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The Treating Psychiatrist as Forensic Evaluator

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ABSTRACT: Much has been made in the literature of the importance of "objective" or "impartial" expert psychiatric testimony in forensic psychiatric cases; one result of this emphasis is a strong feeling that a treating physician cannot present unbiased testimony in court on issues such as competency to stand trial and especially criminal responsibility. Many states have explicit regulations designed to ensure that expert psychiatric witnesses who testify in criminal cases are not contaminated by past (or even the potential of future) treatment relationships with defendants. The author argues that such policies often prevent mentally ill defendants from receiving treatment from psychiatrists with the most experience in working with forensic psychiatric patients; and that the opportunity to treat as well as to evaluate such patients might well attract more treating psychiatrists to the forensic science field.

KEYWORDS: psychiatry, jurisprudence, testimony, mental illness

There has been much discussion in both the clinical and legal literature of the necessity for "impartial" or "objective" expert psychiatric testimony in criminal cases [*1-16*]. Authors have criticized the adversarial system of eliciting such testimony as inevitably leading to simplifications and distortions of complex clinical issues [*7*], for making psychiatrists into "hired guns" with resulting loss of credibility for psychiatry as a profession [*4*], for forcing psychiatrists to testify on nonclinical issues such as criminal responsibility [*2, 7, 15*], and for paying too much attention to a profession the scientific basis for whose opinions is so questionable [*2, 17*]. A number of critics have called for the abolition of the use of psychiatrists as expert witnesses in the guilt phase of criminal trials; some would eliminate psychiatric testimony altogether [*2*], while others feel that it can be useful during the dispositional phase of criminal trials [*17*]. (While this article will refer to the use of psychiatrists as forensic science evaluators, the arguments can refer to other clinicians, such as clinical psychologists, who are now permitted to qualify as expert witnesses in many states.)

Many authors who do not go so far as to cry for abolition still recognize several potential conflicts of interests involved in expert psychiatric testimony in criminal trials. The goals of the psychiatric and legal professions are quite different, especially in the area of the criminal law, where the legal profession's chief goal is to protect society while psychiatrists are dedicated to helping individuals. The questions asked are also different—psychiatrists are concerned with the diagnosis, prognosis, and treatment of mental disorders, while courts are concerned with sociological and moral questions of guilt and responsibility.

Other theorists are not particularly concerned with such issues; they point out that the

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same potential conflicts arise in all cases, both civil and criminal, which involve expert testimony, and yet receive relatively little attention except in highly publicized insanity cases [*18*]. They hold that the principle of the adversary system is basic to Anglo-American jurisprudence, and provides an effective mechanism for arriving at the truth through the clash of opinions and evidence presented by the opposing sides [*3,11,15*].

Many authors who agree that psychiatric testimony poses significant problems, but feel that clinical experts should continue to participate in the guilt phase of criminal trials, propose that expert psychiatric witnesses should be appointed by the court, and be examined initially by the judge, as in the European inquisitorial model; the opposing attorneys could then cross-examine as is currently done. This would allow the psychiatrist to present opinions fully without the editing that is imposed by the adversarial system [*1,4,5,9,14*], and it would also help to eliminate some of the "expert shopping" which occurs under the strict adversary system [*1*]. This model has been criticized by other authors who feel that it would lead to judges and juries placing undue weight on the opinions of psychiatrists who testify under the imprimatur of the court [*3,8,10*]; it presents the same problem as does Plato's Philosopher King—the choice of the expert often determines the outcome, and that choice takes place outside the scrutiny and balancing of the trial process.

Another controversy surrounding expert psychiatric evaluation concerns possible conflict of interest experienced by the psychiatrist—in his expert witness capacity, he is a servant of the state and therefore cannot have the same relationship with the person he is evaluating as if he were simply the treating psychiatrist [*16*]. This issue has even reached the U.S. Supreme Court in a case in which the evaluating psychiatrist did not properly inform the defendant of the purpose of his interview [*19*]. Because of this conflict, it has been argued that psychiatrists should neither testify on forensic science issues concerning patients whom they are treating, nor undertake to treat patients whom they have evaluated for the courts, although this view has seldom appeared in the literature.

Some states have statutes or policies that implement this philosophy, particularly in the case of criminal responsibility determinations, by requiring or encouraging that such evaluations be done by private psychiatrists who have not treated the defendants, and who will not be responsible for any future treatment in state facilities which receive patients found not guilty by reason of insanity (NGI) [*3,5,20*]. A major concern in such situations is that psychiatrists who perform evaluations and are subsequently responsible for the treatment of NGI patients might change their opinions depending on whether or not their facilities want to reduce or increase censuses, or on whether the facility wishes to treat certain types of patients. Such a situation was clearly involved in the change of opinion of the staff at St. Elizabeth's Hospital as to whether or not antisocial personality disorder should be considered a mental illness for purposes of criminal responsibility determinations [*21*]; this abrupt change in philosophy, based on logistical rather than clinical considerations, was a major factor in the ultimate rejection of the Durham Rule, with its reliance on clinical testimony, in the District of Columbia [*22*].

