

Insanity Defense Evaluations: Toward a Model for Evidence-Based Practice

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The insanity defense has been described as a symbol of the relationship between law and psychiatry (Stone, 1984b). As such, it has always been the subject of intense legal and public scrutiny, despite the fact that it is infrequently raised and seldom successful. Forensic psychiatrists are often depended upon by the criminal justice system to provide these evaluations, which require a high degree of training and expertise. In 2002, the American Academy of Psychiatry and the Law published its *Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense* (AAPL, 2002). While noting that any attempt to promulgate guidelines will be limited by evolving legal doctrine and psychiatric science, the intent of the guidelines was to describe "acceptable forensic psychiatric practices."

KEY WORDS: insanity defense, forensic psychiatry, law, mental disease, evidence-based, practice guidelines.

In seeking to achieve a model of evidence-based insanity evaluations, we will begin by identifying primary objectives. Table 1 lists some primary objectives that have been cited elsewhere as fundamental and generally accepted goals for forensic psychiatrists when conducting evaluations for the courts (AAPL, 2005; AAPL, 2002; Dietz, 1996).

These objectives may serve as guideposts around which evidence-based sanity evaluations can be modeled as progress in psychiatry and law evolves. Because of the interplay of legal and psychiatric perspectives, evidence-based insanity evaluations must be informed

by an understanding of relevant historical and legal developments in the area.

Insanity Standards

The insanity defense, in varying forms, existed long before psychiatry (American Psychiatric Association [APA], 1982). References to the insanity defense date to biblical times. The Babylonian Talmud (Epstein, 1935) refers to the insanity defense in the statement: "It is an ill thing to knock against a deaf mute, an imbecile, or a minor . . . if they wound others they are not culpable." The famous *McNaughtan* standard was the product of experimentation with various insanity standards in England throughout the 1700 and 1800's. The *McNaughtan* standard stated:

To establish a defense on the ground of insanity, it must be clearly proved that, at the time

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TABLE 1. Insanity Defense Evaluation Primary Objectives.

Educate the court
Clarify psychiatric issues
Be honest and objective
Strive for accuracy
Offer opinions based on factual data and sound reasoning
Readily acknowledge limitations

of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as to not know the *nature and quality* of the act he was doing; or, if he did know it that he did not *know* he was doing what was wrong . . . and whether the accused at the time of doing the act knew the difference between *right and wrong* . . . in respect to the very act with which he is charged.

Prior to the *McNaughtan* standard, the insanity test assessed whether the defendant had the capacity to tell right from wrong in the global sense, not with respect to the current offense. With the *McNaughtan* standard, the jury question was changed to the more narrow focus of whether the defendant knew the specific criminal act was wrong.

In 1955, the American Law Institute developed a proposed criminal law code, called the Model Penal Code (MPC). Various sections of the MPC have been adopted by many state and federal jurisdictions. The Model Penal Code insanity standard states:

A person is not responsible for his criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.

The terms “mental disease or defect” do not include an abnormality manifested only by

repeated criminal or otherwise anti-social conduct.

The MPC insanity standard contains a liberalized version of both the right–wrong test from the *McNaughtan* standard as well as the irresistible impulse test. In 1981, John Hinckley was found Not Guilty by Reason of Insanity (NGRI) for his attempted assassination of President Ronald Reagan. Public outrage about the verdict led to demands for reform. As a result, the Federal Insanity Defense Reform Act of 1984 narrowed the insanity standard in federal jurisdictions. Many states also dropped the volitional prong from their statutes. The revised federal standard is a *McNaughtan* standard with the requirement of a *severe* mental disease or defect at the time of the act:

It is an affirmative defense to a prosecution under any federal statute that at the time of the commission of the acts . . . the defendant, as a result of severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.

The majority of jurisdictions in the United States now utilize a similar insanity standard which addresses only knowledge of wrongfulness. A minority of states add some variation of the irresistible impulse test where evidence of volitional impairment is accepted. The knowledge of wrongfulness issue in *McNaughtan* raises the question of the defendant’s knowledge of moral, as opposed to legal wrongfulness. Legal wrongfulness is defined as the defendant’s concrete understanding at the time of the offense that his act was against the law. Moral wrongfulness is more abstract and can be further separated into “subjective” moral wrongfulness and “objective” moral wrongfulness.

Subjective moral wrongfulness refers to the defendant who commits an offense with knowledge that the act is illegal but believes it is

personally morally justified. In contrast, objective moral wrongfulness refers to the defendant who, as a result of a psychiatric disorder, lacks the capacity to know that society considers his act to be wrong. Many jurisdictions in the United States do not specify which type of wrongfulness is to be applied to the case, leaving this issue up to the trier of fact.

Incidence and Recent Developments

Research shows that changes in insanity tests have had little substantive effect on insanity defense outcomes (Appelbaum, 1994; Borum, 1999). Approximately 1% of defendants charged with a felony plead insanity, and only 15–25% of defendants who plead insanity are actually found NGRI (Callahan, Steadman, McGreevy, & Robbins, 1991). Several studies have found that approximately 12% of defendants evaluated by court examiners were opined to be insane, (Cochrane, Grisso, & Fredrick, 2001; Warren et al., 2004).

Juries are much less likely to render an insanity verdict than judges. Eighty percent of successful insanity verdicts are not contested by the prosecution (Rogers, Bloom, et al., 1984). However, when evaluators disagree on the issue of sanity, an insanity plea is infrequently successful. In a sample of eight, 138 defendants raising an insanity defense, an inverse relationship was found between a high volume of insanity pleas and insanity acquittals (Cirincione, Steadman, & McGreevy, 1995).

