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Report

32

USE OF PSYCHIATRIC DIAGNOSES IN THE LEGAL PROCESS

REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE ON USE AND MISUSE OF PSYCHIATRIC DIAGONSIS IN THE COURTS
REVISED EDITION

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INTRODUCTION

In recent years, our legal system has increasingly called upon psychiatrists to help resolve legal conflicts[1]. There are many reasons for this trend, including increased complexity of problems facing the law, greater sophistication of the legal system, heightened public awareness of mental illness, expansion of laws concerning mental illness and disability, and an expansion of the knowledge base in the mental health field. It is also likely that the American Psychiatric Association's publication in 1980 of a reliable and widely accepted diagnostic nomenclature (DSM-III)[2] has encouraged courts to rely more heavily on psychiatric expertise. Whatever the reasons, there is an increased demand for psychiatric testimony and formal diagnostic terminology has appeared with greater frequency in testimony.

The use of psychiatric diagnoses in legal settings has been controversial.[3,4] Some friction is created because there is an imperfect fit between legal constructs and psychiatric impairments, and between such impairments and actual diagnoses. The intuitions of lay judges and jurors about the legal relevance of psychiatric disorders often diverge from what is actually known about them. Misunderstanding is common, and both psychiatrists and lawyers have, at times, become frustrated and disenchanted with the use of psychiatric diagnoses in the courtroom. Some psychiatrists have gone so far as to argue that diagnoses do not provide any information useful to legal determinations and that clinical terminology often confuses rather than clarifies legal issues. At the same time, other psychiatrists have criticized expert witnesses who do not link their opinions to the diagnostic methodology of the profession on the grounds that such unanchored opinion exceeds their expertise as psychiatrists. At one time or another all psychiatrists probably have been troubled by the uses to which diagnoses have been put in the courtroom, especially when the ensuing controversy and confusion threaten to undermine public confidence in psychiatry and the therapeutic aims of the nomenclature.[5]

In the opinion of the Task Force, psychiatric diagnoses can be useful to all parties making legal decisions involving mental incapacity. However, diagnostic information can be misunderstood by non-professionals in ways that prove detrimental both to the interests of justice and to the interests of psychiatrists and their patients. This Task Force Report describes the ways in which diagnoses may be useful in the legal process and details some of the more common misunderstand ings, It is hoped that this document will help all participants in legal decisions involving mental disability to make better informed use of psychiatric diagnoses.

THE NATURE OF PSYCHIATRIC DIAGNOSES

In order to understand the special applications and limitations of diagnostic information to forensic questions, it is necessary to understand how and why the current diagnostic nomenclature came to exist.

The classification of phenomena is necessary for the systematic pursuit of knowledge in all scientific disciplines. In medicine, symptoms and signs of illness complaints of the suffering and the overt evidence of dysfunction— are classified into diagnoses. In the field of psychiatry, the DSM-III-R represents the most widely accepted diagnostic scheme.[6]

Phenomena are placed into a classification scheme to improve communication and to permit systematic study. In psychiatry, the process of diagnosis begins with an observation of a cluster of signs and symptoms which appear together with some regularity in patients presenting for care. y attaching a readily communicated diagnostic term to such clusters (or syndromes) clinicians find it easier to share their experiences about similar patients. Research can be initiated to examine the clinical course and natural history of groups of patients with a particular syndrome. In this way

clinicians can accumulate information collectively and systematically, rather than in isolation. This enables them to benefit from one another's experience and study. As such knowledge grows and is disseminated, the ability of clinicians to make predictions about the course of the illness is also enhanced. Once the course of the illness, or prognosis, is known, treatment interventions can be tested on similar groups of patients in an effort to find ways to favorably alter the course of the illness. The capacity to.' group patients also permits investigation into shared traits or abnormalities that may lead to greater understanding of what causes and sustains a particular disorder.[7]

The DSM-III-R comprises all syndromes identifiable in the universe of patients presenting for psychiatric attention. Inclusion in the diagnostic scheme occurs when there is sufficient agreement that a distinct syndrome can be recognized. This inclusion does not require that the cause, the course, or the treatment of the syndrome be established; rather, it is a means to discovering those ends. It is especially important for non-physicians to appreciate that each DSM-IU-R diagnosis is at its own stage of this scientific evolution. Some diagnoses have lengthy histories, having been recognized by physicians for many years. Much may be known about their course and treatment. In some instances, for example, organic mental disorders, the causes are also known. For many of the diagnoses in the current diagnostic manual, however, information about long-term course is only gradually accumulating and causes are certainly not known. Some of the characteristics of newly recognized disorders are far from fully agreed upon and some currently listed disorders may turn out to have little clinical usefulness.[8]

Classification is not static but is a means to further permit the pursuit of new knowledge. Research facilitated by classification inevitably leads to changes in our understanding of mental disorders and the need 'to revise the classification scheme to reflect that greater understanding. In some instances, when new information is taken into consideration, a consensus may be reached by researchers and clinicians that certain conditions do not warrant a place in the diagnostic nomenclature. Other disorders may be uncovered or the need for subclassifying may be called for over time, with research, better classification schemes should result from earlier ones. This is an ongoing process. Many of the revisions appearing in the DSM-III-R were based on over 2,000 scientific publications which cited DSM-III.[9]

One of the distinct advantages of the DSM-III-R diagnostic system over previous systems is that it has increased the level of agreement of different clinicians who use it. It is generally acknowledged that the diagnostic system has high reliability (agreement as to diagnosis by different observers). This markedly increases its value for research.'° The reliability of DSM-IU-R also makes diagnostic observations more appealing to the legal system insofar as their use facilitates a more standardized discussion of complex issues related to mental abnormalities.

In sum, the diagnostic nomenclature is designed to further communication between mental health professionals and to improve knowledge about the mental disorders they treat. To the extent that each version of the nomenclature achieves greater reliability, it is a step towards realization of this overarching goal.

