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# Some Issues in Psychiatry, Psychology, and the Law

RENEE L. BINDER\* AND DALE E. MCNIEL\*\*

## INTRODUCTION

In this Essay, we discuss some issues in psychiatry, psychology, and the law with the goal of increasing understanding across disciplines. We begin by describing differences in how psychiatry/psychology view certain concepts versus how they are viewed by the legal system. We then discuss special ethical issues that arise when a psychiatrist/psychologist is acting as a consultant to a court of law as opposed to participating in a treatment relationship. We also comment on the “Diagnostic and Statistical Manual” which has been called the “bible of psychiatry.”<sup>1</sup> Finally, we consider research developments that bear on the courts’ considerations of psychiatric/psychological testimony on violence risk assessment.

## I. DIFFERENT CONCEPTS IN PSYCHIATRY, PSYCHOLOGY, AND THE LAW

### A. CERTAINTY VERSUS PROBABILITY

In the courts, psychiatrists and psychologists are often asked to testify “within reasonable medical certainty” or “within medical probability.”<sup>2</sup> The legal system wants certainty. Attorneys and judges want scientific facts and statistical projections, in part because the resolution of disputes requires making absolute decisions such as: Is the defendant guilty or not guilty? Should the plaintiff be compensated for damages or not? In contrast, clinicians are less concerned about certainty. They deal with probabilities: What is the likelihood that a certain treatment will work for a certain illness? With the constellation of

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1. See, e.g., Roger K. Blashfield, *The Vulgate DSM-IV: A Review of Am I OK? A Layman’s Guide to the Psychiatrist’s Bible*, 189 J. NERVOUS & MENTAL DISEASE 3, 3-7 (2001).

2. THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 336 (3d ed. 2000); accord *Bockrath v. Aldrich Chem. Co.*, 980 P.2d 398, 403 (Cal. 1999).

presenting signs and symptoms, what is the likelihood that this represents bipolar affective disorder or a substance-induced manic episode? Clinicians may wind up finding that the signs and symptoms are related to an uncommon illness with a low probability of occurrence and causation of the symptoms. Clinicians are comfortable with this concept. In contrast, opinions about low probability events are not helpful to the legal system when decisions are being made about incarceration or about compensation of plaintiffs. Courts want more certainty on these matters.

#### B. PURSUIT OF JUSTICE

A difference also exists in the legal and mental health systems regarding their values about the pursuit of justice. Decisions about psychological issues (e.g., civil commitment, insanity) made by courts involve societal/moral judgments, not scientific ones. One of the ways mental health professionals can assist the trier of fact is to present the data relevant to the legal issue at hand, rather than leaping to the ultimate issue. If the mental health professionals testify about ultimate legal issues, they should make explicit the fact that such opinions are value judgments and moral statements, and are not scientific determinations.

This is exemplified during the civil commitment process for clients who have serious mental illness. Clinicians are sometimes seen as trying to help people at the expense of their liberty. They may be concerned about whether or not the patient needs hospitalization and whether the hospitalization will keep the patient safe from dangerous behaviors such as suicidal or assaultive acts. Hospitalization may be seen as an opportunity to initiate treatment which may ameliorate the signs and symptoms of the illness. In contrast, the legal profession often is concerned with advocacy for civil liberties and important legal principles that will benefit society and not just an individual patient. The key issue in a specific case may not be whether the patient meets the criteria for involuntary hospitalization, but whether the legal process was carried out appropriately, e.g., whether the forms for involuntary hospitalization were completed accurately with appropriate signatures at the appropriate time. We have been involved in civil commitment hearings where the patient was released to the community because the nurse on-call in the emergency room did not complete the necessary forms appropriately. From the perspective of the legal system, this outcome may be justifiable because each client is entitled to due process,<sup>3</sup> including having forms completed accurately. From the perspective of the clinician, the outcome may be seen as not justifiable because the clinician wants the patient to receive necessary treatment whether or not

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3. See U.S. CONST. amend. V, § 1; U.S. CONST. amend. XIV, § 1.

a particular form is filled out accurately.