A defendant adjudicated NGRI is technically acquitted of the offense, and the court may not punish defendants who are acquitted (Noffsinger & Resnick, 1999). Insanity acquittees usually remain under the jurisdiction of the trial court or of a legislatively created panel to supervise insanity acquittees. The disposition of an insanity acquittee balances the acquittee's need for treatment with concern

about public safety. In most U.S. jurisdictions, a legal finding of NGRI results in a separate hearing on the issue of dangerousness for commitment to a psychiatric inpatient facility. Only a relatively small number of insanity acquittees are directly placed on "conditional release" in the community.

Recently, the U.S. Supreme Court decided the insanity case, *Clark v. Arizona* (2006). While the Court did not make any substantive rulings about the insanity defense as a concept, it did provide some important insights into its current attitudes on the issue. Firstly, the Court reaffirmed the notion that "due process imposes no single canonical formulation of legal insanity." This long-standing principle leaves individual states free to define their own insanity standards. Secondly, the Supreme Court indicated that it conceptualizes the testimony of psychiatrists in insanity cases as falling into three general categories:

1. Observation evidence (an expert's description of a defendant's speech, thought or behaviors which may lend support to the diagnoses).
2. Mental disease evidence (whether at the time of the crime a defendant suffered from a mental disease or defect).
3. Capacity evidence (whether the disease or defect left the defendant incapable of performing a mental process defined as necessary for sanity, such as appreciating the nature and quality of his act or knowing that it was wrong).

The Supreme Court's approach of breaking down evidence into categories when analyzing sanity cases "reframes" the vital issues (Wortzel & Metzner, 2006). However, this reframing will require future clarification in appellate courts. In particular, it may not be entirely clear to the forensic psychiatrist where observational evidence ends and mental disease evidence begins. Perhaps more relevant to the

topic of evidence-based insanity evaluations was the Court's admonition that there is the "potential of mental-disease evidence to mislead," as well as concerns about the dangers of "according greater certainty to capacity evidence than experts claim for it" (p. 34). The Court sums up what could be a call to arms for forensic psychiatry—essentially an indictment of the soundness of our conclusions:

... there is the potential of mental-disease evidence to mislead ... through the power of this kind of evidence to suggest that a defendant suffering from a recognized mental disease lacks cognitive, moral, volitional, or other capacity, when that may not be a sound conclusion at all (p. 35).

In *Clark*, the Court recognized that the forensic psychiatrist must move from methods and concepts designed for treatment, to concepts of legal sanity. This "leap" from one discipline to another requires cautious, objective judgment. Here, the Court reminds us that it is capacity evidence, in particular, that requires judgment which may be "fraught with multiple perils." In order to avoid such perils, a standard evaluation procedure is recommended that maximizes objective reasoning.

Insanity Defense Evaluation Procedure

Prior to beginning an insanity defense evaluation, the psychiatrist should determine whether he has the proper "knowledge, skill, experience, training or education" required (Federal Criminal Code & Rules, 1995). Federal Rule 702 regarding expert testimony states:

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 by

knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

Once the qualification issue has been resolved, the psychiatrist should obtain the exact legal insanity standard utilized in the jurisdiction at the time of the crime. This standard can be obtained from the court, prosecutor or defense attorney who referred the defendant for the evaluation. The next step will be learning the facts of the case by reviewing all relevant sources of information. Table 2 lists recommended procedure and gives a list of collateral information to be reviewed. The most critical sources are the defendant's psychiatric records, observations of the defendant made at the time of the offense (including witness, victim, and police reports of the defendant's behavior), and a personal interview of the defendant (with particular focus on the defendant's account of the offense).

The defendant's medical and psychiatric records should be reviewed prior to interviewing the defendant, especially the defendant's psychiatric records closest in time to the offense. This is important because these records may contain critical information about the defendant's mental state shortly before or after the offense. Some defendants are psychiatrically hospitalized after committing their crime or placed in a jail mental health unit. If the defendant does not sign a release for these records, a court order should be sought to obtain them.

Victims, witnesses, and police often record detailed statements after a defendant has been arrested. These statements are a rich source of information regarding the defendant's mental state at the time of the offense. These statements should be reviewed for indications that the defendant was behaving bizarrely, intoxicated, hallucinating, or delusional at the time of the offense. If statements are not available, personal

TABLE 2. Procedure.

Obtain initial fact pattern from consulting agent
Determine if case falls within area of expertise
Obtain correct legal standard
Review collateral data (Review all relevant sources of information)
Police reports, narratives, interrogations
Audio or videotape of defendant immediately before, during, or after offense
Victim and witness statements
Other relevant observations of the defendant made at the time of the offense
Crime scene photos and/or visual inspection of crime scene if necessary
Autopsy report and photos
Defendant's medical records
Defendant's psychiatric records
Other expert evaluations, testimony
School records
Military records
Work records
Financial records
Correctional records
Personal communications (journals, letters, Emails, etc.)
Collateral interviews if necessary
Forensic interview
Inform defendant of limits of confidentiality
Conduct forensic psychiatric evaluation of defendant
Apply relevant legal standards to the facts of the case
Formulate opinion on insanity
Prepare clear, concise report (see Table 5)
Give objective testimony (see Table 1)

interview with the victims or key witnesses should be attempted.

The defendant should be interviewed as close in time to the offense as possible; however, this may not always be feasible. Defendants are often evaluated for sanity many months after the offense. Early evaluation reduces the likelihood that the defendant will have been coached about the legal criteria for insanity. Further, as time passes, defendants may change their account of the offense due to unconscious

distortion or attempts to malingering insanity. Finally, prompt examination enhances the psychiatrist's credibility in court.