On the other hand, forensic psychiatrists and legal scholars have argued *against* the principle of the "impartial" expert psychiatric witness, even if such could be found [*3,6, 10,11,15*]. Diamond and Louisell [*6*], as well as Weihofen [*10*], feel that all too often impartiality is achieved at the expense of sufficient time to do a thorough evaluation; and Diamond [*3*] argues that the courtroom is both an appropriate and an effective forum from which to educate society and its courts concerning the viewpoints of forensic psychiatrists.

It is the thesis of this paper that, at least in some cases, it would be *preferable* for treating psychiatrists to serve as forensic science evaluators when issues concerning criminal responsibility of their patients come up in court, and to treat such patients if they are subsequently imprisoned or hospitalized. There are several arguments in favor of this approach:

1. The determination of criminal responsibility, unlike that of competency to stand trial, is complex and requires not only a thorough diagnostic workup, but often considerable in-

vestigation into past history and behavior. Few defendants, especially those afflicted with mental disorders, can afford the expense of obtaining evaluations privately; and even those states that provide facilities for such evaluations typically cannot afford the individualized attention necessary in many complicated cases [*3,23,24*].

2. The states that have no forensic science facilities, or that (like Wisconsin) do not use their state facilities for criminal responsibility determinations, may provide private evaluations for indigent defendants; but they often fail to allocate sufficient funds to provide thorough evaluations in any but the simplest cases. Encouraging clinicians who treat patients also to do forensic science evaluations would provide courts with thorough workups instead of the typical hasty and incomplete ones which are often presented out of necessity [*3,23,24*].

3. With the growing complexity of psychiatric diagnosis, exemplified by the inclusiveness of *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III), many new complex diagnostic categories have been making their ways into the courts, such as compulsive gambling [*25,26*], pathological intoxication [*27*], posttraumatic stress syndrome [*28*], and multiple personality [*29–34*]. The majority of clinicians has never diagnosed or treated any of these conditions, and many question the very existence of any of these diagnostic categories, much less accepting that they should relieve a defendant of criminal responsibility. If those clinicians who do have the clinical experience do not provide the courts with their expertise, then the criminal justice system will continue to be denied the necessary information to determine responsibility. As it is now, a few recognized experts have become "circuit riders," travelling from state to state testifying about of these conditions based on their general experience, without actually having the time to evaluate individual defendants carefully [*23*]; there is a significant danger that the testimony of such experts may be overvalued by lay juries if it is not balanced by opinions from treating psychiatrists who have greater familiarity with the individual patients charged with crimes. Unfortunately, many psychiatrists with considerable clinical or research knowledge or both of these less common or controversial conditions do not have the inclination or the forensic science experience to make credible witnesses in court. As a result, many patients who suffer from such conditions are never diagnosed at all, and they and the courts are denied access to legally relevant information [*29,31,34*].

Another problem with the use of these relatively new defenses is that the media tend to be highly critical whenever such conditions result in a jury returning a verdict of not guilty by reason of insanity, or even diminished capacity. If these disorders are to become recognized as "legitimate," it is crucial that more knowledgeable clinicians participate in legal as well as in clinical dialogue. When forensic psychiatry loses credibility as a result of public outrage over unpopular and misunderstood decisions, it has a significant impact on the credibility of psychiatry in general, and in turn may create a backlash against psychiatric input into the legal process [*18*], and result in withdrawal of both clinical and legal benefits for mentally disordered offenders.

4. Until relatively recently, the insanity defense had in practice been reserved for defendants with psychotic illnesses, especially schizophrenia, who were accused of major crimes. Such defendants tend to remain demonstrably disordered during trial procedures, and juries had relatively little difficulty in appreciating the degree of illness involved. By contrast, the behavior of patients with many of the newer diagnoses may appear quite normal much of the time, even without treatment. It requires both a high clinical index of suspicion and often considerable time with a defendant as well as a thorough past history to be able to recognize the presence of such conditions. Forensic clinical staff at state facilities typically have neither the time nor the interest to become adept at discovering such relatively rare conditions; the very volume of patients that they see often leads to a cynicism towards all but the most obvious illnesses which predisposes them to ignore the signs of the rarer illnesses [*34*]. Treating clinicians may be less suspicious, and often have the time to pursue their interests in less common or obvious disorders.