THE NEEDS OF THE LEGAL SYSTEM

Most of the issues the legal system calls upon the psychiatrist to clarify are related to a person's capacity to perform certain mental functions or to choose to behave in certain ways.[11,12] Courts may be concerned with present or contemporaneous capacities, with past or retrospective capacities, or with future or prospective capacities.[13] In the criminal justice system, the law is often concerned with the defendant's state of mind at the time of a crime (retrospective capacity), with the defendant's capacity to perform the various mental and behavioral tasks required in the various phases of the criminal justice process (contemporaneous and future capacity), and with the patient's capacity to deal with various future environmental circumstances without committing disruptive or harmful acts (prospective capacity).

In the civil setting, the court may be concerned with the competency of individuals to manage their affairs and to take care of their basic health needs (contemporaneous capacity). Civil litigation may also pertain to an individual's capacity at some time in the past to make a will or to make other decisions concerning property (retrospective capacity), and may turn on predictions as to whether people have the psychological capacity to master future tasks, typically in employment settings (prospective capacity). The process of civil commitment also deals with predictions as to the patient's current capacity to avoid committing disruptive or harmful acts in a non-protected environment.

Only a small number of forensic roles do not deal specifically with the assessment of capacities. Courts sometimes ask psychiatrists to simply describe the degree of ham) a patient has experienced. This commonly occurs in personal injury and malpractice cases. Although some harms can be viewed as a diminution of the patient's capacity to perform various actions, other aspects of harm are more experiential and relate to the patient's pain and suffering. In instances of malpractice litigation, the court may also be interested in having the psychiatrist assist in describing whether professional standards of care were violated and whether such violations caused injury to the patient or others.

From the legal perspective, consideration of the appropriate uses of psychiatric expertise takes place within the context of the law of evidence. In order to be properly introduced, evidence must meet a test of relevance. The Federal Rules of Evidence succinctly define 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." [Rule 401][14]

Relevance, then, has two components: the evidence must address a fact that is the subject of legal dispute, and it must be of probative value with regard to that fact—it must make an incremental contribution to the determination of the truth or falsehood of the fact Testimony judged not to be relevant will be excluded. Under some circumstances, relevant testimony may be excluded if its prejudicial effect outweighs its probative value, or if it is repetitive, or c or would be misleading to the jury. If the premises on which the evidence rests cannot be tested, it may also be excluded. [FRE 403 and 801].[15,16]

Special rules apply to expert testimony. The Federal Rules of Evidence state:

> "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert … may testify thereto…." [FRE 702][17]

The Federal Rules permit liberal use of expert testimony. Some jurisdictions have adopted more restrictive rules to limit the scope of expert testimony about scientific matters. The most frequently used test was laid out in the court's decision in Frye v. United States (1923):[18]

"Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stage is difficult to define. Somewhere in the twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing on which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs."

The Frye rule is intended to guard the decision making of the court against relying on untested ideas. The perceived need for such a special rule probably derives from the considerable weight that might be placed on scientific testimony. However, as noted above the Frye rule is not used in most jurisdictions (or not for psychiatric testimony, at least) and the admissibility of expert testimony is governed solely by the general requirements of the Federal Rules or their state equivalents.[19]

In sum, experts may be called upon when specialized areas of knowledge, beyond the understanding of the lay public, are at issue. The

use of diagnostic information, as with other psychiatric testimony, should be measured against the requirements that testimony be relevant and based on testable premises. In addition, in many jurisdictions, these premises must be accepted by the field of psychiatry. On the other side of the ledger, whether or not diagnostic testimony is confusing must be considered.

USES OF DIAGNOSIS IN THE LEGAL PROCESS

In this section, the ways in which diagnoses might contribute to the soundness and accuracy of legal determinations are discussed. We first address the ways in which psychiatric diagnoses are relevant for particular legal issues, notwithstanding the imperfect fit between diagnoses and the substantive law of mental disability. We then turn to the methodological value of psychiatric diagnosis, an indirect benefit, that tends to improve the quality of psychiatric testimony in general.

Diagnosis as a threshold

Mental disorder is often a threshold requirement in legal determinations. For example, in the criminal law every legal test for criminal responsibility specifies that the legally relevant impairment must be due to "mental disease or defect," and many, though not all, standards for incompetence to stand trial (including the Model Penal Code's) require that the defendants' limitations be due to mental disorder.[20,21] In the civil law, the existence of a mental disorder may be necessary to establish, among other things, that a party was incompetent to contract, unable to write a valid will, or requires a guardian of person or property.[22] The presence of a mental disorder is a necessary condition for civil commitment.[23] Finally, in government disability programs, a diagnosable disorder is, for all practical purposes, a predicate for eligibility.[24]

These threshold requirements limit legally sanctioned excuses, entitlements, and curtailments of liberty to persons who suffer from mental illness. In general, mental disorders serve these threshold functions because they are believed to be meaningfully associated with diminished abilities. In some instances, the diagnostic requirement is meant to serve as a validator of the main legal contention that certain relevant impairments are present.