At the outset of the interview, the defendant must be told about the purpose of the evaluation, the disposition of the insanity report, and the lack of confidentiality. Most U.S. jurisdictions exclude from evidence any incriminating statements made during an insanity evaluation to prove guilt. However, in a limited number of jurisdictions, statements made by a defendant during a forensic evaluation can be admitted.

A careful psychiatric history should be obtained from the defendant, including inquiry into the nature of hallucinations, delusions, and past treatment efforts. When focusing on mental state at the time of the offense, the psychiatrist should request a detailed account by the defendant. It is helpful to have the defendant give a step-by-step account of his actions beginning 1 day prior to the offense. The account should include full information on psychiatric symptoms, medication compliance, and use of intoxicants.

One approach is to let the defendant give his account uninterrupted. After the defendant has given a detailed narrative account of his actions, the psychiatrist may further examine important details by asking more specific questions. Another approach is to periodically interrupt the defendant at critical moments and ask questions about his purpose, motivation, and mental state. Leading questions should be avoided. When a defendant's self-report is contradicted by witness statements, the psychiatrist may wish to confront the defendant with the inconsistent information in an effort to clarify the defendant's account (Resnick, 1999).

Rogers and Shuman (2000) recommend additional evaluation questions for elucidating the defendant's capacity to appreciate the wrongfulness and nature and consequences of the offense. These questions focus on the defendant's

perceptions and emotional responses during the offense. For example, the examiner may consider asking the defendant:

1. What was the victim's emotional response? Did you know why he reacted this way?
2. What were your reactions to the victim's responses? Why did you react this way?
3. How would you have responded if you had been the victim? Why?
4. How would you have responded if someone else had committed the act? Why?

Insanity Defense Opinion Formation

Opinion formation is the most challenging aspect of the insanity defense evaluation. When forming the opinion, the psychiatrist should use the exact language of the insanity standard employed in that jurisdiction at the time of the crime. The underlying reasons for the opinion must be clearly explained. The importance of having a logical rationale for the opinion cannot be overestimated. Jurors and judges often determine the credibility of an expert based on the soundness of the reasoning for the opinion.

Before formulating the opinion, the psychiatrist should strive for a detailed understanding of the defendant's thinking and behavior before, during, and after the offense. The examiner should consider evidence of mental illness (now, in the past, and at the time of the offense), the onset of the psychiatric symptoms, possible psychotic and nonpsychotic motives for the offense, and the defendant's prior legal history and personality style.

The psychiatrist should assess whether the defendant's inability to know the wrongfulness or refrain from the act was due to mental illness or other factors, such as voluntary intoxication

or rage. Finally, the psychiatrist must address the nexus of causation between the mental disease or defect and the impairment in knowledge of wrongfulness or ability to refrain from the act.

Mental Disease Evidence

Virtually all insanity standards require the presence of a "mental disease or defect" at the time of the offense. The term mental disease or defect is a legal term of art and is not defined in the DSM. The DSM-IV-TR contains a disclaimer that the presence of a diagnosis in the diagnostic manual does not imply that it meets legal criteria for a mental disease in an insanity defense. However, the *American Psychiatric Association "Position Statement on the Insanity Defense"* does provide some guidance:

Another major consideration in articulating standards for the insanity defense is the definition of mental disease or defect . . . mental disorders leading to exculpation must be serious. Such disorders should usually be of the severity (if not always of the quality) of conditions that psychiatrists diagnose as psychoses. (APA, 1982).

In a study of 5,175 sanity evaluations, expert opinions finding insanity were significantly associated with the defendant being diagnosed as psychotic and having prior psychiatric hospitalizations (Warren et al., 2004). Similarly, in a study of 8,138 defendants pleading insanity, those who were diagnosed with a major mental illness and had prior psychiatric hospitalizations (suggesting more severe illness) had higher rates of acquittal by reason of insanity (Cirincione et al., 1995). The need for mental disease evidence to equate with psychosis has been supported in other studies (Cochrane et al., 2001; Nestor & Haycock, 1997; Nicholson, Norwood, & Enyart, 1991). In

England, schizophrenia is the most common diagnosis used to support a defense of insanity (MacKay, Mitchell, & Howe, 2006). Thus, the presence of a psychosis, or otherwise severe mental illness, is often considered a requirement for the insanity defense to succeed.

Most courts have held that diagnoses such as schizophrenia, major depressive disorder, and bipolar disorder qualify as a mental disease for the purpose of insanity. Diagnoses such as personality disorders, paraphilias, and voluntary substance intoxication do not usually qualify. Although some state statutes provide guidance on which disorders are excluded, the final decision rests with the trier of fact. A minority of jurisdictions have also recognized posttraumatic stress disorder, dissociative identity disorder, and other dissociative disorders.

Dissociation during a violent crime is quite commonly reported by offenders. Many individuals who have committed homicide claim to have impaired recall of the crime as well as sensations of “watching oneself,” and feeling detached from the event (Moskowitz, 2004). In a study of police officers involved in critical shooting incidents, a substantial percentage was found to have experienced dissociative symptoms. Such findings cast “serious doubt on the credibility of those who argue that dissociation at the time of a crime is a mental disease or defect It would be more reasonable to believe that, in general, dissociation is a normal response of some criminals to the traumatic events they create” (Rivard et al., 2002).

According to the DSM-IV-TR, “transient” experiences of depersonalization (feeling detached, numb and lacking control) are common in individuals exposed to life-threatening danger. For example, depersonalization during violence is commonly reported by men who are violent toward their partners (Simoneti et al., 2000). Thus, violent offenders may be

traumatized by their own acts and may go on to develop posttraumatic stress disorder as a result of the murder they committed (Harry & Resnick, 1986).

