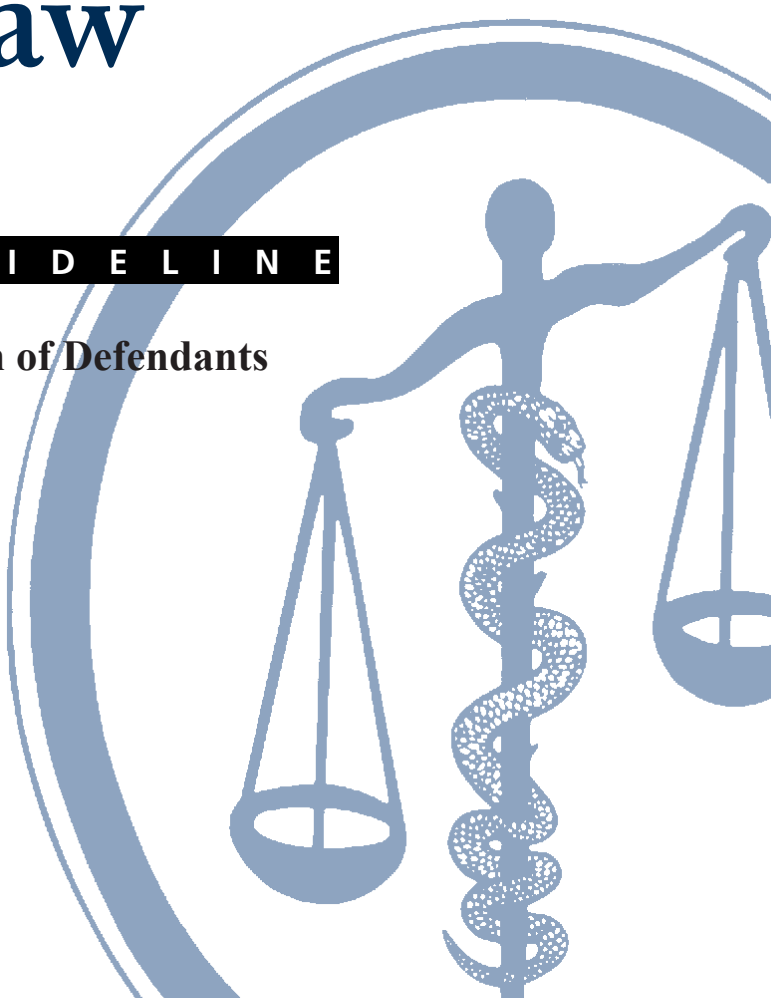
Supplement to

The Journal of the American Academy of Psychiatry and the Law

PRACTICE GUIDELINE

Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense

Volume 30, Number 2, 2002



Practice Guideline

Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense

Task Force

Deborah Giorgi-Guarnieri, MD, JD, Chair

Jeffrey Janofsky, MD

Emily Keram, MD

Sarah Lawsky, JD

Philip Merideth, MD, JD

Douglas Mossman, MD

Donna Schwartz-Watts, MD

Charles Scott, MD

John Thompson, Jr., MD

Howard V. Zonana, MD, Medical Director, AAPL

Acknowledgments

The members of the Task Force wish to thank the following AAPL members who provided written comments on a draft of this report: David Armitage, David Benedek, Ben Bursten, Harold Bursztajn, Robert Chapman, Richard Ciccone, Dave Davis, Thomas Gutheil, Abraham Halpern, Roy Lacoursiere, Gregory Leong, Maria Lymberis, Jeffrey Metzner, Eugene Minard, Jonathan Olin, Theodore Pearlman, Phillip Resnick, David Rosmarin, David Tingle, Thomas Welch, George Wilkinson, and John Young. We also gratefully acknowledge the contribution made by members of the original AAPL Task Force on Practice Guidelines for Forensic Psychiatric Evaluation of Criminal Responsibility: Robert Granacher, Daryl Matthews, Ralph S. Smith, Larry H. Strasburger, David Sprehe, and Stuart Anfang. The draft report of the original Task Force provided guidance and assistance in the preparation of this document. We extend a special appreciation to Richard Bonnie, John S. Battle Professor of Law at the University of Virginia, for his review and suggestions.

The Journal of the American Academy of Psychiatry and the Law

Volume 30, Number 2 Supplement

AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense

Deborah Giorgi-Guarnieri, MD, JD, Jeffrey Janofsky, MD, Emily Keram, MD, Sarah Lawsky, JD, Philip Merideth, MD, JD, Douglas Mossman, MD, Donna Schwartz-Watts, MD, Charles Scott, MD, John Thompson Jr., MD, and Howard Zonana, MD

Statement of Intent

These practice guidelines are intended as a summary of current legal standards and a model for forensic psychiatrists who perform insanity defense evaluations. The goals of these practice guidelines are to aid the individual forensic psychiatrist in the evaluation of insanity defense cases and to provide a comprehensive approach for the subspecialty. Adherence to parameters set forth in this document will not ensure an accurate assessment of a defendant's mental state at the time of the instant offense. These parameters are not intended to represent all acceptable, current, or future methods of evaluating defendants for and drawing conclusions about the insanity defense. The fact situation, relevant law, and the judgment of the forensic psychiatrist determine the ultimate conduct of each insanity defense evaluation.

This guideline is intended for practicing forensic psychiatrists and those psychiatrists who have the competence to accept the role of a forensic evaluator.

Overview

The insanity defense is a legal construct that, under some circumstances, excuses mentally ill defendants from legal responsibility for criminal behavior. The ability to evaluate whether defendants meet a jurisdiction's test for a finding of not criminally responsible is a core competency in forensic psychiatry. This document is intended as a practical guide to insanity defense evaluations of adult defendants. Forensic psychiatrists who are in active general and/or academic practice developed this guideline after a thorough review of the literature and extensive research comparing practice methodologies from different geographic areas and practice settings. Interested members of the American Academy of Psychiatry and the Law (AAPL) have also reviewed the guideline and offered substantive and editorial suggestions. The language used throughout the document is intended to address the insanity defense only and not other issues regarding criminal responsibility, such as diminished capacity or mitigating mental conditions affecting sentencing.

The report acknowledges differences between ethics guidelines and legal jurisdictional requirements. Jurisdictional rules of discovery or hearsay, among others, may compel the forensic psychiatrist to conform to different practices in different locations.

Definitions for the Purpose of This Practice Guideline

Forensic psychiatrist—a psychiatrist with forensic training or a psychiatrist who conducts an insanity defense evaluation.

Mental disease or defect—a legal or statutory definitional criterion for the insanity defense.

Mental disorder—a disorder or symptoms described in the APA's DSM or the International Classification of Diseases (ICD).

Insanity defense—a special defense in the criminal law excusing a defendant from criminal responsibility. A defendant whose insanity defense is successful is adjudicated either not guilty by reason of insanity (NGRI) or guilty but not criminally responsible (NCR), depending on the jurisdiction.

I. Introduction and History of the Insanity Defense

For centuries Anglo-American law has maintained the principle that a person can be found not criminally responsible for an offense if at the time of the offense he was "insane."[1–3] Judge David Bazelon succinctly summarized the moral basis of the insanity defense: "Our collective conscience does not allow punishment where it cannot impose blame."[4] Insanity defense rules have always been controversial. Attempts upon the lives of kings, presidents, and government officials have often led to review and modification of legal standards. The most recent such review occurred in the aftermath of the attempted assassination of President Reagan by John W. Hinckley in 1981.

The case history prior to John Hinckley can be divided into three categories that center on one significant legal event—the trial of M'Naghten. The legal cases prior to M'Naghten, the M'Naghten case itself, and the legal cases after M'Naghten define the three historic periods that shape our present day understanding of the insanity defense. (The spelling of M'Naghten is quite controversial. There is evidence, based on his signature, that it should be McNaughton. The name has been spelled at least nine other ways in the medical and legal literature. We have elected to use the spelling most often found in the legal literature.)[5]

Pre-M'Naghten History

Commentary on Hebrew Scriptures as early as the sixth century B.C.E. distinguished between offenses where fault could be imposed and those that occur without fault. Examples of the latter were those committed by children, who were seen as incapable of weighing the moral implications of personal behavior even when willful and by retarded and insane persons who were likened to children.[6,7]

In the twelfth century, issues of moral wrongfulness began to develop in pre-English law that raised the concept of "madness" as it relates to culpability. Lords of state began granting pardons to individuals who were convicted of a crime and obviously "mad."[8] These "pardons" usually ordered the accused to commitment and treatment in a mental institution instead of a prison. Unfortunately, the mental institutions and prisons lacked both adequate facilities and treatment for the seriously mentally ill. Granting pardons, however, preserved the dignity of the legal process.

In the thirteenth century, the moral wrongfulness requirement of Christian law was merged into English common law, to require both the presence of a criminal act (*actus reus*) and the presence of a guilty mind (*mens rea*). Henry Bracton, who wrote the first study of English law, noted that because children and the insane were incapable of forming both intent and will to do harm, they therefore did not have the capacity to form a guilty intent.[9]

With reference to children, the common law settled into its present form between the fifth century and the time of Lord Coke in the seventeenth century: The *doli incapax* doctrine found in common law consisted of an irrebuttable presumption that children under age seven were incapable of committing a crime. Between the ages of 7 and 13 (inclusive), however, incapacity was presumed but was open to challenge. This rebuttable presumption could be overcome by the prosecution producing evidence that showed the child was intelligent enough to distinguish between right and wrong (or good and evil) and, therefore, aware of the wrongful nature of the act in question.[10] The "knowledge of right and wrong" language denotes a general capacity or status that young children are thought to lack.

Prior to the M'Naghten case, English jurists made several attempts to find the appropriate test for insanity. The "wild beast test" of Justice Tracy in the 1723 Arnold case held that a man must be ". . .*totally deprived* [emphasis added] of his understanding and memory, and doth not know what he is doing, no more than an infant, . . .a brute, or a wild beast. . ." before being found insane.[11] Other English tests included the *offspring of a delusion* test championed by Thomas Erskine in the Hadfield trial of 1800. The importance of this case was that insanity could be partial rather than total. Another important influence during this period was Isaac Ray's *Treatise on the Medical Jurisprudence of Insanity*, written in 1838.[12] Ray was concerned with tests that looked only at cognition and not volition. The 1840 case of Edward Oxford proposed a volitional or behavioral test that introduced the concept of the *irresistible impulse* defense. The test allowed for a person to be acquitted because, as a result of a mental disorder, he could not resist the impulse to commit the crime.[13] Sir Fitzjames Stephen later championed this test. Queen Victoria, however, was not happy with Oxford's ac-

quittal because she was the target of his attempted regicide. The Queen felt that a mentally ill person who attempted a crime should still be held accountable for it.

> . . . . Punishment deters not only sane men but also eccentric men, whose supposed involuntary acts are really produced by a diseased brain capable of being acted upon by external influence.
>
> A knowledge that they would be protected by an acquittal on the grounds of insanity will encourage these men to commit desperate acts, while on the other hand certainty that they will not escape punishment will terrify them into a peaceful attitude towards others [Ref. 8, p 193].