In the opinion of the Task Force, the use of established diagnoses enhances the value and reliability of psychiatric testimony even though the connections of diagnosis to the ultimate functional disability may not be as strong as would be ideal from both legal and empirical perspectives. First of all, by employing established diagnoses, psychiatrists make a large body of clinical and research literature and other information available to legal fact finders. Such information is likely to enhance their understanding of the nature and characteristics of the disorder, and this should improve the ability of the legal decision maker to determine whether the disorder properly falls within the domain established by law. Second, established diagnostic criteria are extremely valuable to the evaluator who is concerned with the problem of deception. The subjects of psychiatric assessment in many legal contexts have powerful incentives to feign mental illness (to escape responsibility for their actions, or to gain compensation or access to entitlements). Knowledge of diagnostic criteria and of symptomatic phenomena associated with diagnoses, allows the examiner to compare reported symptoms and abnormalities with well known patterns. Malingerers, unfamiliar with diagnostic syndromes, often report patterns of symptoms that do not comport with known diagnostic entities.[25]

Relating mental illness to functional capacities and legal standards

When the legal system does seek psychiatric assistance in determining whether or not an individual has a given legal incapacity, diagnoses will be helpful in conducting the evaluation. For example, under the Model Penal Code, a defendant is not responsible for criminal conduct if, due to mental illness, they lacked substantial capacity to appreciate the wrongfulness of their actions, or lacked substantial capacity to conform their behavior to the requirements of the law at the time of the offense.[26] The evaluating psychiatrist will need to make a diagnosis and assess whether symptoms, such as a delusion or agitation, may have affected these discrete, legally defined capacities.

In making a diagnosis, the psychiatrist identifies a range of possible symptoms that may affect the assessment of a functional legal capacity. Access to the scientific literature gained via the diagnosis may contain information of potential relevance to the evaluator and the legal decision maker, including data about the frequency, duration, and quality of these associated symptoms and disabilities.

Diagnosis, and in most instances functional impairments, are not dispositive of the legal issue at hand, either because definitive data are not available or because of inherently moral components of the judgment. But diagnostic information is relevant; that is, it may make the fact finder more or less likely to find the test for legal incapacity has been met. Thus, the diagnosis serves as a point of reference which enhances the reliability and thoroughness of the assessment: the particular subject of evaluation can be assessed in relation to others of the same diagnostic category aided by the cumulative experiences and research of the entire field of psychiatry with this diagnosis.

Diagnosis is also a reliable means of conveying relevant information and psychiatric perspective to the fact finder. For example, a lay jury may view a criminal defendant's claim that he shot his neighbor because he thought the neighbor was part of a conspiracy to kill him as a desperate, self-serving ploy. But when informed by a psychiatric expert that the defendant suffers from paranoid schizophrenia and that delusions of this sort are common, the report is more likely to be viewed as credible by the jury and they may find it relevant to issues of exculpation or mitigation.

While functional capacities are always more relevant to legal standards than diagnoses, a diagnostic statement communicates a great deal as to the nature of functional capacities. A diagnosis immediately provides useful information as to what capacities might be impaired. Often, it provides clues as to the possible duration of such impairment. Insofar as the diagnosis reveals something of the course of an illness it also clarifies past and future incapacities. As will be noted later, this is especially relevant to making retrospective (such as mental status at the time of a crime) or prospective evaluations (such as the prediction of future dangerousness to self or others required in civil commitment proceedings).

The alerting function of psychiatric diagnoses

Because psychiatric diagnoses are often associated with functional incapacities, they are useful in alerting attorneys, judges, and psychiatrists that legally relevant impairments may be present. When a diagnosis is established, attorneys may communicate about their clients with mental health professionals and explore the possible mental health implications of the legal case. In capital crimes, for example, where any evidence offered in mitigation may be crucial, an attorney may be seriously remiss if he or she ignores the existence of a previous diagnosis of mental disorder.[27]

In a similar fashion, psychiatrists conducting forensic evaluations will be guided by earlier diagnostic impressions of others to specific areas of assessment. A diagnosis of dementia, for example, suggests that the individual may have cognitive deficits and diminished capacity to manage his or her own affairs or to make a will. A diagnosis of schizophrenia raises the possibility of hallucinations or delusions being present. Schizophrenia is prevalent among groups of defendants found to be incompetent to stand trial and not guilty by reason of insanity.[28] A diagnosis of major depression borderline personality disorder or schizophrenia is frequently made in patients who must be hospitalized involuntarily because they may harm themselves. Any diagnosis characterized by psychotic features may be associated with impaired decision making capacity. Here, the knowledge of previous diagnosis helps the evaluator to focus on capacities which have legal relevance.

The methodological value of psychiatric diagnoses

The use of diagnosis improves the reliability of testimony about mental disorder and abilities. The current APA diagnostic nomenclature is the focus of unprecedented efforts and scrutiny on the part of the mental health fields. The DSM-III was the first diagnostic system in any branch of medicine to be subjected to field testing before being employed. The operational criteria of the DSM-III and DSM III-R have been incorporated in every facet of psychiatric endeavor, research, treatment and education, and the official diagnostic nomenclature has been adopted by allied professionals as well as the field of psychiatry. When a psychiatrist employs a diagnosis from the current nomenclature, the courts may be assured that countless man-hours of expertise have gone into formulating the diagnostic entity. [29]

The use of the DSM-III-R also meets the standard of general acceptance by the field required by Frye. This cannot be said for other diagnostic systems. While there is undoubtedly a legitimate role for unofficial diagnoses, the courts need to be wary of speculative and unproven testimony. The official APA nomenclature provides a standard for identifying those who describe "syndromes" that have questionable reliability or validity.

The official diagnostic nomenclature, as currently embodied in the DSM-III-R, does not preclude the use of other clinical diagnoses outside its framework. Indeed, investigation into new areas and alternative criteria for recognized mental disorders are necessary to the continued vigor of diagnostic revision and the strength of the process. Whenever non-standard methods are employed, or psychiatrists choose to deviate from the established diagnostic criteria in other ways, however, courts should be prepared to subject these uses to close scrutiny. Too much deviation may represent ungrounded clinical speculation rather than scientific empiricism. Psychiatrists employing non-standard diagnoses should bear the burden of informing legal professionals of the deviation and the reasons for doing so. In some instances, the alternative diagnosis will be one recognized by some subset of clinicians and there will be a body of clinical and empirical writing to serve the same function as with a DSM-III-R diagnosis. When this is not the case, the court should be aware that the diagnosis does not enjoy the general acceptance of the field of psychiatry. In allowing the use of such testimony the court opens the legal process to the risk of unreliable "expert" testimony.