The concept of mental disease as used in legal standards for insanity is “generally construed to refer to a disorder of fixed or prolonged nature in contrast to any transitory emotional state.” (Rogers & Shuman, 2000). Thus, temporary displays of rage or aggression unassociated with a major mental disorder are unlikely to qualify as mental disease. The term “mental defect” most commonly refers to mental retardation or some developmentally acquired disorder of intellect. The finding of a mental defect typically requires intellectual impairment in the range of at least mild mental retardation.

According to the American Academy of Psychiatry and the Law’s Practice Guidelines for Insanity Defense Evaluations, acceptable practices for the establishment of a mental disease or defect should contain “at least a narrative description of a scientifically based disorder, symptom cluster, or syndrome” (AAPL, 2002). Thus, the use of idiosyncratic syndromes or disorders that do not meet the *Daubert* standard would be unlikely to qualify as mental diseases.

Capacity Evidence

All insanity standards, with the exception of the New Hampshire Doctrine, address the defendant’s knowledge of wrongfulness of the offense at the time of the act. Some ALI variants used in U.S. jurisdictions add an understanding of the “nature and consequences” of the proscribed conduct. In *Clark*, the U.S. Supreme Court articulated the test for understanding the “nature” of the act in “practical terms” as: “if a defendant did not know what he was doing when he acted” (*Clark v. Arizona*, 2006).

TABLE 3. Behavioral Evidence Warranting Analysis.

Efforts to avoid detection
Waits until dark
Use of gloves, mask, disguise
Concealment of weapon
Takes victim to isolated area
Use of a false alibi, alias, pretenses
Threats to kill if tells
Disposing of evidence
Wiping off fingerprints, blood
Discarding weapon
Destroying documents
Burying, concealing victim
Efforts to avoid apprehension
Fleeing scene, police
Lying to police, witnesses
Other
Statement that he knew the act was wrong at the time
Rational, nonpsychotic alternative motive
Notifying police, calling 911
Expression of remorse/guilt immediately after the offense

In *Clark*, the Supreme Court noted that “evidence of behavior close to the time of the act charged may indicate both actual state of mind at that time and also an enduring incapacity to form the criminal state of mind necessary to the offense charged” (p. 27). Table 3 gives a list of behavioral evidence warranting consideration by the psychiatrist regarding capacity to recognize the wrongfulness of the act.

When evaluating knowledge of wrongfulness, the psychiatrist should carefully analyze the defendant’s behaviors, statements, and motives. For example, hiding evidence, lying about the offense, and fleeing from the police or the scene of the crime all suggest that the defendant knew his behavior was legally wrong. In contrast, committing a crime with no rational motive, making no efforts to avoid detection, and making no effort to flee may suggest a lack of knowledge of wrongfulness. The defendant’s statements during or after the offense often pro-

vide critical insight into the defendant’s knowledge of wrongfulness. Statements made by the defendant months later that he knew the act was wrong are helpful, but care must be exercised to ascertain whether the defendant’s current mental state allows him to accurately recall his thinking at the time of the crime.

Elucidating the defendant’s motive for committing the offense is a key issue. The examiner must consider the presence of an alternative motive for the offense that does not flow from a mental disease or defect. For example, “ordinary” criminal motives such as revenge or anger must be considered in the case of a jilted wife who kills her estranged husband. Other common nonpsychotic motives for criminal behavior include profit, jealousy, and greed. Genuine psychotic explanations for rape, robbery, fraud, and check forging are quite unusual. Certain crimes are less likely to meet legal criteria for insanity. Such crimes include fraud, white-collar crimes, drug trafficking, and kidnapping for ransom. These crimes require a degree of mental organization that is frequently beyond the capacity of seriously mentally ill individuals (Cochrane et al., 2001). However, it is possible for a kidnapping to be carried out due to a circumscribed delusional belief that a stolen baby belongs to the defendant.

In contrast, a crime without an apparent motive (e.g., random killing of a stranger) may lend credence to a lack of knowledge of wrongfulness caused by a mental disease. The examiner must also consider the presence of a psychotic moral justification. For example, a mother who delusionally believed that her children were in unremitting excruciating pain may believe that killing the children to relieve their suffering is morally right, even though she knew her act was illegal.

In a minority of U.S. jurisdictions (16 states), the insanity standard allows for consideration of the capacity to conform one’s conduct to the requirements of the law. This is known

as the volitional prong. Some states phrase it as inability to adhere to the right, inability to control one's conduct, or irresistible impulse. Some tests require a complete loss of control. Others, such as the MPC, only require that the defendant lacked substantial capacity to conform his conduct to the requirements of the law.

The Assessment of Volition

The American Psychiatric Association took a cautious stance on the volitional arm of the insanity test after the Hinckley verdict:

The line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk The concept of volition is the subject of some disagreement among psychiatrists. Many psychiatrists therefore believe that psychiatric testimony (particularly that of a conclusory nature) about volition is more likely to produce confusion . . . (APA, 1982).

Nevertheless, in some jurisdictions, the forensic psychiatrist will be called upon to form an opinion on this issue. The psychiatrist should be forthright about the limitations inherent in making these determinations. Some guidelines from the literature may be of assistance here. "The notion that mental disorder can cause conduct to become completely involuntary or unintentional is questionable, given current thinking in the behavioral sciences Modern psychological theories view behavior as on a continuum such that actions performed in altered states of consciousness may be goal directed" (McSherry, 2003).