The wide variety of cognitive and behavioral tests, the uncertainty about the insanity defense, and the Queen's displeasure with the outcome of Oxford case set the stage for the most widely publicized case in England: the M'Naghten trial of 1843.

The M'Naghten Rule

Daniel M'Naghten was a Scottish wood turner who believed that the Tory Party of England was persecuting him. He worried that Sir Robert Peel, a leader in the Tory Party, was part of this torment. M'Naghten was thought to have been stalking Peel, but killed Peel's secretary, Edward Drummond. The press followed the case closely because of the controversial nature of the defense: not guilty by reason of insanity. Despite all of the psychiatric witnesses' agreeing that M'Naghten was not of sound mind, and Justice Tyndall's agreeing that M'Naghten was legally insane, the public was outraged at the jury's verdict supporting the plea: Queen Victoria, who was also concerned about the verdict, summoned the 15 Law Lords in the House of Lords and asked them five questions concerning the insanity defense. The answers to two of the questions compose what is now known as the M'Naghten rules or M'Naghten test.[14]

> [E]very man is to be presumed to be sane. . . . [T]o establish a defense on the ground of insanity, it must be proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to 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.[15]

This test became the law of the land in England and was imported by several American states. Although the wording was modified in some jurisdictions, the basic cognitive framework required "a defect in reason caused by a disease of the mind (mental illness), which impairs a person's ability to know the wrongfulness of one's conduct." This language is present in a majority of the insanity tests currently used in the United States.[16]

The Product Test or Durham Rule

The New Hampshire Supreme Court, influenced by Isaac Ray's view that the M'Naghten standard was too narrow, strongly criticized M'Naghten in the 1870 *State v. Pike* decision.[17] The following year, the *State v. Jones* decision announced the "product test": "No man shall be held accountable, criminally, for an act which was the offspring and product of mental disease."[18] The test did not gain wide acceptance by the courts, although it did gain notoriety when Justice Bazelon in the District of Columbia adopted it in the Durham case.[19] This broad test for insanity was so widely abused that Justice Bazelon attempted to modify its impact with a new definition of mental illness in the *McDonald v. U.S.*[20] decision. He also attempted to discourage overly conclusive testimony by psychiatrists in the *Washington v. U.S.* decision, which he felt was undermining the test.[21] In 1972, the D.C. federal court, in *Brawner v. U.S.*, abandoned the product test,[22] as did most jurisdictions, except for New Hampshire[16] and the Virgin Islands.[23]

The Irresistible Impulse Test

This test, first proposed in the 1840 Oxford case, deals with an individual's ability to control impulses or conform conduct to the requirements of the law. The first American legal support for this test is found in the 1886 case of *Parsons v. State*.[24]

> . . .he may nevertheless not be legally responsible if the following conditions occur: (i) if by reason of the duress of such mental disease, he had so far lost the power to choose between the right and the wrong, and to avoid doing the act in question, as that his free agency was at the time destroyed, (ii) and if, at the same time, the alleged crime was so connected with such mental disease, in the relation of cause and effect, as to have been a product of it solely.

The resulting irresistible impulse test focuses on whether the mental disease or defect has prevented the person from controlling his behavior at the time of the offense. The practical aspects of applying this defense have led to problems distinguishing between the irresistible impulse and the impulse not resisted. Thus, as of 1990 no state uses irresistible impulse as its sole insanity defense. A few states combine it with a cognitive M'Naghten "arm" as part of their insanity test.

The Model Penal Code, American Law Institute Test

By 1950 the M'Naghten insanity test was used by two-thirds of the states with one-third of those states adding some volitional or irresistible impulse component. In 1955 the American Law Institute (ALI) formulated the Model Penal Code, which contained what would become a second model insanity test that has had wide influence in the United States. The ALI test, which is described in Section 4.01 of the Model Penal Code, states:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he *lacks substantial capacity* either to *appreciate* the criminality of his conduct or to *conform his conduct* to the requirements of law" [emphasis added].[25]

This is a combination of the M'Naghten test and irresistible impulse concept, with significant modifications in wording. The ALI test used the term "lacked substantial capacity" and deleted "know the nature or quality of the act." This means the impairment needs only to be substantial and not total. Changing "know" to "appreciate" also expands the cognitive prong, which had previously been very strictly interpreted by judges and attorneys. The ALI test was adopted by half of the states and the federal courts prior to the Hinckley trial. By 1980 just before Hinckley's trial, the Model Penal Code, or ALI test, had become the most influential and widely used test for insanity in the United States.

The Trial of John W. Hinckley Jr.

Just like the M'Naghten case 139 years earlier, the Hinckley trial was quite influential in shaping subsequent revisions of the insanity defense. The entire nation watched in horror as John Hinckley Jr. shot President Reagan and his press secretary, Jim Brady. The trial was lengthy, with the psychiatric testimony alone consuming 1,700 pages of transcript.[14] The psychiatric opinions and diagnoses varied widely, from schizophrenia to dysthymia. Just as in the M'Naghten case, when Hinckley was found not guilty by reason of insanity, the public was outraged and could not accept the fact that the president's attacker was being "let off." This led Congress and many states to enact reforms tightening an insanity defense that had become too liberal in the eyes of the public.

Post-Hinckley Insanity Reform: the Insanity Defense Reform Act

The acquittal by reason of insanity of John W. Hinckley Jr. set into motion the widest call for insanity defense reform since the assassination of President Garfield by Charles Guiteau. In the Guiteau trial, the legitimacy of "moral insanity" was the issue of the day.[26] In contrast, after Hinckley, everything was on the table. Five states—Idaho (1982), Kansas (1996), Montana (1979), Nevada (1995) and Utah (1983)—abolished the defense. Altogether, 36 states have imposed some form of insanity defense reform since Hinckley's acquittal. Dozens of bills were proposed in Congress, culminating in the Insanity Defense Reform Act of 1984, which changed the standard for federal courts and formed the basis for much of the post-Hinckley insanity defense reform in the states.[16]

As part of the Comprehensive Crime Control Act of 1984, Congress enacted the Insanity Defense Reform Act, which contained provisions in four areas that limited the scope of insanity acquittals[27,28]:

1. Under the new federal insanity defense test, a defendant was not responsible for criminal conduct if, "as a result of a severe mental disease or defect, [he] was unable to appreciate the nature and quality or the criminality or wrongfulness of his acts."[28] The act provides for a special verdict of "not guilty only by reason of insanity" in such cases.[29] Prior to the enactment of the new test, federal courts had used the Model Penal Code test as a matter of common law with some variations among the circuits.[30–33] Shortly before passage of the new test, the Fifth Circuit had adopted a similar test in *United States v. Lyons*.[34] The language of the statute shows this to be a cognitive test with no volitional prong.[35] (The legislative history indicates that although Congress acknowledged the moral basis of a volitional test, it decided not to include a volitional component in the new federal test because of the difficulty of proving reliably whether a particular defendant was unable rather than unwilling to exercise self-control.) In short, it combines elements of the M'Naghten test and the cognitive prong of the Model Penal Code test. Congress adopted the Model Penal Code's use of the term "appreciate"[36] to designate the cognitive capacity at issue. The new test incorporates both the M'Naghten test's reference to awareness of the "nature and quality" of an act, and the Model Penal Code's reference to awareness of the "wrongfulness"

of an act, to describe the types of appreciation in question. (Note that the cognitive prong of the Model Penal Code test refers only to "appreciation of the wrongfulness or criminality of conduct," omitting the M'Naghten test's explicit reference to "appreciation of the nature and quality of conduct." Since the Model Penal Code drafters declared their intent to use a broad cognitive prong, free of the perceived limits of the M'Naghten test, and since appreciation of wrongfulness or criminality of conduct generally requires appreciation of the nature and quality of conduct, the cognitive prong of the Model Penal Code test should be interpreted to encompass the M'Naghten test. By including the Model Penal Code and M'Naghten formulations explicitly, the new federal test has the virtue of providing greater clarity on this issue.) To emphasize that nonpsychotic behavioral disorders or neuroses do not suffice to establish the defense, the test states that the defendant's mental illness must be "severe" to be exculpatory. The federal test also deletes the Model Penal Code qualification that incapacity due to mental illness is exculpatory if it is "substantial."[36] The ABA recommended a virtually identical test, providing that "[a] person is not responsible for criminal conduct if, at the time of such conduct, and as a result of mental disease or defect, that person was unable to appreciate the wrongfulness of such conduct."[37] These tests do not include volitional components. They are expansive cognitive tests that use the broad terms "appreciate" and "wrongfulness" introduced by the Model Penal Code. The tests, by using the term appreciate to encompass affective dimensions of major mental illness, take into account all aspects of the defendant's mental and emotional functioning relating to an ability to recognize and understand the significance of personal actions (Ref. 37, p 343). They use the term "wrongfulness" to indicate an incapacity to appreciate the immoral as well as unlawful character of particular criminal conduct (Ref. 37, p 344). Along with the new federal test, these tests omit the Model Penal Code's qualification of the relevant incapacity as "substantial" (but without adding the federal test's qualification that the mental illness must be severe). As the ABA Report explains:

> This approach has been taken both to simplify the formulation and to reduce the risk that juries will interpret the test too loosely. By using the "substantial capacity" language, the drafters of the ALI standard were trying to avoid the rigidity implicit in the M'Naghten formulation. They correctly recognized that it is rarely possible to say that a mentally disordered person was totally unable to know what he was doing or to know that it was wrong; even a psychotic person typically retains some grasp of reality. However, it is not necessary to retain the phrase "substantial capacity" to take into account these clinical realities. Sufficient flexibility is provided by the term appreciate, as defined earlier [Ref. 37, pp 344–5].

2. The burden of proof shifted from the prosecution, which had to prove the defendant was sane beyond a reasonable doubt, to the defense, which had to establish the defendant's insanity by clear and convincing evidence, i.e., an affirmative defense.

3. Commitment of the acquittee to the custody of the U.S. Attorney General for treatment was specified, with a provisional term of confinement set at the maximum term of confinement authorized for the offense. The court has the option to revise the confinement if the defendant recovers from his/her illness.[38]

4. The federal courts also introduced a new rule of evidence barring specific testimony by expert witnesses directed to the mental state of a defendant at the time of the alleged criminal act, i.e., the "ultimate issue." This rule states, in part:

> No expert witness testifying with respect to the mental state or condition of a defendant. . .may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto.[39]

In addition, many states modified their insanity defense statutes to make it more difficult to qualify for the defense, or to be released when found not guilty by reason of insanity.

Review of State Statutes and Federal and Military Law

Statutory law defines the test for criminal responsibility in the federal courts and in most states. Case law defines the standards in some states: Florida, Massachusetts, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Rhode Island, Virginia and West Virginia. Providing the opportunity to raise an insanity defense is not, however, constitutionally required. Idaho, Kansas, Montana, Nevada and Utah have repealed their insanity defense. (The Nevada Supreme Court overturned the abolition of the insanity defense as a complete defense; see Finger v. State of Nevada, 27 P.3d 66 (2001).) Kansas, Montana, and Utah allow mental disease or defect to negate an element of the offense. Colorado and North Dakota include *mens rea* as part

of their insanity defense statute. The Idaho statute does not allow the use of mental condition as a defense for any charge of criminal conduct.