Anchoring clinical judgment

The use of diagnoses, particularly when their signs and symptoms are carefully codified as in DSM-III-R, serves to improve the quality of the information presented at thai by allowing experts' reasoning to be tested. Assertions made by expert witnesses about known concomitants of a disorder can be checked by attorneys as well as other psychiatrists assisting the opposing side. The testimony of experts is therefore grounded in the psychiatric literature. This serves as a check on efforts of experts who are poorly informed or who have an adversarial agenda to cloak their entire reasoning process under the rubric of "clinical judgment." Of course, a careful expert might be able to provide useful and accurate assistance to the court without the use of diagnostic information. But even when the character and capacities of such an expert is beyond reproach, his or her testimony may not be as useful as that which is related to a diagnostic system. All individual decision makers eventually make mistakes and reliability is always improved by some means of oversight. Over time, the field of psychiatry advances, information accumulates, and the once dependable expert may become out of date and unreliable. Courts are better served by establishing a system which insures diagnostic reliability.

It is also worthy of note that there is a substantial body of research related to diagnoses that is of considerable value to courts and overlaps with issues psychiatrists are asked to evaluate. Research literature which deals with diagnosis can be valuable to the courts in enhancing the value and reliability of expert testimony.

Disciplining prediction and reconstruction

Psychiatrists are frequently called on to perform assessments in which the relevant legal issue concerns an individual's mental functioning at a past or future point in time, e.g., criminal responsibility evaluations, testamentary capacity. The value of these evaluations are improved by -- and in some instances will be completely dependant on -- the professional's capacity to make knowledgeable predictions about the longitudinal course of symptoms that affect the relevant legal capacity. Psychiatrists' ability to make prognostic or retrospective judgments flow from diagnoses. Correctly diagnosing the patient is an essential step in any such evaluation.

The use of diagnosis serves as a check on ungrounded speculation about past or future events. Consider the situation of a psychiatrist evaluating a defendant for criminal responsibility some months after arrest. The expert will have to consider the defendant's current presentation, medication status and response, and reports of the symptoms suffered at the time of the offense. This information is most useful if it describes a known disorder such as paranoid schizophrenia. Signs and symptoms of this disorder observed at the time of evaluation may suggest the presence of an ongoing process which allows for a more informed assessment of the defendant's capacities at the time of the crime. Only after this process is applied does the witness's testimony become disciplined by the "specialized knowledge" of the psychiatric profession.

Similar considerations apply to making predictions regarding a person's future conduct. To the extent that the diagnosis encompasses continuing mental impairments or incapacities it alerts the clinician and court to factors that are probably relevant to the patient's future behavior. Such knowledge is sometimes helpful in actually evaluating the patient's current capacity to avoid conduct that may be controlled only through hospitalization. It is almost always of value in helping legal and social systems structure environments which can minimize social harm.[30] A clear statement that a particular schizophrenic patient will have difficulty functioning in the community without medication and case management, for example, can be of great assistance to social agencies in making dispositions.

SOURCES OF MISUNDERSTANDING AND CONFUSION

The process and implications of psychiatric diagnosis—as briefly summarized above—are often misunderstood by lay people, and this misunderstanding has led to misuse of diagnostic information in the courts. In turn, misuse of psychiatric diagnoses can distort the administration of justice and generate intense controversy within the professions of law and psychiatry. In this section, the Task Force identifies and discusses those areas that most commonly lead to confusion and dispute.

Conceptual distance between diagnoses and functional capacities

As noted above, the law is ultimately concerned in most situations not with diagnoses, but with the functional limitations resulting from medical and psychiatric disorders. The structure of legal inquiry generally takes the following form: in determining a legal disability, the fact finder will need to be informed about the nature of the disorder, the functional impairments with which it is associated, and, finally, how these impairments affect the ability in question, qualitatively and quantitatively. This is true in the criminal law, for example, in determinations of competence to stand trial and criminal responsibility, and in the civil law, in determinations of competence to make treatment decisions, competence to make a will, and ability to perform job-related tasks.

As also noted previously, the law sometimes makes the presence of a medical or psychiatric disorder a threshold requirement prior to inquiry about functional limitations. Legal excuses, burdens or entitlements may be limited only to those who have an identifiable disorder. The policy considerations behind these practices may rest on traditional assumptions that the mentally ill experience symptoms beyond their control and are,

therefore, rightly subject to differential legal treatment, or upon the belief that the known psychiatric disorders are usually associated with the legally relevant' disabilities.

While the importance of diagnosis as a threshold is well established, it must be remembered that judicial attention is ultimately focused on incapacities that have legal relevance. Thus, a psychiatrist who establishes a diagnosis without describing these incapacities does not provide sufficient information required for a legal determination: Unfortunately, courts may place too much significance on the diagnosis itself and may pay insufficient attention to specific information more relevant to the legal issue in dispute. Forensic specialists have long criticized the expert witness who testifies in conclusory terms—e.g., "Mr. Jones is schizophrenic and therefore not competent to stand trial and not criminally responsible," or, "this patient is demented and cannot manage his own affairs," or, "Ms. Smith is a paranoid schizophrenic and, therefore, dangerous."[31,32] When a diagnosis is presented to the court without clarification of its relationship to relevant legal capacities, two types of serious error may occur: (1) variation of individuals' impairments within a given diagnosis may be ignored; and (2) diagnoses are used as if they are dispositive in the determination of legal standards, when, in fact, they are not.