The difference in values about justice can also be seen in whether evidence is introduced where it is considered both probative and highly prejudicial. In the medical care system, all evidence, including details about prior problems, is considered relevant to understanding a patient and to providing appropriate culturally-sensitive care.<sup>4</sup> In the legal system, information is excluded if it is considered unfairly prejudicial.<sup>5</sup> Renee L. Binder was involved as an expert witness in two different cases that illustrate this issue. In one case, a patient died while in a psychiatric hospital and his mother was seeking damages for wrongful death and pain and suffering for herself and his five-year-old son. Part of the deceased's history included a long criminal record, including physical attacks against his mother and physical abuse of his child. This information was excluded from the courtroom as being unfairly prejudicial. The psychiatrist felt that it was relevant in terms of understanding the individual and also the pain and suffering of the plaintiffs. The judge disagreed and this information was excluded.

In another case, a man was accidentally killed by a police officer when he was raising a gun over his head, allegedly as part of a cultural ritual. The police officers claimed that they asked him to stop and when he did not, they shot him, and he died from his wounds. The widow brought a lawsuit against the police department for wrongful death and pain and suffering. Binder met with the widow and reviewed all of her medical and psychiatric records. In the course of the evaluation, it was revealed that the widow married the decedent's cousin one month after the shooting and death of her first husband. From a mental health perspective, this was relevant information to forming an opinion about the pain and suffering that the plaintiff suffered. The judge disagreed. The information was excluded from the courtroom because it was considered overly prejudicial relative to its probative value.

Another example of differences in values about justice occurs when evidence is suggestive of a certain etiology because of a pattern of behavior. Such evidence is often excluded from the courtroom when each item of the pattern has not been proven.<sup>6</sup> An example is where an individual has had multiple problems in the workplace with multiple supervisors, and always gives a different version of events than the employer. An expert witness may opine that the fact that there were repetitive alleged problems would likely suggest that the individual may have been a problem employee. Attorneys could state, however, that the

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4. See ILENE MOROF LUBKIN & PAMALA D. LARSEN, CHRONIC ILLNESS: IMPACT AND INTERVENTIONS 548-49 (2006).

5. FED. R. EVID. 403.

6. See FED. R. EVID. 404-06.

facts of each individual incident were in question. Perhaps there were multiple problem employers; perhaps this person was harassed in every environment; perhaps he or she is the sort of person that is easily picked on. Therefore, it could be argued that the fact that there is a pattern without any of the specific incidents being proven should not be considered evidence about whether or not the current event occurred.

Another example is seen when a patient comes into an emergency room with signs and symptoms of opiate withdrawal. Even if the patient has a negative toxicology screen, most emergency room physicians would treat the patient for opiate withdrawal based on the signs and symptoms. In the legal arena, when the question is raised about whether or not a defendant used opiates, the fact of a negative toxicology screen for opiates would make it unlikely that the defendant would be found to have used opiates.

### C. RELIABILITY VERSUS VALIDITY

Reliability and validity are two distinct concepts about which the law should be aware. In medicine and social science, reliability refers to reproducibility of results. A reliable measuring instrument returns consistent measurements every time a test is done and different people measuring the same variable will arrive at the same value.<sup>7</sup> Validity refers to accuracy.<sup>8</sup> Do the findings accurately represent what is being measured?

The difference between reliability and validity can be seen in the use of practice guidelines developed by medical professional organizations that delineate a consensus of experts concerning the best way of treating a medical condition such as diabetes, hypertension, gastric ulcer, schizophrenia, or bipolar disorder. The practice guidelines are reliable in that different clinicians using them will arrive at similar diagnoses and prescribe similar treatments. The question, however, is whether they are valid. After three and a half years, only 90% remain current.<sup>9</sup> Moreover, after six years, fewer than 50% of practice guidelines remain accurate, and the rest are outdated.<sup>10</sup> Another example involves the use of rating scales of self-reported symptoms such as those that are used to determine whether or not an evaluatee suffers from post-traumatic stress disorder. Some of these scales do not include measures of response style or validity, and depend on the assumption that the evaluatee is giving an

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7. JOHN MONAHAN & LAURENS WALKER, *SOCIAL SCIENCE IN LAW: CASES AND MATERIALS* 54-55 (4th ed. 1998).