Legal standards can be categorized by the presence of a cognitive and/or a volitional prong. They can also be defined as meeting the criteria of the ALI test, M'Naghten standards, or product test. Some include variations of the M'Naghten or ALI standards (see chart, "The Insanity Defense: State and Federal Standards, 2000–2001," at end of text). All require the presence of a mental disease or defect and a related impairment in cognition and/or conduct. Legal standards and rules are always subject to revision. The current compilation reflects the standards as they applied in the year 2000.

The definitions of mental disease or defect vary considerably from state to state. Many states require a "severe" mental disease (Alabama, Delaware, Illinois, Indiana, Maine, North Dakota, Ohio, South Dakota, Tennessee and the federal statute). Other states use specific definitions of mental illness. For example, Indiana's code defines mentally ill as "having a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function"; mentally ill also includes "having mental retardation." Florida's definition of mental illness is "an impairment of the emotional processes that exercise conscious control of one's actions or an impairment in the ability to perceive or understand reality. . .[such that the] impairment seems to interfere with the ability to meet the ordinary demands of living."

Many states define specific exclusions to their statutory definition of mental illness. The most common exclusion is repeated antisocial acts (Alabama, Alaska, Arkansas, Arizona, Colorado, Connecticut, Delaware, Illinois, Kentucky, Maine, Maryland, Missouri, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Wisconsin and Wyoming). Although the legislative intent was to exclude antisocial personality disorders, few mention the disorder specifically.

Some states exclude voluntary intoxication in their statutory definition of mental illness or defect. These states include Arizona, Connecticut, Delaware, Maine, Michigan, North Dakota, South Carolina and Utah. This is not an exhaustive list. We only looked at the criminal statutes; some states use civil code definitions in applying the insanity defense (e.g., Louisiana).

Finally, some states add even more statutory exclusions for mental illness. Utah excludes personality or character disorders. California excludes personality disorders, adjustment disorder and seizure disorder. Colorado states that mental disease or defect should not be confused with "moral obliquity, mental depravity, or passion growing of anger, revenge, hatred, or other motives and kindred evil conditions or when the act is induced by any of these causes. . . ." Connecticut excludes pathological or compulsive gambling as a qualifying mental disease or defect. Florida excludes defendants with mental retardation or autism. Oregon excludes personality disorders. Arizona also excludes character defects, psychosexual disorders, and impulse control disorders. Arizona also excludes: momentary temporary conditions arising from the pressure of circumstances; moral decadence, depravity or passion growing of anger, jealousy, revenge, hatred; or other motives in a person who does not suffer from a mental disease, defect, or abnormality that has manifested itself only by criminal conduct.

Most standards used to define the insanity defense contain a cognitive prong. The volitional prong of many standards has been dropped post-Hinckley. Some states adopted the traditional tests verbatim, including the M'Naghten test and the American Law Institute standard. Some states have modified the M'Naghten and ALI tests. The irresistible impulse test has been adopted in combination with other tests having a cognitive prong.

The M'Naghten Standard

The M'Naghten test focuses solely on the defendant's cognition *vis-à-vis* the criminal act. Modifications include: the substitution of appreciate, understand, recognize, distinguish or differentiate for *know*; omission of the wrongfulness language; or omission of the nature and quality language. States that use the M'Naghten standard or a variation include: Alabama, Alaska, Arizona, California, Colorado, Florida, Indiana, Iowa, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, and Washington. Virginia and New Mexico combine the M'Naghten test with the irresistible impulse test.

Other modifications of the M'Naghten standard include Iowa, which uses the M'Naghten standard

and adds, "Insanity need not exist for any specific length of time before or after the commission of the alleged criminal act." Mississippi uses the following language: "[The accused] did not realize and appreciate the nature and quality thereof and could not distinguish right from wrong." New York uses "lacked substantial capacity to know or appreciate." This language is a mixture of the ALI cognitive prong and the M'Naghten test. South Carolina specifies the type of wrong with "lacked the substantial capacity to distinguish moral or legal right from wrong or to recognize the particular acts charged as morally or legally wrong." Arizona omits the nature and quality clause of the M'Naghten test; Alaska omits the wrongfulness clause of the M'Naghten test.

The ALI Standard

The ALI test uses both a cognitive and volitional prong. While not used as commonly as the M'Naghten standard, ALI is the second most popular standard used. The ALI cognitive prong focuses on substantial capacity to appreciate the wrongfulness of the criminal behavior. Generally, the ALI test is open to broader interpretation than the more narrowly interpreted cognitive M'Naghten test.

Some states have adopted the ALI standard verbatim, while others have modified the cognitive or volitional prong and still others have omitted the volitional prong altogether. States that adopted the ALI standard, or a minor modification of it, include: Arkansas, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, North Dakota, Oregon, Rhode Island, Vermont, West Virginia, Wisconsin, and Wyoming.

Delaware, Illinois, and Maine adopted only the cognitive prong of the ALI test. Delaware uses the volitional prong as the test for a Guilty But Mentally Ill (GBMI) finding. Arkansas omits the word substantial. Connecticut uses the word control in place of conform. North Dakota has language similar to the cognitive prong and adds, ". . .or the conduct is the result of a loss or serious distortion of the individual's capacity to recognize reality, and it is an essential element of the crime." Vermont uses adequate but not substantial. Wyoming omits the word substantial.

The Irresistible Impulse Test

This test requires that an individual not be able to control his or her actions as a result of a mental disease. There are no states that currently use the irresistible impulse test as the sole definition for criminal responsibility. Virginia and New Mexico combine the M'Naghten test with the irresistible impulse test. Georgia uses a cognitive prong and a variant of the volitional prong that states, "because of a delusional compulsion as to such act which overmastered his will to resist committing the crime."

The Federal Standard

The federal test of criminal responsibility, according to the Insanity Defense Reform Act of 1984, is as follows:

> It is an affirmative defense to a prosecution under any federal statute that, at the time of commission of the acts constituting the offense, the defendant, as a result of severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.

This test does not have a volitional or irresistible impulse component.

The Military Standard

Military law consists of the Uniform Code of Military Justice and other statutory provisions to govern persons in the armed forces. According to the 10 U.S.C.S. Sec. 850a(2000):

> It is an affirmative defense in a trial by court-martial that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of the acts. Mental disease or defect does not otherwise constitute a defense.

II. Substance Abuse and the Insanity Defense

Voluntary Intoxication

U.S. jurisdictions uniformly subscribe to the longstanding rule that voluntary drug intoxication may not be used to exonerate a defendant completely. This does not mean that voluntary drug intoxication has no impact on a defendant's criminal responsibility. For centuries, defendants whose substance-induced mental diseases or defects are "settled,"—i.e., present when the individual is not intoxicated (e.g., alcohol-induced dementia)—have been permitted to raise the insanity defense.[40] Two recent cases affirm this principle. *State v. Hartfield*[41] held that the insanity defense may be pled when voluntarily consumed drugs or alcohol have caused a permanent mental condition that has destroyed a defendant's ability to distinguish right from wrong. In *Brunner v.*

State[42] the court held that the defendant is entitled to a jury instruction that long-term drug use can induce insanity.

Most jurisdictions sharply distinguish between "settled" insanity and "temporary" insanity caused by voluntary intoxication, and do not allow the latter to be used as a defense to criminal activity. *Commonwealth v. Tate*[43] held it was proper to exclude testimony about insanity induced by a defendant's voluntary drug use. *Bieber v. People*[44] rejected an insanity defense arising from mental illness caused by a defendant's active, voluntary substance use. A few jurisdictions, however, appear to differentiate between drug-induced psychoses and other forms of drug-induced mental incapacity. Although the case law is sometimes murky, these jurisdictions seem to follow the rule that, although voluntary drug intoxication is no defense to a criminal act, temporary insanity caused by voluntary drug intoxication may sometimes be a valid defense. Examples include a temporary insanity induced by the voluntary use of drugs that does not necessarily subside when the drug intoxication ends, and a unique latent mental illness that remains dormant most of the time, but can be triggered by the voluntary use of drugs.[45]

Two courts have held that because the effects of phencyclidine persist beyond the time of intoxication, individuals who ingested the drug voluntarily, and remained psychotic after the period of intoxication ended, were entitled to raise the insanity defense.[46,47] An older case, *People v. Kelly*,[48] reached a similar conclusion concerning a defendant who stabbed her mother repeatedly after taking mescaline, LSD, and other drugs frequently during a two-month period. The trial judge, acting without a jury, found that the drug use made the defendant psychotic before and after the attack, and rendered her unable to understand the wrongfulness of her actions. The California Supreme Court held that whether the period of insanity lasted several months or merely a few hours, the defendant did not lose the defense of insanity, even though she might also have been high on drugs at the time of the offense.

Current Ohio law does not permit a diminished capacity defense, nor does it allow a defendant to introduce expert psychiatric testimony unrelated to the insanity defense to show that he lacked the capacity to form the specific mental state required for a particular crime.[49,50] But in reversing a conviction on a charge of abduction, the Ohio Supreme Court ruled that the trial judge had to issue a jury instruction on insanity because of testimony that the defendant suffered from cocaine psychosis, along with bipolar disorder, which met the criteria for insanity.[51]

U.S. v. Knott[52] concerned the appeal of a conviction following the trial court's refusal to instruct the jury to consider voluntary alcohol intoxication, together with schizophrenia, when deciding whether the defendant qualified for an insanity acquittal under the federal insanity rule in 18 U.S.C.A. § 17(a). The circuit court observed that the legislative history of the Insanity Defense Reform Act of 1984 showed that Congress had intended to exclude an insanity defense based on voluntary intoxication alone. The appellate court also cited the longstanding Anglo-American principle that "[a] mental disease or defect must be beyond the control of the defendant if it is to vitiate his responsibility for the crime committed. . . . Insanity that is in any part due to a defendant's voluntary intoxication is not beyond his control."[53]

In *U.S. v. Frisbee*,[54] the court ruled that the language of 18 U.S.C.A. § 17—which states that, other than for an affirmative defense of insanity, mental disease or defect is not a defense—does not prohibit the defense from introducing evidence that negates the existence of specific intent and proves the defendant's innocence. More recently, the U.S Supreme Court upheld a Montana statute that provides that voluntary intoxication "may not be taken into consideration in determining the existence of a mental state which is an element of [a criminal] offense."[55] The Supreme Court justices felt that, since voluntary intoxication was an aggravating factor in nineteenth century case law, it was not a fundamental right of a defendant to introduce such evidence, and states could decide how they wished to treat such evidence.