The psychiatrist should not view deviant behavior as *prima facie* evidence of loss of control or mental disease. This approach presents a tautological error in reasoning (e.g., "You act out because you are mentally ill; you are mentally ill because you act out"). "To begin with the

criminal behavior and to attempt to formulate psychological explanations for such behavior is untenable . . ." (Rogers & Shuman, 2000, p. 74). Instead, a "loss of power to choose must be the result of a mental disease or defect and not be merely a strong emotional reaction. Thus, an emotional state flowing from moments of rage would not satisfy this component of the test" (Rogers & Shuman, 2000).

The loss of volitional capacity must be experienced as an internal, nonnegotiable demand. Further, the defendant usually experiences the loss of volitional capacity with a sustained negative effect on his day to day functioning, which may be verified by collateral sources. If the loss of control is based on a mental illness, it often has a disinhibiting or disorganizing effect on the individual's overall functioning. The forensic evaluator should ascertain the defendant's capacity to be deliberate, choiceful, and purposeful with regards to the crime as well as his capability for resisting impulses in other areas of life.

Psychiatrists should strive for enhanced rigor and scrutiny when evaluating a defendant's ability to refrain from committing the offense. Table 4 lists some considerations when analyzing a defendant's ability to refrain from illegal conduct. The psychiatrist should take into consideration the defendant's ability to defer the offense. For example, a defendant may demonstrate considerable restraint by waiting until the victim is alone or other circumstances are advantageous before committing a crime.

The defendant's ability to refrain from the specific offense as compared to carrying out some other legal course of action should be explored. For example, if a defendant heard voices instructing him to "clean up the environment," he may have chosen to pick up litter rather than attempting to kidnap the director of the Environmental Protection Agency for government ransom. A defendant's claim that "I couldn't control myself" should

TABLE 4. Ability to Conform Conduct (Volitional Control).

- Choice versus impulse?
- Mental illness versus rage and/or intoxication?
- Inept versus uncontrollable?
- Refrain versus defer?
- Refrain from specific versus general instructions?
- Ability to foresee and/or avoid circumstances
- Alternatives considered? Choices available and perceived options?
- Deliberateness of actions and decision-making ability
- Seriousness of consequences for not acting?
- Policeman at the elbow test

not be taken at face value. The examiner must carefully investigate the cause of the claimed inability to refrain. For example, was the defendant’s inability to refrain from committing the offense due to mental illness or some other factor, such as voluntary intoxication or rage? Other areas of inquiry that may elucidate the degree of loss of control include:

1. What were the perceived consequences for failing to commit the offense? The magnitude, likelihood, and imminence of consequences for failing to act should be fully examined. For example, the consequences for failing to obey a command hallucination may range from restless sleep to a belief that one’s soul will spend eternity in Hell.
2. Did the defendant have any legal course of action available as an alternative to committing the offense? Did the defendant take actions to exhaust this alternative? For example, could the defendant earn money legally rather than carry out a robbery to further a psychotic goals?
3. What was the defendant’s ability to avoid circumstances leading to the offense? For example, did the defendant seek police intervention to resolve a paranoid belief that her neighbor was sending laser beams

TABLE 5. Insanity Report Format (Example).

1. Identification
2. Statement of nonconfidentiality
3. Sources of information
4. Social history
5. Educational history
6. Occupational history
7. Legal history
8. Medical history
9. Family psychiatric history
10. Psychiatric history
11. Substance use history
12. Current medications
13. Current mental status examination
14. Current diagnosis
15. Prior relationship of defendant to victim
16. Defendant’s account of offense
17. Witness/victim account of offense
18. Summary of police records
19. Relevant collateral information
20. Opinion on sanity

into her mouth before attempting to break into the neighbor’s home to dismantle the laser-emitting device?

4. What is the evidence relative to the defendant’s deliberateness of action and decision-making ability during the offense?

The classic “policeman at the elbow test” may also be helpful in assessing a defendant’s ability to refrain from an offense (Rogers & Shuman, 2000). In this test, the defendant is asked whether, at the time of the offense, he would have committed the crime if a policeman was present at the scene. This line of questioning focuses on whether the defendant would have refrained from committing the offense in the face of immediate apprehension and in the presence of an eyewitness. However, this test may not be useful if the defendant held delusional beliefs about the police, the defendant shot at police during the offense, or in the case of a homicide–suicide plan.

Causal Relationship Between Mental Disease and Lack of Capacity

It is critical for the evaluator to establish the relationship between the defendant's mental disease and the defendant's criminal behavior by analyzing the defendant's "awareness of what they were doing during the crime and what their motivations for actions taken were at that time." (AAPL, 2002). This part of the psychiatrist's opinion requires a well-reasoned analysis.

The relationship between a defendant's mental disorder and his crime generally falls into one of the five possible patterns (Dietz, 1992). Pattern 1 consists of individuals whose crime is a response to psychotic symptoms, usually delusions or hallucinations. Pattern 2 offenders commit crimes that are motivated by compulsive desires. Examples include sex offenses by those with paraphilias or crimes involving disorders of impulse control. Pattern 3 offenders have personality disorders. Their crime is consistent with a maladaptive pattern of voluntary and knowing behavior. Pattern 4 offenders have a genuine mental disease; however, it is merely coincidental and unrelated to the crime.

Although these offender categories do not resolve the question of sanity, certain inferences can be made. Some Pattern 1 offenders will meet the legal criteria for insanity. However, this will depend on the facts of each individual case and the relevant legal standards. Pattern 2 offenders are very unlikely to meet insanity criteria, especially in jurisdictions without volitional prongs. Pattern 3, 4, and 5 offenders will not be candidates for an insanity defense.