8. *Id.*

9. Paul G. Shekelle et al., *Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated?*, 286 JAMA 1461, 1466 (2001).

10. *Id.* at 1467.

accurate self-report.<sup>11</sup> Such scales may be reliable in the sense that the person reports the same symptoms each time that he or she fills out the scale. However, such scales may not be valid for an individual, i.e., an evaluatee can state he or she has nightmares even if that is not really the case.

Another difference between reliability and validity has to do with individual versus group effects of medications or toxins. An example of this is seen in the silicone breast implant litigation and the reported development of connective tissue disease related to these implants.<sup>12</sup> Large studies of groups of women who had silicone breast implants revealed that there was no difference in the development of connective tissue disease between women who had the implants and a matched control group of women who did not have the implants.<sup>13</sup> Nevertheless, there may be validity to the fact that an individual woman who received silicone breast implants could have developed an illness related to it.

The long-term effects of divorce and various custody arrangements about which psychiatrists and psychologists may be asked to opine demonstrate another difference between reliability and validity. It is often difficult to give valid testimony about these many factors. Different variables may interact for any one child or any single parent that affect the impact of various custody arrangements. When mental health professionals are asked to determine who is the best custodial parent, one question is: What is the age of the child? In addition, because their parenting is placed at issue, divorcing parents may be held to a higher standard of parenting competence than nondivorcing parents. One of the criteria that is often used to decide custody is to favor the parent who is more likely to support the maintenance of the relationship of the child with the non-custodial parent.<sup>14</sup> This is a legal standard. A psychological question is: Is it really in the best interests of the child in every case?

Then there is the issue of percentage causality, and where is the science that allows us to give an opinion about this? Expert witnesses are often asked questions such as whether a sexual assault or sexual harassment caused 20% or 80% of a plaintiff's current psychiatric picture. Did it cause 20% of the depression or 80%? Did it cause 20% of his or her inability to seek future employment or 80%? What were the other factors? Such precise estimates are often difficult to determine. When attorneys ask expert witnesses to give opinions about these types

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11. See Mardi Horowitz et al., *Impact of Event Scale: A Measure of Subjective Stress*, 41 *PSYCHOSOMATIC MEDICINE* 209, 209-18 (1979).

12. See Jorge Sánchez-Guerrero et al., *Silicone Breast Implants and the Risk of Connective Tissue Diseases and Symptoms*, 322 *NEW ENG. J. MED.* 1666, 1670 (1995).

13. *Id.*

14. Elizabeth Scott & Andre Derdeyn, *Rethinking Joint Custody*, 45 *OHIO ST. L.J.* 455, 464-65 (1984).

of matters, the opinions may not be valid or reliable.

## II. ETHICAL ISSUES ASSOCIATED WITH FORENSIC EVALUATIONS COMPARED TO PROVIDING TREATMENT

Psychiatrists and psychologists are expected to follow the general ethical principles of their respective professional organizations.<sup>15</sup> Special issues arise when their professional services are provided with the intended purpose of applying their scientific, technical, or specialized knowledge to the law and using that knowledge to assist in resolving legal problems. Additional ethical duties arise in providing forensic services beyond those that exist when psychiatrists and psychologists are providing treatment.

When clinicians are engaged in a treatment relationship, several principles apply. One of them is confidentiality.<sup>16</sup> What a patient says to a treating clinician should be held in confidence. Treating clinicians also engage in patient advocacy. The goal is to advocate for the best interest of the patient. An additional principle is that treating clinicians rely on narrative truth by the patient and use a patient's subjective view of events to provide treatment. If a patient says that her mother was emotionally abusive, the treating clinician does not say, "No, she wasn't. I don't believe you. She seems like a very nice woman to me." The important part of the treatment situation is that the treating clinician is working with patients based on what patients tell the clinician about their perception of what happened to them as a child or as an adult.

