and later at sentencing hearings.

Screening: Case Selection

In his excellent monograph on the insanity defense, Goldstein [*8*] makes an eloquent plea for the assignment of skilled and experienced counsel to cases in which mental illness may be an issue. Experience suggests that effective working relationships between physicians and lawyers require mutual regard and confidence. Therefore, psychiatrists must make constructive efforts to screen referrals to insure that they can work comfortably with the attorneys who seek their services. In discussing a case with a referring attorney, one should be able to determine the scope of the attorney's investigation of the case; the background information which is available to be shared with the psychiatrist; the referring attorney's understanding of the case; and his theoretical approach to its defense. If it develops that the attorney has a paucity of information about the case, is unclear as to why he is seeking psychiatric expertise, or appears to be on a "fishing expedition," the psychiatrist may be well-advised to disqualify himself. In this vein, I find that I decline roughly two out of every three referrals that I receive because of uncertainties and ambiguities which are disclosed in the screening process.

It is my unqualified opinion that the expert must be prepared to assume the role of a partisan advocate when he enters a case and that he must share this role with the defending attor-

ney. Unless the expert can reach a mutual accord with the referring attorney, it is probably best to leave the case alone, always keeping in mind that there is little room for equivocation in an adversary proceding.

A final note on the status of the referring attorney is in order. There is an inclination to disparage the efforts of appointed counsel and even public defenders. However, in my experience, an attorney's competence is not necessarily related to his status, that is, as to whether he is appointed, retained, or serving as a public defender. It is noteworthy to me that a little over half of the cases in this series were ably defended by appointed counsel, leading me to emphasize that foregone conclusions on this score are not warranted.

The Unattractiveness of Murder Cases

Murder is generally abhorrent to all of us, even when thought to have been committed in the "heat of passion" or in response to other provocation. Some murders lead to intense public outrage, particularly those which have the appearance of being brutal and "senseless." Lawyers who accept the responsibility of defending persons who have been charged with these kinds of crimes, and doctors who accept the responsibility of seeking a better understanding of the persons who commit these crimes, must be prepared to operate in an atmosphere of unpleasant hostility, prejudice, and perhaps mistrust. They must be prepared for criticism and at times even intimidation and threat.

By way of illustration let me briefly describe the case of a young, married serviceman who was initially charged with kidnapping, attempt to commit rape, armed robbery, and murder. This man, who functioned well in his military assignment, had nonetheless been hospitalized on four occasions during his military service: twice for suicidal attempts, once for an acute psychotic episode diagnosed as schizophrenia, and once for alcohol intoxication. The investigation in this case showed that this man had forced a young convenience store clerk to leave her post in the store and accompany him to a secluded wooded area where he beat her over the head with a heavy pick handle causing massive crushing injuries. Examination showed this man to be suffering with a schizophrenic disorder. He was preoccupied with the idea that he was being pursued and beseiged by demons, sorcerers, and witches who wanted him dead. He insisted that the victim was one of these witches. As is not uncommon in cases of this kind, observers who were close to the case tended to view this defendant's explanation for his brutal murder as improbable. Because of intense feelings about the crime, the defendant's petition to move the trial to another location was granted. Nevertheless, tension ran high at the trial and heavy security was apparent, it having been rumored that a relative of the victim might shoot the defendant if given the chance.

Clinical Acumen and Communication

The proper examination of criminal defendants requires the exercise of the highest possible clinical acumen. The examinations made in this context should be modeled after the best clinical practice. The history must be taken with care and relevant supportive documentation must be gathered whenever appropriate. The findings are often presented against a backdrop of repugnance, if not disbelief, so that speculation and equivocation tend to be unwelcome. Although the subject matter is often unattractive, there can be a certain symmetry of human understanding in a physician's perceptive clinical evaluation employed in a lawyer's skillful defense.

To gain an empathic understanding of what made a given defendant commit an offensive act is a personal experience which is not easily shared with others. Toward this end, physicians must learn to communicate better to be able to present their findings clearly and succinctly, avoiding, insofar as possible, jargon, speculation, and value judgments.