5. If defendants are found not responsible because of mental disorder, it is important both

for the defendants themselves and for public safety that effective treatment be provided. The major psychotic disorders are typically relatively easily diagnosed and treated without requiring a significant amount of clinical time or expertise; but the effective treatment of many of the newer categories of disorder frequently necessitates a considerable amount of both.

Using treating clinicians in the forensic science system would provide better treatment for patients, better future protection for the public, and a greater incentive for clinicians to become involved in the forensic science process. As opposed to the more common illnesses, in which remissions can usually be easily induced but in which relapses are the rule, successful treatment of conditions such as multiple personality can result in greatly reduced risks of both clinical relapse and legal recidivism [*29,30,33*]. Although juries are not *supposed* to take a defendant's treatability or how long he/she might remain incarcerated if found NGI into consideration when determining criminal responsibility, they frequently consider the probable disposition and potential for "cure" when making their decisions. (Jurors in the case reported in Ref *34* stated that the probable disposition of the defendant if found NGI was a significant factor in their decision to find him criminally responsible.) It can therefore be quite important for clinicians who have experience with both the diagnosis and the treatment of these more complex conditions to become involved in testifying in criminal cases. If juries and judges knew that a competent clinician would assume the responsibility for treatment, they might be less reluctant to find defendants nonresponsible, and less reluctant to consider release from hospitalization before the expiration of the maximum sentence. This in turn would provide an incentive for mentally disordered defendants to cooperate with treatment.

The opportunity to treat patients with relatively unusual and challenging disorders might also attract more treating clinicians into the forensic science field, benefitting patients and also giving clinicians access to a population of patients not frequently seen in private practice—for example, the great majority of male patients with multiple personality who have been reported in the literature have been diagnosed after they were charged with crimes [*29*].

There are reports in the literature in which treating clinicians have become involved in the criminal justice process both before and after the trial [*31,34-36*]; it is clear from these reports that the professional involvement of trained clinicians was of significant benefit both to patients and to the court.

Of course, there are clearly many pitfalls in mixing clinical and forensic science roles in the way I have recommended. There is a significant danger of confusion of roles between what Hollender calls "patient-oriented" and "society-oriented" roles for clinicians [*37*]. It is imperative that patients are absolutely sure exactly what role the clinician is fulfilling if he is to become involved with the courts. Such identification of position is already automatic (or at least *should* be) for both forensic science evaluators and for those who treat patients under civil commitment [*38*]; it would not be too difficult for treating clinicians to include such warnings as a matter of course. Since any information elicited from patients during forensic science evaluations cannot be used as evidence that the patient actually committed the alleged crime (and since in practice the insanity defense is rarely raised unless proof that the defendant actually committed the alleged act is overwhelming), there would be little reason for clinicians to be concerned about causing harm to their patients by becoming involved in forensic science evaluations. In fact, even if the clinical evaluation does not support a patient's stated wish for exculpation, it does not necessarily follow that it is unethical for a treating clinician to so testify; particularly in cases involving relatively minor offenses, it might even be therapeutic for a patient to accept responsibility for his actions when it appears that he in fact had sufficient control over his behavior.

There is also a potential credibility problem—some juries and courts might decide that treating clinicians are not sufficiently "objective" for legal purposes of determination of responsibility or release. In practice, however, this has rarely been a major problem, provided that the clinician is not obviously slanting his testimony to favor his patient's wishes (or his

own desires to protect his patient.) Presently, a significant number of forensic science evaluators continue to testify in this manner even when they are not also treating defendants; it would seem that this tactic is more related to a clinician's personal philosophy about the criminal justice system than to whether or not an actual treatment relationship has been established. Judges and juries can usually tell when a testifying clinician is slanting his testimony or deliberately omitting relevant information in order to further his own personal viewpoint; there is no necessary connection between such testimony and a treatment relationship. In some areas, such as workers' compensation, courts have even held that treating physicians' testimony is to be *preferred* over that of independent evaluators.

At present, a major problem with the use of treating psychiatrists as forensic science evaluators is that most clinical practitioners do not have the knowledge or the experience to participate effectively in courts [*39*]. The ability to translate clinical information into terms that are both legally relevant and understandable by nonclinical judges and juries is still not taught in most psychiatric residencies (although forensic science training is now required by the Liaison Committee on Accreditation of Residency Programs, and more residents than before are exposed to the principles of effective courtroom presentation.)

Conclusion

With certain types of mental disorders, particularly those that are difficult to diagnose or that require long-term psychotherapy for treatment, there might well be an advantage to having clinicians whose major practice is treatment become more involved in the forensic science process. Patients would benefit from increased access to treatment; more clinicians might become interested in the practice if there were more opportunities for them to treat; and the public would benefit each time such a patient could be successfully treated. The potential problems of increased involvement by treating clinicians are no greater than in current practice, and could easily be handled in the vast majority of cases by a frank disclosure of the clinician's role with each individual patient.

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