Different ethical issues arise when psychiatrists and psychologists provide evaluations for the court. Forensic evaluators refer to the person who is being evaluated as an evaluatee or a defendant and not as their patient. Forensic evaluators typically are retained by someone other than the evaluatee, such as the court or the attorney who requested the evaluation. Forensic evaluators have an obligation to be objective, fair, and impartial, regardless of whether or not that information helps the legal case of the evaluatee or the party that retained them.<sup>17</sup> Moreover, forensic evaluators are not serving in the role of a patient advocate. A forensic evaluator attempts to be impartial and fair and can advocate for his or her opinion, but does not advocate for the patient. In addition,

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15. See AM. PSYCHOLOGICAL ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT 2 (2002) [hereinafter ETHICAL PRINCIPLES], available at <http://www.apa.org/ethics/code2002.pdf>; ETHICS COMM. OF THE AM. PSYCHIATRIC ASS'N, ETHICS PRIMER OF THE AMERICAN PSYCHIATRIC ASSOCIATION 81-82 (2001).

16. See ETHICAL PRINCIPLES, *supra* note 15, at 7.

17. See generally AM. ACAD. FOR PSYCHOLOGY & THE LAW, ETHICS CODES OF AAPL COMMITTEE ON ETHICAL GUIDELINES FOR FORENSIC PSYCHOLOGISTS (1991); see also AM. PSYCHOLOGY-LAW SOC'Y, SPECIALTY GUIDELINES FOR FORENSIC PSYCHOLOGISTS (Third Proposed Draft 2008), available at <http://www.ap-ls.org/links/22808sgfp.pdf>; Comm. on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655 (1991).

instead of relying on narrative truth, a forensic evaluator is expected to be objective. There is a need for corroborating facts and evidence rather than only relying on the self-report by the evaluatee.

Because of the special issues that arise when psychiatrists and psychologists provide consultations for the courts, in addition to the general ethical principles of their professions, major professional organizations concerned with forensic issues in psychiatry (American Academy of Psychiatry and the Law) and psychology (American Psychology-Law Society) have developed guidelines that provide further guidance to these professionals in monitoring the quality of their forensic services.<sup>18</sup> These guidelines include topics such as the pursuit of justice; truth telling and honesty; trying to distinguish between facts and inferences; information that is verified versus unverified; specifying the limits of confidentiality; paying special attention to potential conflicts of interest of the examiner or biases of the examiner; not doing forensic evaluations on a defendant before he or she has access to legal counsel; taking cases within expertise; not accepting contingency fees; and performing personal examinations before rendering an opinion or else specifying the limitations of the opinions if the opinions are not based on a personal evaluation.<sup>19</sup>

Treating clinicians often can provide relevant testimony on topics such as the patient's reported history, diagnosis, treatment provided, and response to treatment. However, special problems can arise when a treating clinician also provides testimony on legal issues, such as criminal responsibility, legal causation, trial competency, and the relative merits of parenting capacity. For example, if the treating clinician relies solely on the patient's self report, this may provide insufficient foundation for opinions about these legal questions. Advocacy associated with the treating role can make it difficult for the treating clinician to be impartial and objective. In addition, the forensic role may require testimony that interferes with the treatment relationship (e.g., information about the patient's diagnosis or functional status, or professional opinions that are not favorable to the patient's legal case).

### III. DSM-IV: STRENGTHS AND WEAKNESSES

The fourth edition text revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*<sup>20</sup> is a resource used by attorneys as well as by mental health professionals. It is important to understand its

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18. See sources cited *supra* note 17.

19. See AM. ACAD. OF PSYCHIATRY & THE LAW, ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY 1-4 (2005), available at <https://www.aapl.org/pdf/ETHICSGDLNS.pdf>.