Involuntary Intoxication

In addressing the issue of involuntary intoxication, the courts have defined it in essentially the same terms as insanity.[56] Like insanity, involuntary intoxication potentially excuses a defendant from culpability because intoxication affects the ability to distinguish between right and wrong.[57] Thus, the mental state of an involuntarily intoxicated defendant is measured by the test of legal insanity.[58–61] For example, the Ninth Circuit has recognized involuntary intoxication as a basis for invoking the insanity defense and expressed the rule in exactly the same terms. Involuntary intoxication cases typically re-

quire a finding that there was unintentional ingestion of an intoxicant (often through trickery), and that the defendant could not appreciate the nature and quality or wrongfulness of his acts.[62] Involuntary intoxication claims have also arisen from the use of prescribed psychotropic medications like Prozac. For example, in *Boswell v. State*,[63] Boswell was charged with shooting a police officer. He defended on the theory that he became very inebriated as a reaction to taking the prescribed medications Xanax and Prozac. Boswell had cirrhosis of the liver, which led to a toxic level of Prozac building up in his body. Experts testified that the anti-depressants can cause side effects, such as paranoid reactions and hallucinations and that Boswell was suffering from hallucinations when he "heard a shot" (Ref. 63, p 672). The Florida Supreme Court held that the trial court erred in failing to give the involuntary intoxication instruction, reiterating that "[a] party is entitled to have the jury instructed upon the law which is applicable to his theory of the case, if there is any competent evidence adduced that could support a verdict in his favor" (Ref. 63, p 673). In states that have abolished the insanity defense, involuntary intoxication may serve to negate *mens rea*.

III. Non-Traditional Mental Conditions Considered in Insanity Defense Cases

U.S. jurisdictions have adopted a variety of legal criteria for what constitutes insanity. Nevertheless, all jurisdictions that retain the insanity defense require that the defendant suffer from some form of mental disorder, often termed a disease or defect, to claim criminal nonresponsibility.

The majority of insanity defenses involve individuals who suffer from psychotic disorders or mental retardation. Successful insanity defenses make up well under one percent of all felony cases.[64] The publicity surrounding John Hinckley's 1982 insanity acquittal fueled widely shared myths about the defense, including the belief that defendants who used it were suffering from minor problems or faking serious problems so they could "get off."[65] State and federal legislators responded by revising statutory definitions of insanity in an effort to narrow the class of individuals who might receive insanity acquittals.[66]

Despite these legislative efforts, the last two decades have actually witnessed an expansion of the psychiatric diagnostic categories that may justify an insanity acquittal.[67]

Post-Traumatic Stress Disorder

Although medical practitioners have long recognized that wartime experiences and other emotionally traumatic events might induce long-lasting psychopathology, the 1980 publication of DSM-III marked the first time the term "post-traumatic stress disorder" (PTSD) was recognized in American psychiatry's official diagnostic nomenclature. As described in the APA's current diagnostic manual (DSM-IV-TR), PTSD may follow exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Its characteristic symptoms include re-experiencing the trauma, persistent avoidance of things associated with the trauma, emotional numbing and persistently increased arousal.

Any criterion-satisfying trauma might be the cause of PTSD, but much of the case law concerning PTSD and criminal defendants has centered on Vietnam veterans who have gone to federal prisons.[68] Thus, appellate cases, law review articles, and mental health literature on PTSD and criminal defense issues frequently refer to "Vietnam stress syndrome" and its associated psychiatric problems.

Courts have ruled narrowly concerning which types of experts may testify about the syndrome's effects,[69] whether failure to pursue a PTSD defense represented inadequate assistance of counsel,[70] and the granting of new trials to defendants whose convictions preceded formal recognition of the disorder in Vietnam veterans.[71] Insanity defenses based on Vietnam-related PTSD may be viewed skeptically because establishing the diagnosis depends heavily on self-reports, and because co-existing alcohol or drug abuse may make it difficult to define the degree to which mental incapacity at the time of an alleged act was due to the disorder or to voluntarily consumed intoxicants.

Case law clearly establishes PTSD as at least a potential basis for an insanity defense. For example, when the government sought to prevent a defendant from introducing lay and expert evidence on PTSD to support his insanity claim in *U.S. v. Rezaq*, a fed-

eral court ruled that, although a disorder had to be severe to support an insanity defense, the mere absence of the word "severe" from a PTSD diagnosis did not preclude the possibility that the disorder met the federal severity standard. "[T]he relevance of the evidence pertaining to defendant's PTSD diagnosis turns on whether defendant's case of PTSD is of sufficient severity to constitute an affirmative defense of insanity."[72]

On the other hand, courts have affirmed guilty verdicts in cases where Vietnam veterans presented evidence of PTSD for an insanity defense. For example, in *State v. Felde*,[73] "a rational juror could have found that defendant failed to prove insanity by a preponderance of the evidence and that he had the specific intent to inflict great bodily harm or kill." Moreover, an attorney's failure to pursue a Vietnam veteran's viable PTSD-based insanity defense may constitute ineffective assistance of counsel.[74] However, in a case involving a prison escapee who claimed in his appeal for post-conviction relief that "the stressful circumstances at the penitentiary caused his mind to snap and he began to hallucinate," the court ruled that a decision not to pursue a Vietnam-induced insanity defense was not ineffective assistance of counsel.[75]

Automatism

Automatism has been defined as "the existence in any person of behavior of which he is unaware and over which he has no conscious control."[76] Black's Law Dictionary defines it as "behavior performed in a state of mental unconsciousness. . .apparently occurring without will, purpose, or reasoned intention"[77]). A seminal British case concisely described automatism as "connoting the state of a person who, though capable of action, is not conscious of what he is doing."[78] Automatism manifests itself in a range of conduct, including somnambulism (sleepwalking), hypnotic states, fugues, metabolic disorders, and epilepsy and other convulsions or reflexes.[79,80]

In the states that have addressed the issue, it is well established that automatism can be asserted as a defense to a crime (§ 3(a)).[81] Rather than questioning whether automatism is a defense at all, the debate in these states has focused on the manner in which evidence of automatism can be presented. These jurisdictions are split between recognizing insanity and automatism as separate defenses and classifying automatism as a species of the insanity defense (Ref. 81, §§ 3(b)—(c)). Jurists sometimes favor the latter approach because the defendant is required to interpose a plea of insanity, thus giving reasonable notice to the state of the contention being made. It is also favored because treatment, where appropriate, can be required after a finding that the defendant committed the offense but is not criminally responsible. Distinguishing the two defenses, however, is the majority rule.[82]

Multiple Personality Disorder

Multiple personality disorder (MPD) is the former term for what the DSM-IV-TR calls *dissociative identity disorder* (DID), a condition characterized by "the presence of two or more distinct identities or personality states. . .that recurrently take control of behavior. . .[with] an inability to recall important personal information. . .which is too great to be explained by ordinary forgetfulness. . . ." Most case law, which antedates DSM-IV-TR, refers to the condition with the older term.

Despite its inclusion in the recent diagnostic manuals, the prevalence of DID and, for some clinicians, its mere existence are matters of significant debate.[83] Most insanity defense case law has accepted the existence of MPD, focusing instead on this philosophical issue: is it right to punish a person with MPD for actions committed when the "host" or "dominant" personality was not in control and has no memory of the events leading to the criminal charge?

Courts have responded in several ways.[84] For example, some state courts have held that culpability hinges on the mental condition of the personality that was "in control" at the time of the alleged offense. The lead case, *State v. Grimsley*,[85] was concerned in part with a statute that provided for acquittal of a person who acts unconsciously and without volition. However, Grimsley has been cited frequently in subsequent cases dealing with defendants who raised MPD as an insanity defense.

State v. Grimsley was an appeal of a drunk driving conviction. The defendant contended that, on the day of the offense a report of a lump on her breast had caused her to dissociate into the secondary personality of Jennifer. When she was Jennifer, Robin (the primary personality) was unaware of what was going on, had no control over Jennifer's actions, and had no memory of what Jennifer had done when Robin resumed control. The court found that, even if (as "the uncontroverted evidence" suggested) there was a

complete break between the defendant's consciousness as Robin and her consciousness as Jennifer, and assuming Jennifer "alone" was in control of the defendant's body when the offense occurred, Jennifer was neither unconscious nor acting involuntarily.

> There was only one person driving the car and only one person accused of drunken driving. It is immaterial whether she was in one state of consciousness or another, so long as in the personality then controlling her behavior, she was conscious and her actions were a product of her own volition. . . . [S]he failed to establish her defense of insanity, because. . .[t]he evidence fails to establish. . .that Ms. Grimsley's mental disorder had so impaired her reason that she—as Robin or as Jennifer or as both—either did not know that her drunken driving was wrong, or did not have the ability to refrain from driving while drunk (Ref. 85, pp 1075–6).

Several other jurisdictions have followed Grimsley's approach. *Kirkland v. State*[86] is a Georgia case in which a woman was convicted of bank robbery. The psychiatrist testified that the latent personality who robbed the bank did so with rational, purposeful criminal intent and with knowledge it was wrong. In *Commonwealth v. Roman*[87] a Massachusetts court instructed the jury to consider only the defendant's mental state at time of offense, and declined to instruct the jury to determine whether the core personality possessed the capacity to conform the behavior of the subsidiary personality to the law. In *State v. Rodrigues*[88] the Hawaii Supreme Court held that each personality may or may not be criminally responsible and, therefore, each had to be examined under the state's test for insanity.

A federal appeals court took a different view of this problem in *United States v. Denny-Shaffer.*[89] Here the defendant appealed her kidnapping conviction, arguing that she should have been found NGRI because "her dominant or host personality was neither aware of nor in control of the commission of the offense, and thus was unable to appreciate the nature and quality or wrongfulness of the conduct which the alter or alters carried out" (Ref. 89, p 1013). At trial the district court judge had ruled an insanity defense was not applicable because no evidence had suggested the alter personality could not appreciate the wrongfulness of the alleged offense. The appeals court reversed the conviction. It held that MPD qualified under the federal insanity definition as a "severe mental disease or defect" and that Denny-Shaffer would qualify for an insanity acquittal if she could prove by clear and convincing evidence that, at the time of the alleged offense: (1) "she suffered from MPD"; (2) "her dominant or host personality was not in control. . .and was not aware that an alter personality or personalities were the cognizant parties" committing the offense; and (3) MPD made the host personality "unable to appreciate the nature and quality or wrongfulness of the conduct which the alter or alters controlled" Ref. 89, p 1016).

A third approach was taken in *State v. Wheaton*[90] and affirmed in *State v. Greene.*[91] *Wheaton* and *Greene* both concerned the admissibility of evidence on MPD (or DID) under the Frye rule, which Washington State still follows. In *Wheaton* all the parties stipulated to the defendant's mental condition at the time of the crime, agreeing that there had been a host personality and one alter personality: the alter personality was in executive control of the physical body; the host personality was not in executive control of the physical body and had no independent knowledge of the acts constituting the offense. The defense and court-appointed mental health experts would not give *ultimate issue* testimony about whether Ms. Wheaton met the criteria for an insanity acquittal. The trial court subsequently found the defendant guilty. In *Greene* the Washington Supreme Court also refused to adopt a particular legal standard for assessing the criminal responsibility of a defendant with DID. Although, the Court acknowledged, the question of who should be held responsible for a crime is ultimately a legal decision, it needed more information from the scientific community "in understanding how DID affects individuals suffering from it and how this may be related to a determination of legal culpability." Because the Court found it impossible to connect reliably the symptoms of DID to a defendant's sanity or mental capacity, it affirmed the trial court's ruling excluding the evidence. Using the Frye test, the Court deemed DID a generally accepted, diagnosable psychiatric condition. However, the Court concluded that the evidence of DID was not admissible because it would not be helpful to the trier of fact under Washington State's rules of evidence (Ref. 91, p 1030).