"Touchstones" and Obstacles

In pursuing accurate, evidence-based sanity evaluations, forensic psychiatrists must use reliable methods. Examiners should monitor the

quality and objectivity of their own work. Table 6 gives a list of common mistakes made in conducting insanity defense evaluations.

One potential, yet common barrier to objective, accurate sanity evaluations is the temptation for the expert to opine on matters that primarily involve moral concepts. The task of the forensic psychiatrist is to "shine the light" of psychiatric science on legal matters to help clarify the relevant issues before the court. In dealing with this issue, one principle that may help resolve such dilemmas is the "touchstone" of asking oneself "what the ideal forensic *pathologist* would do in a similar situation" (Dietz, 1996). In as much as we wish to define ourselves as forensic scientists, this standard focuses our testimony on the technical matters of our discipline and may thus reduce biased inferences.

The allure of the court room may lead some psychiatrists to temporarily suspend attention to the limitations of current psychiatric knowledge. The justice system makes, "ceaseless demands for applications of psychiatry and psychology to the law which are frequently inappropriate, impossible, and highly undesirable" (Diamond, 1992).

When the forensic psychiatrist strays too far from the touchstone of forensic scientist, there is increased risk of encountering problems of fact-value distinction. (Stone, 1984). It is difficult to argue that psychiatrists are not constantly making value judgments, either implicitly or explicitly. As the psychiatrist moves away from evidence-based science, and toward illusory moral concepts, the line between fact and value becomes increasingly blurred.

There may always be some degree of tension between what the courts want from forensic psychiatry and what we believe that we should give them. For example, Redding, Floyd, and Hawk (2001) gave a hypothetical insanity defense case to a study group of judges and

TABLE 6. Clear Errors.

Confusing competence to stand trial with insanity
Equating mental disorder with insanity
Equating psychosis at the time of the act with insanity
Equating current psychosis with insanity
Equating abnormal brain imaging with insanity
Referring to global or abstract wrongfulness (rather than focusing on knowledge of wrongfulness for the crime charged and at the time of the crime)
Failure to review relevant medical records
Failure to review police reports, defendant statements, and other relevant collateral information
Failure to interview the defendant
Failure to analyze every offense in a multiple offense crime
Failure to support opinion with factual data
Failure to support testimony with factual data (<i>Ipsi dixit</i> testimony)
Failure to use the correct legal standard for sanity
Failure to address causal nexus between mental disorder and cognitive and/or volitional prongs
Failure to address all prongs of the sanity test
Failure to consider motives for the offense that do not flow from mental disorder
Psychodynamic explanation for the offense given as an excuse (rather than focusing on the legal standard for sanity)
Failure to consider voluntary intoxication versus insanity
Failure to consider malingering

attorneys and asked for their preferences on types of mental health evidence. Legalists were primarily interested in: (a) clinical diagnosis; (b) an analysis of whether the condition met the relevant legal threshold, and (c) an ultimate opinion on the legal issue. The group found research and actuarial evidence far less interesting.

Boundaries and Limitations

Striving for objectivity and accuracy mandates a careful assessment of the boundaries of psychiatric knowledge and the limits of the current science. Some degree of skepticism already exists in U.S. courts about diagnostic boundaries and evidence of mental disorders (Appelbaum, 2006). The progress of psychiatric science results in an ever-shifting boundary between disease and deviance (Rosenberg, 2006). Thus, it can be expected that the legitimacy of many disease categories will remain

the subject of “professional ferment” for extensive periods.

For this reason, forensic psychiatrists must strive not only for accuracy in diagnosis, but also honesty about limitations in the field. For example, there is growing interest in applying brain science, particularly brain imaging, to the issue of sanity. However, at the present time the implications of neuropsychiatric imaging for the law are still unclear (Morse, 2004). In a PET scan study of 41 murderers pleading insanity, murderers were found to have lower glucose metabolism in the prefrontal cortex and other areas as compared to a control group (Raine, 1999). Yet the authors were careful to mention that the findings were preliminary and cannot be taken as evidence that murderers pleading insanity are not responsible for their actions.

Perhaps more importantly, brain imaging “cannot identify thoughts or ascribe motives” (Reeves, Mills, Billick, & Brodie, 2003). Imaging

may discover an abnormality, yet this may or may not equate with dysfunction. Many steps in the process of brain imaging have not yet been fully standardized, and “with its many technological variables and requirements for clinical inference, [imaging] has not advanced to the point that it can be introduced in court without real and significant caveats” (Reeves et al., 2003, p. 89). To date, functional deviations seen on imaging have never been causally associated with complex criminal behavior.

Thus, while neuroscience is continually identifying potential “associations” between biology and violence, the courts deserve to be informed of their preliminary and hypothetical nature (Eastman & Campbell, 2006). Other areas in which the psychiatrist must currently acknowledge distinct limitations include involuntary conduct, dissociative states, and other mental conditions that do not clearly meet the *Daubert* standard. Limitations may occur in the area of clinical science as well as in the area of individual judgment (Faust, 1988). Every forensic psychiatrist is potentially subject to the effects of cognitively distorting biases. Commonly observed reasons that psychiatrists intentionally or unintentionally claim greater certainty in ill-defined areas include a desire for a “just” outcome and having an agenda of bringing public attention to a particular mental condition.

Detection of Malingered Insanity

When evaluating criminal defendants in a forensic setting, the clinician must always consider malingering (AAPL, 2002). Concern about defendants faking mental illness to avoid criminal responsibility dates back to at least the 10th century (Brittain, 1966; Collinson, 1812; Resnick, 1984). By the 1880s, many Americans considered physicians generally impious, mercenary, and a cynical lot who might participate in the “insanity dodge” (Rosenberg, 1968).