In the preparation of reports it has been useful to provide a formulation at the close of the

report describing the defendant's mental condition, how it may have related to the offense charged, and any recommendations for treatment. In making these formulations we generally avoid offering any conclusary opinions on legal issues that have not yet been formally raised, as well as those that may have been tenatively considered. In these respects, this statement would be essentially the same kind of opinion that we would offer to a family that had brought one of its members in to us seeking a diagnosis of his mental condition, and an opinion as to how his condition might likely affect his behavior. In this instance, we expect the patient and his family to join with us in deciding the disposition that is to be made of his mental problem. When we submit a report to a defendant's attorney we assume that it is the attorney's job to determine the ultimate use which is to be made of the findings in the legal proceeding that is pending.

Discussion

Intense controversy persists over the use of psychiatric expertise in criminal proceedings. In my judgment, the question of the use of psychiatry to add understanding to problems of criminal intent lies at the heart of this controversy. In contemplating wrongdoers, the presumption of criminal intent is a bench mark of the law's quest for efficient social control. It is probably true that psychiatry generally has little to add to the understanding of criminal intent. However, it can help us to understand the vissicitudes of individual wrongdoers, especially in those cases where emotional disorder and mental illness can serve in mitigation, when the moral persuasion is to be lenient.

Norwood East [*1*] has suggested that the findings of clinicians, including psychiatrists, may assist in grading murder. For instance, distinctions need to be made between levels of ordinary provocation that should be familiar to average men and degrees of provocation that are based in disordered or even delusional thinking. Clinical studies of defendants can provide important insights into personality structure, ability to handle stress, and, hopefully, improved understandings of the dynamics of certain wrongful behaviors. When mental disorder is present, relationships between the disorder and the defendant's wrongful behavior may be demonstrated. If a defendant is significantly incapacitated by mental disorder or emotional stress, the evaluative process can be turned to a therapeutic purpose, with relief of anxiety and depression or even treatment of incapacitating major mental disorder. In cases of emotionally disordered defendants, clinical examination can be helpful in resolving questions of risk that may arise if the defense strategy suggests that the defendant should consider testifying in his own behalf.

In addition to theoretical questions, several practical concerns loom high in the current debate over the employment of psychiatric expertise in criminal proceedings. For instance, some observers decry the fact that conflicting psychiatric testimony tends to obfuscate the trial process, sometimes introducing irrelevant issues to the determination of guilt or innocence [*9*]. Another concern has to do with the seemingly everpresent fear that psychiatric testimony may help a defendant to win a lesser punishment or even to escape punishment. A third compelling concern is that defendants with means and those whose cases achieve considerable notoriety are more likely to be able to engage psychiatric experts in their defense than are defendants of little means and little renown. Finally, there is a practical dilemma for psychiatrists who involve themselves in the criminal justice process, namely, the lack of dispositional alternatives and the dearth of opportunities for prevention and treatment. It is my belief that these are the sources of our frustrations, which at times lead us to join our detractors in their contentious criticism of the slender efforts which we now make in this area.

If there is some truth in all of these notions, it seems to me that what we are really saying is that we need more, rather than less, psychiatric involvement in criminal proceedings. If we seek to understand why defendants commit murder, and what can be done about it, the methods and resources that we use to answer these questions are woefully inadequate to the task.

To remedy this situation I would recommend improving and enlarging treatment facilities for mentally ill offenders. A beginning might be made by setting up pilot programs on a regional basis. I would suggest that these facilities be operated under the auspices of correctional services, because of the special security requirements for these patients, and to ensure that treatment programs are arranged in a manner compatible with court-mandated confinement. These institutions should provide multifaceted programs for diagnosis, treatment, research, and training, and they should have appropriate affiliations with existing institutions which have similar programs to serve nonoffenders.

In closing, let me observe that human suffering attends all killing, be it accidental or intentional. One does not cease to be human because he kills. Illness can lead to killing, and illness can follow the act of killing. Certainly, it is a proper role for physicians to care for illness and suffering, even that which attends murder. In my judgment, to do otherwise is to neglect a proper physicianly role, and perhaps even to deny the true nature of humanity.

Notes

[1] East N., *Society and the Criminal*, Charles C Thomas, Springfield IL., 1949.

[2] For example, in his article entitled, "Psychiatry and the Conditioning of Criminal Justice," 47 Yale L.J. 319 (1938), George H. Dession recommends the involvement of psychiatrists in the sentencing process. He states: "The psychiatrist ... is commonly understood to represent a generalized approach with respect to problems of personality and of human behavior quite at variance with the attitude finding expression in our criminal law as a whole. He carries this distinctive attitude with him when called upon to participate in the administration of criminal law."