There may be considerable variation in impairments, abilities, and disabilities within a diagnostic category.[33] While a diagnosis is instrumental in gaining access to clinical and research data defining the range of impairments associated with its symptoms, it does not inform the legal decision maker about the actual impairment of a particular patient. The range of possible functioning (whether it involves mental capacities or behavioral performance) within a diagnosis is broad. In fact, while certain diagnoses commonly may be found among those who are characterized as "incompetent" or disabled for legal purposes, the prevalence of legally relevant disability among all those suffering from a disorder may be quite low. For example, while there is considerable literature on competence to stand trial that indicates that defendants suffering from schizophrenic disorders are prevalent among those thought to be incompetent, the majority of individuals with schizophrenia are indisputably capable of assisting in their defense.[34]

When diagnoses are used to infer functional impairments in a global, categorical fashion, a disservice is performed to the courts, to the psychiatric profession, and to patients. The court cannot test the premises used by the evaluating psychiatrists in reaching their conclusions. Such conclusory testimony implies that the relationship between diagnosis and the legal capacity is beyond the understanding of the lay person. Often the finder of fact is left to judge the expert's opinion on faith or according to the weight of his or her credentials. The court is deprived of essential data about the relationship of disorder to impairment and dysfunction, and the expert's opinion is placed beyond the reach of tests that may reveal bias, lack of thoroughness, or misconceptions, which are unlikely to be discovered by other means. The reliability of legal determinations inevitably suffers. In the opinion of the Task Force, when diagnoses are used in this way they are of little value, and, in some cases, can result in confusion and judicial error.

Testimony which does not focus on capacities also implies that the complex legal issue confronting the court is a medical determination that is nested within the diagnosis. The legitimate fact-finder, the judge or jury, is diverted from performing its full fact finding function and the individual in litigation is denied adjudication by impartial lay people. If this happens, the opinion of a single physician employing unarticulated, unchallenged reasoning may substitute for the painstaking effort to ascertain the truth associated with legal adjudications. Courts would best be served by demanding that the expert who testifies in this way offer further explanation or by excluding such testimony altogether.

These practices also do a great disservice to patients. Influential lay people, judges, attorneys, and others present in the court, are misinformed that a given diagnosis invariably leads to a disability. Patients who have that disorder may be falsely assumed to have certain disabilities. Such assumptions may diminish their employability or acceptance in a variety of social situations. Public understanding of mental illness is also compromised. When participants or observers of the legal process have had experiences at variance with that expressed by the expert the credibility of the profession may be undermined, and patients may face new forms of prejudice and stigmatization.

Unfounded intuitions about mental disorders and individual control

Another source of misunderstanding is the widely shared set of intuitions among lay people that mental disorders refer to conditions outside the individual's control. These intuitions may reflect legitimate strivings for a more perfect system of justice that refuses to punish that which cannot be controlled and compensates for impairments that are not the fault of the individual. For example, courts will be interested in whether or not certain behavior should be attributed to a disorder or to a person's willful acts.[35] Even if a disorder is present, courts may be uncertain whether the disorder itself should be attributed to individual choices. The problem of volition is especially vexing when the disorder is largely defined on the basis of behavioral characteristics. The paraphilias, for example, are for the most part defined on the basis of deviant behavior, and often these behaviors are gratifying to the patient and appear to be self serving. Con will usually find it difficult to believe that pleasurable activities cannot be controlled.

Questions involving choice or volitional capacity are not unique to psychiatric medicine. Individuals who lead certain lifestyles may develop medical problems at high rates.[36] Nor are the legal conundrums unique to psychiatry. While medical disorders are rarely the subject of concern in the criminal law, physicians from other branches of medicine have struggled with the volitional problem in the area of work disability. Indeed, when the government's disability system was being established, Congress conducted extensive hearings to gather information on' how the system should be set up. Many physicians testified that medical disorder was' not a reliable predictor of inability to work and that no methodology existed to assess this functional capacity. Nonetheless, in order to provide some evaluative framework—and reliably limit claims—a requirement of a medical disorder was incorporated into the disability program.[37]

Many psychiatrists share with lay persons some of the intuitions that certain disorders are associated with diminished volitional powers and that others are not. Nonetheless, these common beliefs do not yet amount to scientific evidence. Unfortunately, public expectations that psychiatrists and the diagnoses they' describe can reliably address questions of volition, particularly when these questions are asked to resolve moral issues, may be so unrealistically high as to lead inevitably to disappointment and disharmony.

In psychiatry, some of the most difficult cases related to questions of volition involve diagnoses based largely on aberrant behavior, e.g., disorders of impulse control, substance abuse, and substance dependence disorders. Difficult determinations, in need of resolution, abound. This is especially true when addiction is an issue. Repetitive use of certain substances may set up a powerful biologically based urge which, in turn, may compromise the person's capacity to refrain from further use of these substances. There will be differences of opinion as to how much "choice" they actually have.

The problem of determining volitional capacity in the legal context is also compounded by the reality that the law often seeks to draw bright categorical lines. Yet, volitional capacity is almost always a quantitative rather than an all-or-none issue. It is rare for mental disorders to be associated with incapacities which obviate the possibility that the patient can make more than one behavioral response to a situation. Because some element of choice (however difficult that choice may be) is usually present it is rarely correct to talk about behavioral symptoms as "involuntary" or "beyond the patient's control."

A related source of misunderstanding concerns the relationship between knowledge of the "causes" of mental disorders and about the patient's control over the "symptoms" of those disorders. Lay persons tend

to assume that conditions diagnosed are "caused" by forces outside the person's control and that if the disorder is characterized by a particular behavior or mental disturbance, this too was not chosen by the individual. But, as previously discussed, inclusion in the diagnostic nomenclature does not require knowledge about the cause of a disorder. Rather, diagnosis is a means of advancing investigation that may uncover causative factors. This is not to say that there are no available explanations of the causes of disorders. There are many competing theories which exist in the absence of an established cause. For most disorders, however, sufficient empirical data do not exist to validate any etiologic explanation.