Although the exact percentage of offenders attempting to malingering insanity is unknown, empirical data suggest that that is not uncommon for some offenders to feign insanity to avoid criminal responsibility. Cornell and Hawk (1989) studied 39 criminal defendants diagnosed as malingering psychotic symptoms by experienced forensic psychologists. The prevalence of malingering was 8.0% for 314 consecutive evaluations in a forensic hospital.

Malingering is described in DSM-IV-TR as a condition the clinician may encounter that is not attributable to a mental disorder. It is defined as the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by “external” incentives (American Psychiatric Association [APA], 2000). Despite its clear-cut definition, the diagnosis of malingering is difficult and requires a very thorough approach. For a more comprehensive discussion on detecting malingered psychosis, see Resnick and Knoll (2007).

Defendants who present with a mixed picture of schizophrenia and antisocial features may pose difficulties for the psychiatrist due to negative countertransference feelings. Such a scenario may cause the clinician to focus on the antisocial traits to the exclusion of a genuine comorbid illness (Travin & Protter, 1984). The psychiatrist must guard against the temptation to accept a psychotic version at face value as well as the temptation to dismiss it out of hand. Any facile attempt to dichotomize a defendant into “mad” (assuming the credibility of the psychotic symptoms) or “bad” (assuming the fabrication of psychotic symptoms) may reduce the accuracy of the forensic assessment.

The psychiatrist should consider recording the defendant’s early account of the crime, even if he is not competent to stand trial. Once defendants are placed in a jail or forensic hospital, they may learn how to modify their story to avoid criminal responsibility (Samenow,

1984). Recording the early version also reduces the likelihood of being misled later by a defendant's subsequent memory distortions. Another helpful approach is for the psychiatrist to take a careful history of past psychiatric illnesses, particularly details of prior hallucinations, before eliciting an account of the current crime. Malingers are less likely to be on guard because they infrequently anticipate the relevance of such information to the current insanity issue. If a defendant should subsequently fake hallucinations to explain his criminal conduct at the time of the offense, it will be too late to falsify past symptoms to lend credence to the deception. Whenever possible, a defendant's report of prior hallucinations and delusions should be confirmed by review of past hospital records.

Kucharski et al. (1998) found that malingers who had no history of psychiatric hospitalization or treatment were likely to evidence current psychiatric presentations inconsistent with their recent Global Assessment of Functioning and atypical hallucinatory experiences. Jaffee and Sharma (1998) investigated malingered psychiatric symptoms among criminal defendants charged under California's "Three Strikes and You're Out" law. Malingered defendants were found to exhibit more uncommon psychiatric symptoms such as corprophagia, eating cockroaches, and seeing "little green men."

The evaluating psychiatrist should determine whether a defendant is malingered psychosis at the time of the offense only or is alleging continued psychosis through the time of the examination (Hall, 1982; see Table 7). The importance of the differentiation was demonstrated using the schedule of affective disorders and schizophrenia diagnostic interview (Rogers et al., 1984). Although the schedule of affective disorders and schizophrenia successfully differentiated between sane and insane defendants focusing on the time of their crimes, no

TABLE 7. Probable Errors.

Failure to use DSM-IV-TR diagnoses
Use of idiosyncratic disorders that do not meet Frye or Daubert standards
Concluding that a non-psychotic mental illness qualifies as mental disease
Concluding that a deviant, bizarre or unusual crime is evidence of insanity
Adding new data in the opinion section
Concluding a lack of volitional capacity without rigorous analysis and supporting data
Mentioning disposition or future dangerousness if not applicable
Desire for a "just" outcome (to the detriment of accuracy, objectivity)

significant differences were found in the schedule of affective disorders and schizophrenia summary scales of the defendants at the time of their evaluations. Some malingers mistakenly believe that they must show ongoing symptoms of psychosis in order to succeed with an insanity defense. When defendants present with current psychiatric symptoms, the psychiatrist has the opportunity to see whether the alleged symptoms are consistent with contemporaneous psychological testing.

Several clues can assist the psychiatrist in the detection of fraudulent insanity defenses (see Table 8). A psychotic explanation for a crime should be questioned if the crime fits a prior pattern of criminal convictions. Gacono et al. (1995) compared legitimate insanity acquittees with individuals who had successfully malingered insanity. They found that malingers were significantly more likely to have a history of murder or rape, carry a diagnosis of antisocial personality disorder or sexual sadism, and produce greater PCL-R factor 1, factor 2, and total scores than insanity acquittees who did not mangle. Underscoring the importance of detecting malingered was the fact that the malingers were also significantly more likely

TABLE 8. Malingered Psychosis During a Crime.

Faking psychosis while actually committing the crime (very infrequent)
 Faking in the evaluation of “psychosis during the crime” and either
 Claiming to be well now
 Still faking psychosis
 Actually psychotic during the crime, but superimposing faked exculpatory symptoms at the evaluation.

to be verbally or physically assaultive, have sexual relations with female staff, deal drugs, and be considered an escape risk within the forensic hospital.

Malingers may tell a far-fetched story in an attempt to “retro-fit” the facts of their crime into a mental disorder. For example, one malingerer with prior armed robbery convictions claimed that he robbed only upon commands of auditory hallucinations and gave away all the stolen money to homeless people. Malingering of insanity should be suspected if a partner was involved in the crime. This is because most accomplices of normal intelligence will not participate in a crime that is motivated by psychotic or bizarre beliefs. In a study by Thompson et al. (1992), 98% of insanity acquittees were found to have acted alone. If a partner was involved, the psychiatrist may further assess the validity of the alleged insanity by questioning the codefendant.