"Presenting another viewpoint of psychiatry, the late Mr. Justice Frankfurter observed, speaking for the Supreme Court in *Greenwood v. United States*, 350 U.S. 366, 375 (1956): " ... their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment...." *Id.* at 325.

More recently, expressing yet another viewpoint, Chief Justice, John Biggs, Jr., speaking for the Third Circuit Court of Appeals in *United States v. Currens*, 290 F.2d751, 770 (3rd Cir. 1961) observed: "Since the turn of the century great strides in the advancement of psychiatry have been made and since the beginning of World War II the treatment and the cure of the mentally ill, the insane, has progressed at an astounding pace. But the criminal law has failed utterly to move forward with this achievement. In this country it has with few exceptions noted remained unchanged. It is as if those who sit cannot read."

For a contemporary critique of the involvement of psychiatry in legal proceedings *see also* Ennis, B. J. and Litwack, T. R., "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," *California Law Review*, Vol. 62, 1974, p. 693.

[3] Lawyers and judges are not alone in this area of controversy. Psychiatrists have their own intradisciplinary differences. For instance, writing in a commentary entitled, "The Psychiatrist as Physician," *Journal of the American Medical Association*, Vol. 234, 1975, p. 603, Dr. Arnold M. Ludwig makes the following statements: "If psychiatry is to regain its sanity and credibility as a medical profession, it will have to undertake a painful reexamination of the legitimacy of its many roles.... In my opinion, there can be only one sound foundation for psychiatry, that based on the medical model, and only one legitimate domain of expertise, that pertaining to mental illness.... According to this conceptualization, disorders such as problems of living, social adjustment reactions, character disorders, maladaptive learning patterns, dependency syndromes, existential depressions, and various social deviancy conditions would be excluded from the concept of mental illness, since these disorders arise in individuals with presumably intact neuro-physiological functioning and are produced primarily by psychosocial variables. As such, these nonpsychiatric disorders could be appropriately handled by nonmedical professionals."

Expressing a somewhat different viewpoint in an essay entitled, "The Life of Psychiatry," *American Journal of Psychiatry*, Vol. 133, 1976, p. 495, Dr. Bertram S. Brown makes the following statements: "Psychiatry is undergoing severe criticism from within and without, but the demand for psychiatric services has shown no concommitant diminution and none is in sight.... The interface between psychiatry and social systems is an area in which psychiatry has in some ways overpromised. This interface is the site of hope for integrating prevention efforts with social concerns, for integrating scientific knowledge with humanistic concerns, and, in my opinion, it is a proper domain of psychiatry."

For a general discussion of the relationship between psychiatry and law *see also* Robitscher, "The Impact of New Legal Standards on Psychiatry" or "Who are David Bazelon and Thomas Szasz and

Why Are They Saying Such Terrible Things About Us?" or "Authoritarianism Versus Nihilism in Legal Psychiatry," and Bartholomew, A. A., "Some Problems of the Psychiatrist in Relation to Sentencing," *The Criminal Law Review*, Vol. 15, 1972, p. 325. and Smith, C. E., "A Contemporary View of Psychiatry in Corrections," *Federal Probation*, Vol. 25, 1961, p. 16.

[4] Smith, C. E. and Strawberry, K. R., "Mental Competency Proceedings in Federal Criminal Cases," *Public Health Reports*, Vol. 75, 1960, p. 7.

[5] Smith, C. E., "Recognizing and Sentencing the Exceptional and Dangerous Offender," *Federal Probation*, Vol. 35, 1971, p. 3.

[6] Hall, J., *Law and Society*, Little, Brown & Co., New York, 1935.

[7] In its 2 July 1976 opinion that invalidated North Carolina's death penalty statute, the Supreme Court stated: "A third constitutional shortcoming of the North Carolina statute is its failure to allow the particularized consideration of relevant aspects of the character and record of each convicted defendant before the imposition upon him of a sentence of death.... 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 frailties of humankind. It treats all persons convicted of a designated offense not as uniquely individual human beings but as members of a faceless, undifferentiated mass to be subjected to the blind infliction of the penalty of death."

[8] Goldstein, A. S., *The Insanity Defense*, Yale University Press, New Haven, 1967.

[9] Giuliani, R., "Insanity Defense: Abolish in All But a Few Cases," *Justice Assistance News*, Vol. 3, 1982, p. 8.

Address requests for reprints or additional information to
Charles E. Smith, M.D.
Department of Psychiatry
235 Medical School, Wing C
University of North Carolina
Chapel Hill, NC 27514