Problems may arise when psychiatrists from different schools of thought base their explanations to the court on their competing theories. These theories may assign a greater or lesser degree of individual control over symptoms associated with a particular diagnosis depending on the nature of the explanation. Biological explanations, for example, may lead to the assumption that the disorder compromises choice more than psychological or social explanations.[38] Legal fact finders may be confused by testimony which a that disorders or diseases do or do not "cause" a person's mental experiences or behaviors, particularly when such testimony is not identified as theoretical.

A more useful approach to assessing an individual's volitional impairment involves analysis of the clinical practices of psychiatrists. While no science of volition exists, the nature of clinical practice regularly requires psychiatrists to make judgments as to their patients' responsibility. For utilitarian reasons, clinicians hold patients responsible for some mental occurrences, but excuse others.[39] In practice, clinicians tend to believe that experiential symptoms (e.g., mood disturbance, hallucinations, delusions) are less under the control of patients than behavioral symptoms (e.g., substance ingestion, impulsivity). Patients are generally not held responsible (in clinical interactions) for symptoms associated with cognitive impairments or severe mood variation, nor are they usually directed to cease experiencing symptoms related to such dysfunction. At the same time, clinicians will usually hold patients accountable for behavioral symptoms, particularly when such symptoms can be modified by minor changes in the patient's environment. (The patient who engages in some deviant behavior only when the environment is one in which punitive consequences are unlikely is usually assumed to be capable of controlling that behavior.)

Clinicians are also aware that no diagnostic category automatically is associated with complete absence of individual control. Even in those instances when the diagnostic nomenclature suggests diminished capacity of patients to control their acts, the prevailing clinical practice is to emphasize to patients who behave inappropriately that they have some capacity to exert their will over their conduct. In many instances, patients demonstrate their ability to do so.

The clinical practices of psychiatrists may provide some clues for dealing with volitional issues for purposes of treatment. But it must nonetheless be emphasized that These practices do not provide firm guidance in dealing with the social and moral issues of legal responsibility. Again, such determinations cannot be made on the basis of existing scientific knowledge.

Variation in levels of knowledge about different diagnoses

Legal decision makers sometimes assume that all disorders in the diagnostic nomenclature have achieved equal scientific stature. It may be assumed incorrectly that the field of psychiatry has had similar degrees of historical experience, knowledge about longitudinal course, and conviction about the validity of each disorder's place in the diagnostic taxonomy. As discussed above, however, there is considerable variability among disorders on these and other important facets of understanding. Diagnoses serve first as clear descriptions of disorders which are instrumental to the process of gathering further empirical data. These data may confirm or disconfirm initial beliefs about the disorder and may result in significant modification of diagnostic criteria or elimination altogether from future diagnostic schemes. Inclusion in the diagnostic taxonomy reflects a general consensus that some patients may be described meaningfully by the established criteria and further study should occur, but it may not tell us much more.

In many instances courts will benefit by insisting on more inquiry into substantive knowledge about a diagnosis. With assistance from the empirical literature and experts, courts may employ exclusionary rules of evidence to limit the use of diagnoses whose scientific status is still under scrutiny. For example, some courts across the United States have ruled that Pathological Gambling Disorder does not meet the threshold requirement of mental disorder for criminal non-responsibility and have excluded psychiatric testimony which argues that it does.[40]

Specific instances of misuse of diagnosis

While psychiatric experts cannot always control the content of tertimony regarding diagnosis, it is important that they not mislead the courts.

The risk of misuse of a psychiatric diagnosis is heightened when the diagnosis is based largely on self reporting of symptoms. Whenever a patient gains a great deal (either excuse from blame or monetary award) by receiving a diagnosis (such as post-traumatic stress disorder) which is largely based on self-reporting, the use if that diagnosis in the courtroom requires special scrutiny. The diagnosis of post- traumatic stress disorder especially may be prone to legal misuse since it is defined on the basis of largely self reported symptoms which are assumed to he "caused" by a stressful event such as an accident which may have legal significance.[41] It is misleading for the expert to imply that making this diagnosis clarifies any legal issue unless the precise relationship of the current symptoms to the stressful event is carefully documented.

There have been recent instances in which psychiatrists have testified that the presence of symptoms related to post-traumatic stress disorder (often described as a new syndrome such as battered spouse syndrome) is powerful evidence that certain abusive events such as rape or child molestation have taken place. Here. a diagnosis based on a DSM-III-R category is used to conclude that criminally actionable conduct has occurred. In the absence of a scientific foundation for attributing a person's behavior or mental condition to a single past event, such testimony should be viewed as a misuse of psychiatric expertise.

Another common misuse of psychiatric diagnosis occurs when unwarranted conclusions concerning treatment and prognosis are based solely on the diagnosis. Testimony relating diagnosis to standards of care or extent of damages is often introduced in malpractice litigation. Statements that particular diagnoses per se necessitate particular treatments generally are not justified by our current state of knowledge. For example, the failure to hospitalize a patient is frequently an issue both in ordinary malpractice and in duty-to-protect cases. Yet, no diagnostic category by itself requires hospitalization. There is also reason to question testimony that certain diagnoses mandate specific treatments. With rare exceptions psychiatrists are not in full agreement on this issue.[42]

Problems in evaluation: Time and access to information

Not all of the problems associated with the use of diagnoses emanate from conceptual misconceptions or oversimplification. Often, the problems result from the routine pressures inherent in consultation to the legal system. For example, many attorneys and judges, while recognizing the importance of diagnoses, fail to understand that information from third parties is often necessary for adequate diagnostic assessment. Some tend to view the evaluation process as vulnerable to contamination from third parties. Materials may be withheld from the examiner to avoid "bias." Although this practice may be motivated by a desire to influence the outcome of the evaluation, it can also result from the misguided belief that the diagnostic process is a biopsy-like procedure which is best performed in isolation.