Impulse Control Disorders

The courts' traditional skepticism regarding impulse control disorders as defenses to criminal acts is well illustrated by the following comment, taken from a case in which the defendant sought to have his conviction for intoxication overturned because alcoholism was a disease:

> If chronic alcoholism or dipsomania were to be accepted as a defense to a charge of drunkenness, would it not also be logical to accept it as a defense to a charge of driving while drunk? If so, how are we to eliminate or slow down the greatest cause of death on the highways? And why not accept a plea of pyromania by an arsonist, of kleptomania by a thief, of nymphomania by a prostitute, or a similar plea of impulse and non-volitional action by the child molester? Many other examples might be listed. What criminal conduct can be regulated or controlled if "impulse," a "feeling of compulsion," or of "non-volitional action" arising of these situations is to be allowed as a defense? This Pandora's box had best be left alone for now.[92]

Some states' statutes specifically preclude impulse control disorders from being used to support an insanity defense.[93] This and intermittent explosive disorder are all generally related to factors affecting the volitional prong.

Intermittent Explosive Disorder (IED)

As a result of *United States v. Lewis*,[94] intermittent explosive disorder (IED) is not considered a severe mental disorder as defined by Article 50a, UCMJ, 10 U.S.C. § 850a, which applies the federal insanity standard for military prosecutions. Thus, evidence that a court-martialed defendant suffered from IED did not obligate the judge to order inquiry concerning the defendant's mental responsibility.

In other jurisdictions, however, IED may be the basis for an insanity defense. In *Robey v. State*[95] the appellate court affirmed the trial court's finding a mother guilty of involuntary manslaughter after she failed to seek necessary medical treatment for her child, whom she battered. At trial the mother asserted that IED had rendered her unable to understand what she was doing. She was found NGRI for the beatings themselves. The appellate court, however, found ample evidence that the mother experienced several "lucid intervals" *after* the beating incidents, which supported the trial court's conclusion that she was sane and criminally responsible for failing to seek medical treatment for the child.

People v. Smith[96] also concerned a case in which IED was accepted as the potential basis for a valid insanity defense, although in this case the jury rejected the defense. The appellate court found the verdict was "not against the weight of the evidence." The prosecution presented convincing expert testimony and documentary evidence that the defendant, a 13-year-old charged with killing a 4-year-old, did not have IED. Similarly, in *State v. Filiaggi*,[97] the trial court permitted expert testimony on IED-related insanity, but the jury ultimately found the defendant guilty of aggravated murder. *State v. Ellis*[98] held that a defendant was entitled to present expert testimony on IED to establish a diminished capacity defense, subject to admissibility under Evidence Rule 702 and subject to appropriate instructions to the jury.

At least two cases have dealt with the interaction between IED and the "guilty but mentally ill" (GBMI) verdict. In *People v. Wiley*,[99] the court held that the presence of IED did not require a GBMI verdict. In *People v. Grice*,[100] the appellate court rejected the defense's suggestion that a GBMI jury instruction could occur only if the state had presented testimony indicating the defendant was mentally ill but not insane. At trial Grice had asserted an insanity defense based on IED, which was sufficient to justify the trial judge's giving the GBMI instruction to the jury.

Pyromania

Courts have long recognized that pyromania is a mental disorder. As an example, see *Hanover Fire Ins. Co. v. Argo*,[101] which refers to "'the many weird motivations of a pyromaniac." The disorder has been variously described in case law as a psychoneurosis, or a psychopathic state in which the pyromaniac has an intense urge to set fires, or has little control over his urge to set fire. What's more, impulse control can be further reduced by factors such as intoxication.[102–105] Because pyromaniacs typically set fires for the psychological gratification derived from starting and observing the fires they set, their disorder has been used to negate the specific intent requirement in certain types of arson offenses.[104] Such defenses may be vitiated, however, by evidence of premeditation, such as plans to escape or profit from the fire.[106]

In a 1956 case, *Briscoe v. United States*,[107] a pyromaniac was permitted to withdraw his guilty plea and enter an insanity plea. This suggests that pyromania might be grounds for an insanity acquittal. No reported case describes a pyromania-based insanity acquittal, however.

Pathological Gambling

The 2000 edition of the American Psychiatric Association's DSM-IV-TR lists the criteria for pathological gambling in its section on "Impulse-Control Disorders Not Elsewhere Classified," where it states that the essential feature of this disorder is "persistent and recurrent maladaptive gambling behavior. . .that

disrupts personal, family, or vocational pursuits." Following its listing as a disorder in the 1980 diagnostic manual (DSM-III), several courts have considered—and usually rejected—pathological gambling as an exculpatory condition for purposes of an insanity defense.

In cases that were decided before the Insanity Defense Reform Act removed the volitional prong from the federal insanity definition, two federal courts ruled that pathological gambling was irrelevant to an insanity defense because of the notion that persons with the disorder lacked the substantial capacity to conform their conduct to the requirements of the law and because it was not "generally accepted" by psychiatrists and psychologists.[108,109] Other federal decisions held that expert testimony on the disorder was irrelevant because the testimony could not establish a causal link between pathological gambling and the defendant's offenses,[110] and thus lacked probative value.[111] A recent Illinois decision, *People v. Lowitzki*,[112] held that pathological gambling was unavailable as a defense to a charge of theft.

One of the most frequently cited cases in this area is *United States v. Torniero*.[113] In September 1982 Torniero was charged with interstate transportation of stolen jewelry. He wanted to argue at trial that he was legally insane under the volitional prong of the then-operative ALI insanity test. He asserted that his gambling compulsion had rendered him unable to resist stealing from his employer (a jewelry store) to support his habit. The government asked the trial court judge to abolish the insanity defense outright. Failing this, the government sought to prevent Torniero from presenting any evidence related to compulsive gambling. After holding several days of hearings at which several forensic psychiatrists testified about the relationship between compulsive gambling and the ability to conform conduct, the district (trial court) judge ruled that the relationship between compulsive gambling and the desire to steal was too tenuous to permit introduction of expert testimony. Torniero was tried and convicted. He then appealed, contending that the trial judge had erred by refusing to let the jury consider his compulsive gambling defense.

The circuit court held that, for expert testimony on pathological gambling to be relevant, respected authorities in the field must agree that the disorder is a mental disease or defect that could impair a defendant's ability to desist from the offense charged or to appreciate the wrongfulness of his conduct. The appellate court did not decide this issue, but looked only at whether the trial judge's decision to exclude expert testimony was reasonable. Even if compulsive gambling constituted a mental disease under the ALI test, said the court, there is still ample basis for the trial court's conclusion that Torniero's compulsive gambling disorder is not relevant to the insanity defense. The trial judge correctly noted that the relevance standard requires that the alleged pathology have "a direct bearing on [the] commission of the acts with which [the defendant] is charged."[114] To sum up, "a compulsion to gamble, even if it constitutes a mental disease or defect, is not *ipso facto* relevant to the issue of whether the defendant was unable to restrain himself from non-gambling offenses, such as transporting stolen property."[115] The circuit court concluded that, given the disagreement among the experts who testified, the trial judge had not abused discretion in finding that the connection between compulsive gambling and stealing was not satisfactorily established.

However, in a 1981 Connecticut case, *State v. Lafferty*,[116] a defendant used pathological gambling to obtain an insanity verdict after all the examining experts agreed that the disorder left him unable to conform his conduct to the requirements of the law. The Connecticut legislature subsequently amended its definition of mental disease or defect to exclude pathological gambling as a potential insanity defense.[117]

Paraphilias

Despite their inclusion as mental "disorders" in DSM-IV-TR, there has been ongoing debate among mental health professionals about whether paraphilias should constitute a mental illness for purposes of civil commitment or other court-ordered confinement. As Supreme Court Justice Stephen Breyer points out in his dissenting opinion in *Hendricks v. Kansas*,[118] however, it is because of the paraphiliac's "specific, serious, and highly unusual inability to control his actions" that "[t]he law traditionally has considered this kind of abnormality akin to insanity for purposes of confinement."

The principal holding in *Hendricks* was that a paraphilia is a mental condition that could justify post-imprisonment hospitalization, and that the statutory scheme under which Kansas planned to confine Hendricks for treatment did not amount to dou-

ble jeopardy or *ex post facto* legislation and was, therefore, constitutional.[119] *Hendricks*, like *In re Linehan*,[120] concerned individuals with paraphilias and did not deal with an individual who had been found NGRI or who was attempting to enter an insanity plea.

One would assume that states with a M'Naghten-type insanity standard (knowledge of wrongfulness), would make it difficult for defendants who suffer only from a paraphilia (and who do not have an accompanying psychotic disorder) to mount a successful insanity defense. Yet several decisions have recognized that a paraphilia-based insanity defense is at least conceivable. For example, a New York appellate court upheld a conviction after the defendant had unsuccessfully mounted an insanity defense, noting, "Whatever diseases the defendant suffers from, none are of such proportion as to cause the defendant to lack substantial capacity to know or appreciate the nature and consequences of his conduct or that it was wrong. Although the defendant clearly suffers from pedophilia, it does not cause the requisite mental incapacity."[121] This case implies that pedophilia might be the basis of an insanity defense in New York, though for the defense to be successful, the disorder would have to render a defendant unable to recognize the wrongfulness of his acts. Similarly, *United States v. Benedict*[122] also implied that pedophilia, although not a psychotic disorder, might be the basis of an insanity defense. *State v. Mace*[123] involved a convicted rapist who "suffered from the ego dystonic form of obsessive compulsive paraphilia" (Ref. 123, p 1374), and claimed on appeal that Utah's insanity statute was unconstitutional. The statute permits insanity acquittals only if mental illness prevents a defendant from forming the requisite mental state required as an element of the offense. Medical testimony stated the defendant knew his conduct was wrong, but acted on an irresistible impulse. The Utah Supreme Court upheld the state's abolition of the insanity defense.

Several cases have looked at whether paraphilias might constitute mental disorders that, for legal purposes, would justify the continued confinement of insanity acquittees. In *Parrish v. Colorado*[124] a federal court ruled that an insanity acquittee with gender identity problems, antisocial personality disorder, and "difficulty controlling his emotions and relating to others" could remain confined, even though his condition might not be curable. In *Osborn v. Psychiatric Security Review Bd.*[125] and *Rios v. Psychiatric Security Review Bd.*[126] the Oregon Supreme Court decided that pedophilia was not a personality disorder or a condition characterized simply by criminal conduct. It, therefore, qualified as a mental illness under the state's laws pertaining to supervision of insanity acquittees. It could also potentially justify continued placement under the jurisdiction of the review board that monitors Oregon insanity acquittees. *State v. Simants*[127] found that pedophilia and dangerousness were legitimate grounds for continued post-NGRI acquittal commitment.