Malingering should be carefully considered in the case of a defendant who alleges a sudden or irresistible impulse. The psychiatrist should be skeptical of an impulse that is not a symptom usually associated with a recognized mental disorder. If a defendant denies any previous knowledge of an impulse, lying should be suspected. Experience has shown that it is extremely improbable for an obsessional impulse to be uncontrollable at its first appearance (East, 1927). Genuine obsessions are

TABLE 9. Model Criteria for the Assessment of Malingered Psychosis in Defendants Pleading Insanity.

Malingering should be suspected if any of the following are present

1. A nonpsychotic, alternative rational motive for the crime
2. Suspect hallucinations or delusions (see Resnick & Knoll, 2007)
3. Current offense fits a pattern of prior criminal conduct
4. Absence of active or negative symptoms of psychosis during evaluation
5. Report of a sudden, irresistible impulse
6. Presence of a partner in the crime
7. “Double denial” of responsibility (disavowal of crime + attribution to psychosis)
8. Far-fetched story of psychosis to explain crime
9. Alleged intellectual deficit coupled with alleged psychosis

characterized by a pathological persistence of a thought or feeling that is experienced as ego-dystonic (Saddock & Saddock, 2003). They are often accompanied by anxiety symptoms and feelings of anxious dread that leads the individual to take specific countermeasures against the thoughts.

Malingering defendants may present themselves as “doubly blameless” within the context of their feigned illness. This was demonstrated by a defendant who pled insanity to a charge of stabbing a 7-year-old boy 60 times with an ice pick. He reported that for 1 week prior to the homicide, he was constantly pursued by an “indistinct, human-like, black blob.” He stated that he was sexually excited and intended to force homosexual acts on the victim, but abandoned his plan when the boy began to cry. When he started to leave, he alleged that “10 faces in the bushes” began chanting, “Kill him, kill him, kill him.” He yelled, “No,” and repeatedly struck out at the faces with an ice pick. He alleged the next thing he knew, “the victim was covered with

blood.” The autopsy revealed a tight cluster of stab wounds to the victim’s neck, which was inconsistent with the defendant’s claim that he struck out randomly at multiple faces in the bushes. The defendant’s version of the offense demonstrates a double avoidance of responsibility: (a) the faces told him to kill and (b) he claimed to have attacked the faces and not the victim. After his conviction, he confessed to six additional unsolved, sexually sadistic murders.

Dissimulation after Psychotic Crimes

Forensic psychiatrists are trained to be vigilant for the possibility that a defendant may malingering insanity during a forensic evaluation. However, there has been little study of defendants who seek to conceal genuine illness—that is, to “simulate” sanity. “Dissimulation” is the concealment of genuine symptoms of mental illness in an effort to portray psychological health. Injustice may result from such dissimulation when an individual commits a crime while genuinely psychotic. The denial of psychiatric symptoms is not uncommon in persons who have committed crimes (Diamond, 1956).

One reason that defendants dissimulate is to avoid the stigma and consequences of being labeled with a mental illness (Halleck, 1975). For example, in the case of Theodore Kaczynski (the Unabomber), some experts opined that he suffered from paranoid schizophrenia. However, he was highly averse to the notion of raising mental illness as a defense, or even for mitigation of the death penalty, because he believed it would undermine the credibility of his anti-technology “manifesto.” Diamond (1994, p. 166) has noted that, “To admit one’s actions were motivated by delusions, rather than reality, and that one was and is mentally deranged is a public humiliation destructive to one’s self-esteem.” Since the burden of raising the issue of

insanity most often rests on the defendant, there is the potential for a miscarriage of justice if the defendant conceals psychotic symptoms that would meet the criteria for insanity.

Some genuinely mentally ill defendants may retrospectively distort accounts of their offenses due to amnesia, delirium, or simply the desires to have their irrational behavior make sense. Caruso et al. (2003) found that dissimulators could be classified as either intentional or unintentional. Intentional dissimulators concealed their symptoms voluntarily, while unintentional dissimulation was due to a lack of insight into their illness. Unintentional dissimulators were older and more likely to be psychotic than intentional dissimulators. When compared to dissimulators, malingerers were more likely to have a diagnosis of a personality disorder, to feign cognitive deficits, and to be facing charges related to financial crimes (Caruso et al. 2003).

Conclusions

Areas of potential research for evidence-based insanity defense evaluations include studies on threshold criteria for mental disease or defect, malingered insanity (incidence, correlates, and detection methods), and the systematic use of feedback from triers of fact.

The interplay of legal demands and psychiatric progress mandates that evidence-based insanity evaluations be informed by advances in both areas. Many aspects of insanity defense evaluations do lend themselves to evidence-based psychiatry, such as a standard procedural approach, accuracy of diagnosis, and quality monitoring. Insanity defense evaluations require the psychiatrist to accurately address: (a) the presence of mental disease evidence, (b) capacity evidence, and (c) the relationship between the mental disease and the crime.

The U.S. Supreme Court has noted that insanity defense opinions require a “leap” from methods and concepts designed for treatment to legal concepts of criminal responsibility. Forensic psychiatrists owe a duty to the courts to be sure this leap is sure footed, accurate, and based on scientific evidence. In addition, it is our responsibility to uphold the “credibility of our profession” by improving our practice in this highly public interface between psychiatry and law (Stone, 1984). Evidence-based insanity defense evaluations following well-accepted guidelines will be more likely to result in objective, well-reasoned opinions that will assist the trier of fact.

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