Access to information may also be limited by procedural rules governing evidence. For example, in some jurisdictions, psychiatrists

consulted by the defense in a criminal case may not have access to victims' or eyewitnesses' statements. Furthermore, sufficient time for evaluation is sometimes not provided. Lawyers may pressure clinicians to formulate opinions and diagnoses in brief amounts of time. Attorneys may not recognize mental health issues in a timely fashion, and when they do, courts may be inflexible in allowing time for assessment In some circumstances, of course, the call for rapid evaluation may be an unavoidable consequence of the need for emergency assessment and immediate disposition. For example, a psychotic individual in jail may need to be transferred for urgent treatment at a civil facility. Provisional diagnoses assigned at these times indicate the need, at a later point, for further accumulation of diagnostic information.

In the opinion of the Task Force, adequate time and access to information is essential to the ability of psychiatrists to employ diagnoses appropriately. Clinicians generally acknowledge the essential nature of third-party information, gathering data from spouses, children, colleagues, and friends, as well as past psychiatric history from medical records and other mental health professionals who have had previous contact with the patient. Empirical evidence demonstrates that such information improves diagnostic reliability for certain disorders.[43]

There is good reason for psychiatrists performing assessments for legal purposes place greater emphasis on outside sources of information than other psychiatrists. For example, malingering is uncommon in routine clinical practice, but special care is needed to diagnose it in forensic practice. The subject of evaluation often has something to gain by a finding of mental illness and may attempt to feign a psychiatric disturbance. (Or conversely, in some settings such as prisons or forensic hospitals, subjects may try to fake normality.) As noted above some mental disorders are diagnosed on the basis of symptoms that are self-reported and, in routine clinical practice, psychiatrists often rely on self-reporting of behavioral problems. While diagnostic parameters serve as useful tools in uncovering malingered mental illness, external corroborating information is essential in establishing a diagnosis in many instances.[44] Legal decision makers should realize that ultimately, a diagnosis is only as reliable as the body of information upon which it rests.

Some of these misunderstandings may stem from misconceptions about the diagnostic process. The operational criteria employed in the DSM-III and DSM-III-R have been falsely assumed to suggest a mechanical application of reported symptoms to diagnostic "menus."[45] The easily-comprehended presentation of criteria has led to the perception in the legal profession that making a diagnosis is a quick, simple task. Actually, this is almost never the case. It is the opinion of the Task Force that greater efforts need to be made to educate the legal profession regarding the difficulties and nuances of clinical decision making and the necessity of third party sources of information.

CONCLUSION

The sources of misunderstanding and confusion identified in this report are not easily erased or modified. Many pressures intrinsic to legal adjudication induce experts to offer testimony beyond their expertise and it is not easy to correct the tendency of lay persons to assume that more is implied by a diagnosis than is warranted. Courts are burdened with determining justice in cases involving conflicting evidence where legal standards are ambiguous and difficult moral judgments must be made. Understandably, they might welcome assistance from psychiatrists in discharging such responsibilities, and in seeking their assistance, they are tempted to find more significance and certitude in a diagnosis than is justified by current knowledge.

In the view of the Task Force the temptations to misapply psychiatric expertise must be vigorously resisted. Misuse of psychiatric diagnosis serves the interest of neither the legal system nor the psychiatric profession. Psychiatric testimony that attributes too much explanatory or excusing power to diagnoses encourages adversaries in the legal process to avoid the rigorous task of thinking through the precise relationship mental impairment should have to the legal decision at hand. Defining that relationship involves consideration of moral dimensions and societal needs. Ultimate legal determinations are rightly the domain of representatives of the community. The moral dimension of determining responsibility is not a task to be ceded to psychiatrists.

The misuse of psychiatric diagnoses also has a corrosive effect upon the psychiatric profession. As the use of diagnostic information in legal and policy decisions continues to proliferate, it will increasingly come under the scrutiny ot advocates for special interest groups (such as various types of victims) struggling to gain advantage for their members in legal determinations. These attorneys may seek experts who are unrepresentative of mainstream psychiatric thought and who may have snatched up the banner of advocacy themselves. Policy makers faced with the task of ascertaining the appropriate weight to give the contentions of these groups are likely to pressure the field of psychiatry for definitive answers. Worse, there may be mounting pressures placed on the process of diagnostic revision, as groups see inclusion as a means of validating their claims for legal recognition, and as decision makers grope for a principled means of adjudication of these claims. Already, considerable political pressure has surrounded the inclusion of certain new diagnostic categories in the DSM-III-R. And insurance companies, seeking to limit their obligations, have made requests that the APA identify "real mental illnesses" in future diagnostic manuals.

These efforts threaten to distort the therapeutic aims of psychiatric diagnoses. Diagnoses must continue to serve primarily as a means of promoting communication within the field, facilitating research, and guiding treatment. These interests are central to the very identity of the field of psychiatry. They are not served if the profession's diagnostic system is shaped by legal, political or economic interests. By the same token, however, the profession itself bears the responsibility of preserving the integrity of its diagnostic system. One important feature of this effort is to clarify us legitimate uses in legal adjudication and its limitations. The report of this Task Force is a first step in the effort to fulfill this responsibility.