20. See generally AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. text rev. 2000) [hereinafter DSM-IV].

purpose and the fact that it is not a “bible.”<sup>21</sup> The DSM-IV is a consensus document.<sup>22</sup> Experts on a particular diagnosis are appointed to a committee to develop a consensus about what the literature and the research say about the criteria for a certain diagnosis. The revisions in each updated edition of the manual are based on research and clinical experience.<sup>23</sup> The DSM-IV is useful for classification purposes for insurance, research protocols, and treatment protocols. Thus, if an insurance company will only pay for certain diagnoses, the question will be whether an individual patient’s symptoms meet those diagnostic criteria. In addition, in terms of research and treatment protocols, it is important that clinicians who are treating a patient or are doing studies on patients in New York or in San Francisco are comparing their results on similar patients who meet specified diagnostic criteria. The DSM-IV is also a multi-axial assessment. It includes not only the primary diagnosis, but it also includes personality disorders upon which the primary diagnosis is superimposed, medical conditions, a list of stressors in the patient’s life, and a global assessment of functioning scale. The DSM-IV defines a mental disorder as “a clinically significant behavioral or psychological syndrome . . . that is associated with present distress or . . . disability.”<sup>24</sup> The DSM-IV also is explicit about what is not a mental disorder. “[A]n expectable and culturally sanctioned response to a particular event” is not a mental disorder.<sup>25</sup> Deviant behavior or conflicts with society are also not classified as mental disorders, according to DSM-IV, unless the deviance or conflict is a symptom of a mental disorder as defined above.<sup>26</sup>

In the Supreme Court decision of *Atkins v. Virginia*,<sup>27</sup> which considered the constitutionality of imposing the death penalty on defendants who are mentally retarded, Justice Stevens refers to the DSM-IV,<sup>28</sup> and the joint amicus curiae brief of the American Psychological Association and the American Psychiatric Association.<sup>29</sup> Justice Stevens stated, “clinical definitions of mental retardation require not only subaverage intellectual functioning, but also significant limitations in adaptive skills . . . that became manifest before age 18.”<sup>30</sup> In contrast, Justice Scalia, focusing on this definition in his dissent stated,

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21. Andrew E. Taslitz, *Mental Health and Criminal Justice: An Overview*, 22 CRIM. JUST. 4, 5 (2007).

22. See DSM-IV, *supra* note 20, at xxxiii.

23. See *id.*

24. *Id.* at xxxi.

25. *Id.*

26. See *id.*

27. 536 U.S. 304 (2002).

28. *Id.* at 308 n.3.

29. See *id.* at 316 n.21.

30. *Id.* at 318.

“the symptoms of this condition can readily be feigned.”<sup>31</sup> Thus, we see that the DSM-IV was used by some of the Justices in their decision making about whether there is a true diagnosis of mental retardation and how it can be diagnosed in any one defendant. There is clearly controversy about this issue among the Supreme Court Justices. It is important to note that included in the DSM-IV is a cautionary statement which says the “assignment of a particular diagnosis does not imply a specific level of impairment or disability.”<sup>32</sup> Thus, an individual may be depressed, but that may or may not result in a level of functional impairment that warrants a determination of disability. Also, a diagnosis does not imply a legal standard, for example, incompetence, disability, or lack of criminal responsibility. A defendant may have a diagnosis of schizophrenia, yet he or she may still be competent to stand trial. In addition, a diagnosis does not imply whether a behavior can be controlled. Thus, severe mania in an individual with bipolar disorder may or may not affect whether the person can control his or her behavior. The diagnosis does not tell whether a defendant charged with a crime had an irresistible impulse or whether he had an impulse not resisted. This distinction is one that courts must keep in mind.

#### IV. RESEARCH ABOUT VIOLENCE RISK ASSESSMENT AND APPLICATION TO LEGAL DETERMINATIONS

In the last two decades, there has been a significant amount of scientific research about violence risk assessment. The legal system has been interested in this research, because violence potential is relevant to many legal decisions. For example, civil commitment criteria in most states rely on a dangerousness standard. In California, for instance, one of the criteria for emergency civil commitment is that, as a result of a mental disorder, the individual is a danger to others.<sup>33</sup> There has been controversy about the scientific basis for mental health professionals' judgments of dangerousness among persons with mental disorders.<sup>34</sup> There has also been concern about the limitations of the ability of mental health professionals to forecast future violence, and controversy about whether and how mental disorder is related to violence risk.<sup>35</sup> Studies over the last twenty years have supported that:

- (1) Although the proportion of violence in society that is

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31. *Id.* at 353 (Scalia, J., dissenting).