Battered Woman Syndrome

Over the last quarter century, several state supreme courts have addressed the question of whether expert mental health testimony concerning the battered woman syndrome (BWS) can assist a jury in analyzing a battered woman's claim that she acted in self-defense. Although decisions and statutes dealing with this issue usually refer to the plight and mental state of adult women who are abused by male partners, a growing body of case law has permitted children, non-heterosexual women, and even adult men to raise past battering as a defense to a criminal charge. The vast majority of jurisdictions have held that expert testimony concerning how domestic violence affects the perceptions and behavior of battering victims should be admissible at trial.[128] Such testimony can allay inaccurate stereotypes and myths regarding battered women and help jurors understand why battered women remain with their mates, despite their longstanding, reasonable fear of severe bodily harm. With increasing frequency, courts have held that BWS has "gained a substantial enough scientific acceptance to warrant admissibility."[129]

Testifying mental health professionals may be asked to tell jurors how battered women react to batterers; explain why battered women may believe that danger or great bodily harm is imminent; and rebut the argument that battered women can easily leave their dwellings to seek safety. Mental health testimony may help jurors assess issues concerning credibility, a defendant's belief that she was imminently threatened, the subjective or objective reasonableness of that belief. Many jurisdictions, however, limit experts to providing information about the syndrome in general, and do not permit them to address ultimate issues, such as whether the particular defendant suffered from BWS, whether her perceptions of

danger were objectively reasonable, or whether she acted with specific intent to kill.[130]

Although defendants with BWS may offer testimony about the syndrome as part of an insanity defense, the syndrome typically is not conceptualized this way. Testimony on BWS has been accepted in cases where the syndrome is asserted in support of a traditional claim of self-defense. Courts uniformly have held that the BWS defense is not a separate, new defense to criminal charges.[131] BWS evidence usually is adduced to justify behavior under a traditional self-defense doctrine, arguing that the syndrome represents a normal response to an awful situation[132] In contrast, an insanity defense represents an excuse from criminal responsibility by someone whose severe mental disability renders that person blameless.[133]

Women who have BWS typically do not suffer from the sorts of severe mental disorders usually required to sustain an insanity defense. For example, in *State v. Moore*[134] the court held that the defendant's actions before, during, and after she shot her husband did not indicate she was suffering from a mental disease or defect that left her unable to distinguish right from wrong. A rational jury, therefore, could have easily concluded she was not insane.[135] Ohio, however, specifically permits the introduction of BWS as part of an insanity defense plea.

> If a defendant is charged with an offense involving the use of force against another and the defendant enters a plea to the charge of not guilty by reason of insanity, the person may introduce expert testimony of the "battered woman syndrome" and expert testimony that the defendant suffered from that syndrome as evidence to establish the requisite impairment of the defendant's reason, at the time of the commission of the offense, that is necessary for a finding that the defendant is not guilty by reason of insanity. The introduction of any expert testimony under this division shall be in accordance with the Ohio Rules of Evidence.[136]

Many courts have found that battered woman syndrome is not a mental disease, defect or illness.[137–141] Rather, BWS is considered a form of post-traumatic stress disorder, which is "an anxiety-related disorder. . .occur[ring] in response to traumatic events outside the normal range of human experience."[142]

IV. Agency Relationships

The defendant's attorney, the prosecuting attorney, a judge or an administrative agency can retain forensic psychiatrists to evaluate a defendant's state of mind for an insanity defense. Before beginning such an evaluation, the forensic psychiatrist must know to whom a duty is owed and the limits of confidentiality.

When retained by the defense, the forensic psychiatrist owes a duty to the defense attorney. The forensic psychiatrist must communicate data and opinions completely and honestly to the retaining attorney. In many jurisdictions, the opinions of defense experts are covered under the attorney-client privilege.[143,144] This means that if the psychiatrist's opinions are not helpful to the defense, they are not discoverable by the prosecution or the court. The forensic psychiatrist must clarify with the defense attorney whether this privilege protects the information obtained during the forensic evaluation and if the attorney has clarified this with the defendant. The defense evaluator should be familiar with the discovery status of information obtained from the interviews, since in some states, if there are multiple evaluations, all evaluations are discoverable, should the defense go forward.[145]

In some jurisdictions the defendant's attorney can impose an insanity defense plea over the objections of a competent defendant.[146] In most jurisdictions a competent defendant can prevent the defense attorney from filing an insanity defense plea.[147–149] Before a plea is withdrawn, the defense evaluator also may be asked to assess the defendant's capacity to weigh the risks and benefits of an insanity defense plea. If the defense evaluator feels the defendant is not competent the defense attorney should be so informed.[150]

The defense evaluator also may actively consult with and advise the defense attorney.[151] Some attorneys prefer to have consultants who are not evaluators, and some experts believe that consultants should not testify because of the risk of excess advocacy.[152]

Insanity defense pleas are exceedingly rare.[16,153] Even an experienced defense attorney may have tried only a few insanity defense cases. The experienced forensic psychiatrist can educate the defense attorney about the risks and consequences to the defendant of a successful defense in a case involving a minor crime where the potential jail time is minimal, but where the potential time of criminal commitment to a mental hospital may be substantial and the stigma greater. In such cases the defense evaluator may recommend alternative dispositions, such as a guilty plea with

probation conditioned on receiving mental health treatment.

Evaluating a defendant in a case where the prosecution has given notice of intent to seek the death penalty raises additional issues for defense evaluators. Mental state and detailed behavioral data that evaluators obtain from the defendant that seemingly support a finding of insanity may, if the insanity defense fails, be used by the state to argue for the death penalty.[154] These issues should be discussed with the defense attorney prior to the initial evaluation of the defendant.[155]

The forensic psychiatrist has a duty to further the interests of justice, regardless of the identity of the retaining party. Prosecution or court-retained evaluators should be particularly careful to follow the ethical and legal guidelines that are meant to protect the defendant's rights.[156] AAPL ethics guidelines preclude evaluation of a defendant prior to access to or the availability of defense counsel, except to treat an emergent psychiatric condition.[157] Non-defense evaluators are generally not permitted to interview the defendant until a court order has been obtained. Defendants must be informed of the following: who has retained the evaluator; that they can refuse to participate in the evaluation; that they may choose not to answer any particular question; and that there may be legal consequences for non-cooperation with a non-defense forensic psychiatrist.[158] The defendant should also understand that any non-cooperation might be reported to the retaining attorney, court or administrative agency.

A prosecution- or court-retained forensic psychiatrist should not initiate an evaluation if the defense attorney is unaware of the evaluation order or has not had an opportunity to raise any appropriate legal concerns. It is important to reiterate the lack of confidentiality to the defendant and to assess the defendant's capacity to understand the non-confidential nature of the evaluation; the purpose of the evaluation; and the fact that it may be used against the defendant's interests. The American Bar Association's (ABA) Criminal Justice Mental Health Standards[159] recommends that the defendant's mental condition at the time of the offense should not be combined in any evaluation to determine competency to stand trial, unless the defendant requests it or unless good cause is shown. However this is not the practice in all jurisdictions. Some states combine competence to stand trial and criminal responsibility in the same evaluation. This may create ethics problems for the prosecution- or court-retained evaluator if he feels the defendant is incompetent to stand trial but is revealing information that may be incriminating. In such situations the evaluator should terminate the evaluation and inform the retaining party of the defendant's incompetency.

V. Ethics Guidelines and Practice Guidelines

As physicians, forensic psychiatrists are bound by the ethics standards of the medical profession. However, psychiatric evaluations conducted in a legal context often involve different ethics issues.

In the absence of a traditional physician-patient relationship, traditional medical ethics do not provide clear guidance for forensic psychiatrists in their consultations to the legal system. However, the American Academy of Psychiatry and the Law[160] and the American Bar Association (Ref. 159, Sections 7-3.10 and -3.11) have formulated guidelines specific to the practice of forensic psychiatry.

Scope of Participation

As mental health professionals with special training and experience, forensic psychiatrists are permitted, indeed encouraged, to consult with the criminal justice system (Ref. 160, Section III). Forensic psychiatrists are in a unique position to promote cooperation among the people legitimately concerned with the medical, psychological, social, and legal aspects of mental illness (Ref. 160, Section III).

Forensic psychiatrists who participate in the evaluation of the insanity defense have an ethical obligation to conduct such evaluations competently. Forensic psychiatrists should have sufficient professional knowledge to understand the relevant legal matters and conduct an evaluation that addresses the specific legal issues involved in an insanity defense evaluation. In addition, forensic psychiatrists should limit their opinions to those within their area of expertise[161] (also Ref. 160, Section III).

Honesty and Objectivity

Forensic psychiatrists have an ethical obligation to adhere to the principle of honesty and to strive for objectivity in conducting insanity defense evaluations (Ref. 160, Section IV). In evaluating the defendant's mental state at the time of an alleged offense, the forensic psychiatrist has an obligation to conduct

a thorough assessment and to formulate objective opinions based on all available data no matter who initiated the request for the evaluation. In doing so, forensic psychiatrists should be aware of any biases that may distort their objectivity and do their best to counter them (Ref. 159, Section 7-1.1).

Confidentiality

Forensic psychiatrists who perform insanity evaluations for the defense must be ever mindful of their ethical obligation to safeguard the confidentiality of the information, within the constraints of the law.[162]

Insanity defense evaluations usually require a written report, and/or testimony as to the statements made by the defendant during the interview. The forensic psychiatrist should clearly explain that his/her role is as a forensic evaluator and not the defendant's treating physician. Forensic psychiatrists have an ethical obligation to give the defendant an appropriate explanation of the nature and purpose of the evaluation and its limits on confidentiality. This explanation should identify who requested the evaluation and what will be done with the information obtained during the interview. If during the course of the evaluation the defendant appears to believe that a therapeutic relationship exists, then the psychiatrist should take appropriate steps to correct the misimpression.

Assent

Forensic psychiatrists ordinarily are ethically obligated to obtain informed consent, when possible, from an evaluee before performing a forensic evaluation. Where consent is not required, the evaluee should be informed of the nature of the evaluation. When an insanity defense evaluation is court-ordered, the informed consent of the defendant may be sought, but ethically is not required.

If a defendant in a court-ordered insanity defense evaluation refuses to participate in the evaluation, the forensic psychiatrist should explain that the court has authorized the evaluation. The forensic psychiatrist may also inform the defendant that the defendant's refusal to participate in the evaluation will be included in the psychiatrist's report or testimony, and may have legal consequences in relation to presentation of the insanity defense (Ref. 159, Section 7-3.4(c), and See Ref. 160, Section III). The referring attorney should be notified of any lack of cooperation.

Conducting the Evaluation

Forensic psychiatrists generally have wide discretion in how they conduct insanity defense evaluations, depending on their knowledge and skills and the particular circumstances of each case.

Forensic psychiatric ethics suggest that psychiatrists not form an insanity defense opinion without first attempting to personally interview, or otherwise to evaluate, the defendant.[163] (Also see Ref. 159, Section 7-3.11(a)(iii).) In cases where no personal examination is possible, forensic psychiatrists must state that their opinions, reports, and testimony are limited by that fact (Ref. 160, Section IV).