FOOTNOTES

1. Curran, W.J., and McGarry, A.L. The Psychiatrist as Expert Witness. In, W.J. Curran, A.L. McGarry, and S.A. Shah (Editors), Forensic Psychiatry and Psychology. F.A. Davis, Philadelphia, 1986.
2. Diagnostic and Statistical Manual of Mental Disorders (Third Edition). American Psychiatric Association, Washington, D.C., 1980.
3. Curran, W.J., and McGarry, A.L. The Psychiatrist as Expert Witness. In, W.J. Curran, A.L. McGarry, and S.A. Shah (Editors), Forensic Psychiatry and Psychology. F.A. Davis, Philadelphia, 1986.
4. McGarry, A.L. Pathological Gambling: A New Insanity Defense. Bulletin of the American Academy of Psychiatry and the Law. 11:301-308, 1989.
5. Miller, R.D. Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era. Chapter I, Mental Disorder. Charles C. Thomas, Springfield, IL, 1988.
6. Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised). American Psychiatric Association. Washington, D.C., 1987. Unless the context requires otherwise, references to DSM-III-R should be understood to refer to DSM-IV and succeeding editions of the Diagnostic and Statistical Manual of Mental Disorders.
7. Spitzer, R.L., Williams, J.B.W, and Skodol, A.E., DSM-III: The Major Achievements and an Overview. American Journal of Psychiatry. 137:151-164, 1980.
8. Woodruff, R.A., Goodwin, D.W., and Guze, SB. Psychiatric Diagnosis. Oxford, NY, 1974.
9. Williams, J.B.W. Psychiatric Classification. In, J.A. Talbott, R.E. Hales and S.C. Yudofsky (Editors), The American Psychiatric

Association Textbook of Psychiatry. American Psychiatric Press, Washington, D.C., 1988.
10. Williams, J.B.W. Psychiatric Classification. In, J.A. Talbott, R.E. Hales and S.C. Yudofsky (Editors), The American Psychiatric Association Textbook of Psychiatry. American Psychiatric Press, Washington, D.C., 1988.
11. Melton, GB., Petrilla, J.A., Poythress, N.G., and Slobogin, C. Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers. Guilford Press, New York, 1987.
12. Weiner, I.B., and Hess, A.K. Handbook of Forensic Psychiatry. John Wiley, New York, 1987.
13. Halleck, S.L. Evaluation of the Psychiatric Patient. Plenum, New York, 1991.
14. Federal Rule of Evidence 401.
15. Federal Rule of Evidence 403.
16. Federal Rule of Evidence 801.
17. Federal Rule of Evidence 702.
18. Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923).
19. Daubert v. Merrell Dow Pharmaceuticals, Inc. — U.S. — (1993).
20. Shah, S.A. Criminal Responsibility. In, Curran, W.J., McGarry, AL., and Shah, S.A. (Editors), Forensic Psychiatry and Psychology. F.A. Davis, Philadelphia, 1986.
21. Model Penal Code and Commentaries (Official Draft and revised comments). American Law Institute, Philadelphia, 1980.
22. Brakel, S.J, Parry, J., and Weiner, BA. The Mentally Disabled and the Law, Third Edition. American Bar Foundation, Chicago, 1985.
23. Simon, R.J. Clinical Psychiatry and the Law. American Psychiatric Press, Washington, D.C., 1987.
24. 42 U.S.C. Section 423 (d) (1935).
25. Rogers, R. (Editor). Clinical Assessment of Malingering and Deception. Guilford Press. New York, 1988.
26. Model Penal Code and Commentaries (Official Draft and revised comments). American Law Institute, Philadelphia, 1980.
27. Bonnie, R.J. Psychiatry and the Death Penalty: Some Emerging Problems in Virginia. Virginia Law Review, Vol. 66, No. 1, 167-189, 1980.
28. Monahan, J., and Steadman. Hi. Mentally Disordered Offenders. Plenum, New York. 1983.
29. Williams, J.B.W. Psychiatric Classification. In. J.A. Talbott, RE. Hales and S.C. Yudofsky (Editors), The American Psychiatric Association Textbook of Psychiatry. American Psychiatric Press. Washington, D.C., I988.
30. Miller, R.D. Involuntary Civil Commitment. In, Simon, R.J., (Editor), Review of Clinical Psychiatry and the Law, Volume 2. American Psychiatric Press, Washington, D.C., 1989.
31. Halleck, S.L. Law in the Practice of Psychiatry. Plenum, New York, 1980.
32. Appelbaum, P.S., and Gutheil, T.G. Clinical Handbook of Psychiatry and the Law. 2nd Ed. Williams & Wilkins, Baltimore, 1991.
33. Spitzer, R.L., Skodol, A.E., Gibbon, M., et al. DSM-III Case Book American Psychiatric Association, Washington, D.C., 1981.
34. Roesch, R., and Golding, S. Competency to Stand Trial. University of Illinois Press, Champaign, IL, 1980.
35. Halleck, S.L. The Mentally Disordered Offender. American Psychiatric Press, Washington, D.C., 1987.
36. Matarazzo, J.D., Weiss, S.M., Herd, J.A., et al. Behavioral Health. Wiley, New York, 1984.
37. Report of a Study by a Committee of the Institute of Medicine, "Pain and Disability: Clinical, Behavioral and Public Policy Perspectives." National Academy Press. Washington, D.C., June 1987.
38. Jeffery, C. Biology and Crime. Sage, Bever)y Hills, California, 1979.
39. Halleck, S.L. Which Patients are Responsible for Their Illnesses? American Journal of Psychotherapy, Vol. 42, No. 3, 338-353, July 1988.
40. U.S. v. Lewellyn, 723 F.2d 615 (Eighth Circuit, 1983).
41. Sparr, L.F.. and Atkinson,R.M., Post-Traumatic Stress Disorder as an Insanity Defense: Medicolegal Quicksand. American Journal of Psychiatry. 143:608-612. 986.
42. Treatment of Psychiatric Disorders. American Psychiatric Association. American Psychiatric Press. Washington. D.C., 1989.
43. Scheiber, S.C., Psychiatric Interview, Psychiatric History and Mental Status Examination. In, Talbott, J.A., Hales, R.E., and Yudofsky, S.C. (Editors), Textbook of Psychiatry. American Psychiatric Press, Washington, D.C., 1988.
44. Rogers, R. (Editor). Clinical Assessment of Malingering and Deception. Guilford Press, New York, 1988.
45. Reis, W.H., and Wise, M.C. DSM-III Training Guide. Brunner Mazel. New York, 1989.