32. DSM-IV, *supra* note 20, at xxxiii.

33. See CAL. WELF. & INST. CODE § 5150 (West 2006).

34. Thomas R. Litwack, *Actuarial Versus Clinical Assessments of Dangerousness*, 7 PSYCHOL. PUB. POL'Y & L. 401, 410-11 (2001).

35. See, e.g., Richard A. Friedman, *Violence and Mental Illness: How Strong Is the Link?*, 355 NEW ENG. J. MED. 2064 (2006).

attributable to persons with mental disorders is small,<sup>36</sup> persons with severe mental disorders, particularly with co-occurring substance related disorders are at a higher relative risk than others.<sup>37</sup>

- (2) For acutely mentally ill persons who are eligible for emergency civil commitment, symptoms of mental disorder increase the short-term risk of violence.<sup>38</sup>
- (3) Clinical judgments of violence potential made by mental health professionals in the context of emergency civil commitment are associated with the risk of later violence, although the predictive validity of their risk assessments is far from perfect.<sup>39</sup>
- (4) Research has validated a number of decision support tools that can enhance assessments of the risk of future violence by people with mental disorder, by grounding them in variables that are empirically associated with the probability of future violent acts.<sup>40</sup>
- (5) Recent research suggests that when trained in the new methods, the ability of clinicians to make scientifically-based risk assessments for violence improves.<sup>41</sup>

Although these advances have the potential to improve the validity of mental health professionals' assessments of patients' risk for violence, decisions about how much risk is necessary to justify decisions about deprivation of liberty through civil commitment remain value judgments that are not scientific. For example, some individuals who clinicians have determined have a high likelihood of violence, will not actually commit

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36. *Id.* at 2065.

37. See Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 *AMER. J. PSYCHIATRY*, 1397, 1401 (2006).

38. See Dale E. McNeil, Jane P. Eisner & Renee L. Binder, *The Relationship Between Aggressive Attributional Style and Violence by Psychiatric Patients*, 71 *J. CONSULTING & CLINICAL PSYCHOL.* 399, 401 (2003); see also Dale E. McNeil & Renee L. Binder, *The Relationship Between Acute Psychiatric Symptoms, Diagnosis, and Short-Term Risk of Violence*, 45 *HOSP. & COMM. PSYCHIATRY* 133, 136 (1994); Dale E. McNeil, Jane P. Eisner & Renee L. Binder, *The Relationship Between Command Hallucinations and Violence*, 51 *PSYCHIATRIC SERVICES* 1288, 1288 (2000).

39. See Dale E. McNeil, Judy N. Lam & Renee L. Binder, *Relevance of Interrater Agreement to Violence Risk Assessment*, 68 *J. CONSULTING & CLINICAL PSYCHOL.* 1111, 1113–14 (2000); see also Dale E. McNeil, David A. Sandberg & Renee L. Binder, *The Relationship Between Confidence and Accuracy in Clinical Assessment of Psychiatric Patients' Risk of Violence*, 22 *L. & HUM. BEHAV.* 655, 664 (1998); John Monahan, Tarasoff at Thirty: *How Developments in Science and Policy Shape the Common Law*, 75 *U. CIN. L. REV.* 497, 500–01 (2006).

40. See Dale E. McNeil et al., *Utility of Decision Support Tools for Assessing Acute Risk of Violence*, 71 *J. CONSULTING & CLINICAL PSYCHOL.* 945, 948 (2003); John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 *VA. L. REV.* 391, 408–13 (2006).

41. See Dale E. McNeil et al., *Impact of Clinical Training on Violence Risk Assessment*, 165 *AMER. J. PSYCHIATRY* 195, 195 (2008).

violence. The legal system needs to decide how much likelihood of future violence is necessary to deprive an individual of civil liberties through civil commitment. We expect that clinicians' testimony based on scientifically valid data about violence risk will assist legal professionals in making such decisions.

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