Due to ethics considerations regarding informed consent, and legal considerations regarding due process, forensic psychiatrists should avoid performing insanity defense evaluations before an attorney has been appointed or retained to represent the defendant. However, if a defendant needs emergency medical or psychiatric evaluation or treatment, it is ethically permissible for a psychiatrist to evaluate the defendant's need for treatment, or to refer or provide any needed treatment to a defendant prior to the availability of an attorney.[164] (See also Ref. 160, Section III.)

Fees

A psychiatrist may charge a higher fee for a forensic mental evaluation than for clinical work. It is ethical, and at times desirable, for the forensic psychiatrist to request a retainer, or to be paid in advance of an evaluation. However, contingency fees are unethical (Refs. 161 and 160, Section IV). Some jurisdictions or courts have a fixed amount of funding available for psychiatric evaluations. Therefore, it is important to clarify fees and funding sources before beginning the evaluation. Fixed fees are often insufficient to cover the costs of tests such as MRIs or psychological testing, which may be necessary for a competent evaluation. If fixed fees are set artificially low, the evaluator may be unable to perform an adequate evaluation. Clarifying these issues up front may affect the decision to undertake the evaluation.

Conflicts

Forensic psychiatrists have an ethical obligation to attempt to resolve conflicts of interest that may affect their objectivity. For example, forensic psychiatrists should generally avoid performing insanity defense evaluations on persons with whom they have a cur-

rent or former physician-patient relationship (Ref. 160, Section IV). Forensic psychiatrists employed in the public sector, such as a state forensic facility, may be unable to avoid providing both forensic services and clinical care.[165] Forensic psychiatrists also should be mindful of having multiple roles with conflicting obligations in the same case that may affect their objectivity or cause a potential conflict in agency relationships.

Finally, forensic psychiatrists should be aware that ethics standards and practice guidelines do not trump the law of the jurisdiction where the insanity defense evaluation takes place. Because laws on the insanity defense and expert testimony vary among jurisdictions, forensic psychiatrists who perform out-of-state evaluations should query the appropriate authorities about medical licensure requirements and the insanity defense test for that jurisdiction.[166]

VI. The Forensic Interview

Before beginning the interview, the forensic evaluator must have the permission of the defendant's attorney or be acting under court order. The evaluator must inform the defendant of the evaluator's role, the non-confidential nature of the interview and the difference between a forensic and a clinical examination.

Here is an example of a non-confidentiality warning for a prosecution- or court-retained examination:

> I am a physician and psychiatrist who has been asked by [the court or the prosecuting attorney] to answer three questions:
>
> 1. What was your mental state at the time of the crimes you have been charged with committing?
> 2. Did you have a mental disorder?
> 3. At the time of the crime you are charged with committing, were you so mentally ill that the court should find you not criminally responsible?
>
> Although I am a psychiatrist, I will not be treating you. My purpose is to provide an honest evaluation, which you or your attorney may or may not find helpful. You should know that anything you tell me is not confidential, as I have to prepare a report that the judge, the prosecutor and your attorney will read. It is important for you to be honest with me. You don't have to answer every question, but if you choose not to answer one, your refusal will be noted in my report. Do you have any questions? Do you agree to continue with the interview?

Here is a confidentiality warning for a defense-retained examination in a jurisdiction where the defense evaluator works under the attorney-client privilege:

> I am a physician and psychiatrist who has been asked by your defense attorney to answer three questions:
>
> 1. What was your mental state at the time of the crimes you have been charged with committing?
> 2. Did you have a mental disorder?
> 3. At the time of the crime you are charged with committing, were you so mentally ill that the court should find you not criminally responsible?
>
> Although I am a psychiatrist, I will not be treating you. My purpose is to provide an honest evaluation, which you or your attorney may or may not find helpful. If your attorney feels my opinion is helpful, what you tell me will be revealed in a report or in testimony in court. If your attorney feels my opinion is not helpful to your case, only you, your attorney and I will know what we discussed. It is important for you to be honest with me. You don't have to answer every question, but if you choose not to answer one, your refusal will be noted in my report. Do you have any questions? Do you agree to continue with the interview?

Some evaluators choose to review all available collateral data and prior medical records before interviewing the defendant. These may include police reports, witness statements, police laboratory data, and a copy of the defendant's prior criminal record. Others begin the evaluation with the clinical interview.

The insanity defense evaluator may also be asked to perform a simultaneous assessment of the defendant's competency to stand trial. If so, the evaluator should first complete the full competency evaluation. If the evaluator assesses the defendant as not capable of understanding the insanity plea, the interview may have to be suspended (especially if both competency and responsibility evaluations are court-ordered to be conducted simultaneously), and the requesting party informed. However, the evaluation may continue if the psychiatrist is working for the defense and under the attorney-client privilege. This situation often arises if the psychiatrist evaluates a defendant within hours or days of a crime. In other situations, a prosecution-retained psychiatrist may have early access to a defendant to evaluate criminal responsibility, but may not communicate with the prosecutor until the defendant is deemed competent and files an intent to employ an insanity defense.

The forensic psychiatrist performing an insanity defense evaluation must answer three basic questions:

1. Did the defendant suffer from a mental disorder at the time of the alleged crime? (This is a retrospective mental state evaluation.)
2. Was there a relationship between the mental disorder and the criminal behavior?
3. If so, were the criteria met for the jurisdiction's legal test for being found not criminally responsible?

The elements assessed to evaluate and diagnose the presence or absence of a mental disorder at the time of the alleged crime follow the general principles elucidated in the APA's *Practice Guideline for Psychiatric Evaluation of Adults*, Section III,[167] with some notable additions. The defendant's history of contacts with the legal system should be explored. If the defendant served in the military, was he or she the subject of an Article 15 hearing or court martial? What type of discharge did the defendant receive? Has the defendant been arrested? How many times? For what types of crimes? How much time has the defendant spent in jail or prison? If previously incarcerated, was there evidence of malingering symptoms? How much "good time" did the defendant lose? Did the defendant spend time in lockup (punitive segregation)?

While inquiring about a history of substance abuse is part of any standard psychiatric evaluation, obtaining a history of alcohol and prescribed or illicit drug use that may have affected the defendant's mental state at the time of the alleged offense is critical to an insanity defense evaluation. Many jurisdictions exclude from consideration an insanity defense plea for mental disorders caused by voluntary intoxication (see Refs. 40–55). In contrast, mental disorders caused by the side effects of prescribed medications may help explain the acute onset and rapid resolution of bizarre behavior and thinking related to the defendant's alleged actions. The evaluator might ask the defendant which substances were used, how much they used, and the time-course of use in relation to the crime. Defendants may have had a blood or urine sample taken at the time of arrest. If the arrest occurred soon after the crime, a toxicology screen performed on the sample will be useful.

Unlike a standard clinical evaluation, which focuses on the patient's chief complaint and present illness, the focus of the insanity defense evaluation is on the defendant's thinking and behavior at the time of the alleged crime. The evaluator must obtain the defendant's version of the events before, during and after the alleged crime, including thinking, motivation, self-description of behaviors and abnormal mental phenomena. The evaluator must then compare the defendant's report with data supplied by victims, witnesses, and arresting and investigating law enforcement officers. If there are discrepancies between the collateral data and the defendant's version of events, the evaluator may ask the defendant for an explanation. Treatment records and interviews with family members, friends, employers, mental health professionals and anyone else who can report on the defendant's behaviors and thinking around the time of the crime, may be particularly helpful. Records of the defendant's behavior in custody after arrest, from an emergency room (where the defendant may have been taken upon arrest), jail administrative files, psychiatric or medical records, or the oral reports of custody officers should also be reviewed.

Defendants entering an insanity plea may be more likely to malinger mental illness symptoms than other individuals seeking treatment.[168,169] On the other hand, defendants pleading insanity who suffer from paranoia or other mental disorders may, like others with such symptoms, hide their symptoms.[170] Both possibilities should be taken into consideration during the interview.

As in all psychiatric practice, forensic evaluators should consider—and counter—their own possible biases for and against defendants, victims and collateral informants. Such biases may color the evaluator's judgment and affect the validity of the data collected.

If the forensic psychiatrist audio- or videotapes the interview, the evaluator should be generally familiar with AAPL's guidelines for "Videotaping of Forensic Psychiatric Evaluations."[171] If translators are necessary, the psychiatrist should make sure that both the evaluator's and defendant's statements are conveyed accurately.

VII. Collateral Data

A thorough review of collateral information, including that related to the fact situation, can help the forensic psychiatrist formulate and support a well-reasoned, forensic opinion. Before considering the collateral information, the forensic psychiatrist should become familiar with the relevant insanity test, as this will help guide the collection, review, interpretation and application of the information.

The collateral data can help the evaluator arrive at a more objective understanding of the defendant's mental state at the time of the offense. Additionally, the forensic psychiatrist can use collateral information to check the defendant's account of his history, which may help to assess his overall truthfulness or detect any malingering.[172,173]

Obtaining Collateral Information

The referring attorney or court typically gathers collateral information and provides it to the forensic psychiatrist. When retained by either the prosecuting or defense attorney, the forensic psychiatrist may include a statement in the retainer agreement that the attorney agrees to provide access to all of the relevant information available and that the attorney will make every effort to obtain any additional information requested by the psychiatrist. Sometimes this will require the attorney to seek a court order to compel opposing counsel to produce information deemed relevant by the forensic evaluator. When retained by the defense, or directly by the court, the forensic psychiatrist may obtain written consent directly from the defendant for medical record release. The forensic psychiatrist should not contact opposing counsel, or other sources of information, before consulting with the retaining attorney. The forensic psychiatrist may interview collateral witnesses after consultation with and approval by the retaining counsel. When retained directly by the court, the forensic psychiatrist may speak to both the prosecution and defense attorneys.

Ideally, the forensic psychiatrist should review first-hand any relevant information that is summarized or referred to, but not included in, any available records. Whenever possible, the forensic psychiatrist should avoid relying on summaries of documents or audio and videotapes. In addition to obtaining original sources, the forensic psychiatrist may identify missing information that could help formulate the forensic opinion. For example, the psychiatrist may find employment records useful when assessing a defendant's claim that psychiatric symptoms affected work performance.

Information requested, but not obtained, by the forensic psychiatrist may be noted in the forensic report, along with the reason why access was denied. It is appropriate for the forensic psychiatrist to include in the report a statement reserving the right to change the opinion should any conflicting information subsequently become available.

Managing Collateral Information

All material reviewed by the forensic psychiatrist is considered confidential and under the control of the court or the attorney providing it; and should not be disclosed or discussed without his or her consent (Ref. 160, Section II). The forensic psychiatrist should be aware that notations made on this material may be subject to direct and cross-examination if referred to during testimony. Material generated by the forensic psychiatrist during the course of the evaluation (e.g., interview notes, videotapes) is initially considered the work product of the referring attorney; as such, it should not be disclosed or discussed without the attorney's or the court's consent. It is appropriate for the forensic psychiatrist to furnish copies of this material to the referring attorney or court, if requested to do so. If the evaluator testifies, opposing counsel may request the interview notes. These records are not considered a work product of the prosecution. The forensic psychiatrist should retain copies of all collateral materials reviewed throughout the course of the evaluation, trial and subsequent appeals.

Common Types of Collateral Information

Written Records

1. *Police Reports*—The evaluator should review the police report of the instant offense, paying particular attention to documentation of the underlying facts, the crime scene, and the defendant's mental state at the time of the crime, as well as any defendant statements or confessions. Arrest history, rap sheets, and autopsy reports also can be useful and if not provided, should be requested.

2. *Psychiatric, Substance Abuse, and Medical Records*—Psychiatric, substance abuse, and medical records may help the evaluator understand the defendant's psychiatric symptoms and diagnosis, past response to treatment, and knowledge and appreciation of the risks of treatment non-compliance. A review of family history may be useful as well. Appropriate consent must be obtained for all of these records.

3. *School Records*—School records may shed light on when any psychiatric symptoms first developed and help evaluate any defendant reports of psychiatric symptoms impairing school functioning. Special education records such as individual education plans (IEPs), counseling records and psychological testing reports may have to be requested specifically.

4. *Military Records*—Military records may reveal evidence of oppositional or anti-social behavior or, conversely, stable behavior and exemplary military performance. These may be reflected in reports of Article 15, Captain's Mast or court martial proceedings, or in honors, medals, successfully completed

military occupational specialty assignments and promotions. Deterioration from previous good performance and the type of discharge may also be significant.

5. *Work Records*—Personnel files may corroborate or contradict the defendant's account of job requirements, work performance and psychiatric disability. Disciplinary actions and improvement plans should be noted as well.

6. *Other Expert Evaluations and Testimony*—Evaluations performed by other experts, both in psychiatry and other disciplines, can help determine the consistency of the defendant's reports and scores on psychometric testing. Expert evaluations and testimony relating to previous crimes may also be considered.

7. *Custodial Records*—Jail and prison records document mental and physical health treatment during incarceration, total length of incarceration and compliance with custodial requirements (e.g., any disciplinary actions, time spent in administrative segregation, loss of good time). Prison work and school records may also be reviewed.

8. *Personal Records*—The forensic psychiatrist may request access to the defendant's personal records to corroborate statements made in the interview. For example, records of sophisticated financial transactions may refute defendants' claims that their psychosis rendered them unable to manage their assets. Diaries or journals may be very helpful as well.

9. *Psychological Testing, Hypnosis, Brain Imaging, and Other Special Procedures*—The use of psychological testing in insanity defense evaluations is somewhat controversial. Testing is often obtained to inform the psychiatrist's clinical impressions. This can undercut criticisms that the expert merely relied on the defendant's report of symptoms and his/her version of the history. Testing can also provide information about personality traits and aspects of the person's cognitive style that are relatively stable over time (e.g., IQ tests). Psychological testing cannot speak to the specific state of mind at the time of the offense or absolutely make a diagnosis. But it may reveal an organic disorder and suggest a more extensive neurological evaluation. Neuropsychological testing may help identify specific deficiencies that result from dementias or traumatic brain injuries. Unless the psychiatrist has specific training in this area, it is important to refer testing to an experienced psychologist who can interpret the results and testify. Psychiatrists should not testify regarding details of testing, if it is beyond their expertise. However, psychiatrists routinely perform some psychological tests.

The U.S. Supreme Court has determined hypnosis of a defendant[174] to be an acceptable procedure without per se precluding the defendant from testifying. Although witnesses may be precluded from testifying if hypnotized, the defendant's right to explore such possible defenses is permitted. This situation arises when there is a credible report of amnesia for the events surrounding the offense. Videotaping of hypnotic interviews is strongly recommended. A New Jersey landmark case offers guidance for necessary and appropriate procedures for hypnosis in the forensic setting.[175]

Brain imaging is one of the most rapidly developing areas of scientific research. Results from MRI, PET, and SPECT scans are attractive to attorneys, as they seem to show concrete evidence of brain abnormalities. These can be quite persuasive to a jury. Currently imaging procedures may help confirm or establish the diagnosis of certain brain disorders, but they do not provide any evidence that a defendant met either the cognitive or volitional prong of the insanity defense.

Photographs, Audiotapes, and Videotapes

The forensic psychiatrist may review photographs, audiotapes, and videotapes collected during the investigation of the instant offense and subsequent evaluations. These may include photographs of the crime scene and the defendant's residence, as well as tapes of confessions and witness interviews. This material may be forwarded by the court, the defense or the prosecution; or it may have been collected by an attorney's own investigator. Tapes of other forensic evaluations may be reviewed as well.

Collateral Interviews

Performing interviews of collateral sources, such as family members, friends, coworkers, and eyewitnesses, can help form the forensic opinion.[176] The method of contacting collateral sources to be interviewed is arranged in collaboration with either the court or retaining attorney. Interviewees are given a non-confidentiality warning similar to the defendant's. They are further notified that they may be called upon to testify during trial. In addition to a verbal warning, the forensic psychiatrist may also provide a written non-confidentiality statement and ask the interviewee to sign it. The interview may be

recorded with notes or by audiotape or videotape. Records of the interview belong to the court or are the work product of the retaining attorney. They are not discussed or disclosed without the court's or attorney's consent.

Physical Evidence

Although not frequently reviewed by forensic psychiatrists, physical evidence collected by law enforcement may help assess the defendant's mental state at the time of the instant offense in particularly complex cases.

Visits to the Crime Scene or Other Relevant Locations

The forensic psychiatrist may gain insight into the defendant's criminal responsibility by visiting relevant locations, such as the crime scene or defendant's home.

VIII. The Forensic Report

Unlike clinical practice, where the psychiatrist's report serves to diagnose and treat a patient, the forensic psychiatrist's insanity defense report provides the basis of the evaluator's opinion, which ultimately may help in the disposition of the case.[177] When evaluating a defendant for whom an insanity defense is being considered, the evaluator should address the following questions:

1. Did the defendant suffer from a mental disorder at the time of the alleged crime?
2. Was there a relationship between the mental disorder and the criminal behavior?
3. If so, was the relationship sufficient to meet the criteria for the jurisdiction's legal test for being found not criminally responsible?

Opinions of a psychiatrist working for the defense should first be communicated orally to the defense attorney. This conversation may not be discoverable by the prosecution or the court. The decision to write the report is the defense attorney's, while the report's content belongs solely to the evaluating psychiatrist. Some jurisdictions require full written reports from defense experts in all cases (e.g., Virginia).[178]

Ordinarily, the written report contains details of the case facts and other data, as well as information that support the evaluator's opinions. In some jurisdictions, however, there may be good reasons not to write a detailed report. In those cases, the expert should be fully prepared to disclose during testimony any details requested of him and explain the rationale behind the opinion.

The rest of this section describes one way to write a detailed report.

Usually, the primary audience for the written forensic insanity defense report consists of the attorneys and the presiding judge. Most insanity defense cases are resolved before trial, based on experts' reports.[153] A judge typically adjudicates the few cases that do go to trial.[16] When insanity cases are tried before a jury, the jury may have to rely on a redacted report or may not have access to the report.

Any limitations of the report should be clearly spelled out. For example, the defendant may have been uncooperative, the evaluator's access to the defendant or collateral informants may have been limited, or relevant records may have been requested but not received.

The defendant's version of events may differ substantially from those of witnesses or collateral informants. Data provided by witnesses or collateral informants can vary widely, depending on the source. Defendants may even deny participating in the crime itself. The forensic evaluator must remember that the fact finder in a criminal case is the judge or jury, not the evaluator. In cases with more than one factual scenario, the evaluator may need to offer alternative opinions.

Reports should convey data and opinions in language that a non-mental health professional can understand. There is no one correct style or format for writing a report. Several examples are in the GAP (Group for the Advancement of Psychiatry) report and the Melton *et al.* text.[179,180] Here is one possible format, developed by Phillip Resnick, MD[181]:

1. Identifying Information
2. Source of Referral
3. Referral Issue: What are the questions being asked by the referral source?
4. Sources of Information: List all material reviewed, including the dates and time spent interviewing the defendant and collateral informants; which psychological were tests administered; and a list of all records reviewed.
5. Statement of Non-Confidentiality: Did the defendant understand the non-confidentiality warning and agree to proceed?
6. Family History
7. Past Personal History
8. Educational History: Include special education and behavioral disturbances, fighting (specify with teachers or other students), suspensions or expulsions.

9. Employment History: Focus on employment performance around the time of the crime. Was it impaired?

10. Religious History: Does the defendant have religious beliefs relevant to delusions or wrongfulness?

11. Military History: Was the defendant honorably discharged? Was the defendant discharged at a rank appropriate to his time in service? Were there Article 15 hearings or courts martial?

12. Sexual, Marital, and Relationship History

13. Medical History

14. Drugs and Alcohol History: Was there chronic substance use that led to psychotic or mood symptoms in the past? Did alcohol or drugs around the time of the event influence the defendant's mental state?

15. Legal History: Include both juvenile and adult crimes and civil matters. Were the crimes similar to the current offense? Were civil actions related to thinking or behavioral disturbances?

16. Past Psychiatric History

17. Prior Relationship of the Defendant to the Victim

18. State's Version of the Current Offense (witness or victim account of crime)

19. Defendant's Version of the Offense: Direct quotes from the defendant are important. Include psychiatric signs and symptoms that the defendant says occurred at the time of the crime.

20. Mental Status Examination: Psychiatric signs and symptoms present at the time of the evaluation.

21. Relevant Physical Examination, Imaging Studies, and Laboratory Tests

22. Summary of Psychological Testing

23. Competency Assessment: Answers to questions relating to the defendant's ability to understand the proceedings and to collaborate with the defense attorney should be included, if a full competency evaluation was requested by the court. Otherwise the data relating to the defendant's capacity to consent to the insanity defense evaluation may be included, if relevant.

24. Psychiatric Diagnosis: Diagnoses should follow the DSM or ICD relevant at the time of the offense. If a non-DSM or ICD diagnosis is used, citations to the relevant literature should be provided. If there is a differential diagnosis, the reason should be explained. If the diagnosis turns on a fact in dispute (for example, whether or not the defendant's symptoms were induced by intoxication), there should be an explanation as to how the disputed fact affects the differential diagnosis. Diagnoses may change over time. Different diagnoses may be provided for relevant points in time, but the diagnosis at the time of the offense should always be included.

25. Opinion: The opinion section is the most critical part of the forensic report. It should summarize pertinent positives and negatives and answer the relevant forensic questions, based on that jurisdiction's legal definition for being found not criminally responsible. The reasoning behind the opinion should be carefully explained. If the defendant is charged with more than one offense, the issue of criminal responsibility on each charge should be individually addressed.

The exact language of the criminal responsiblity test should be addressed in the report. The federal government and some states now restrict psychiatric testimony to the defendant's diagnoses, the facts upon which those diagnoses are based, and the characteristics of any mental diseases or defects the evaluator believes the defendant possessed at the relevant time. They do not allow psychiatric testimony regarding the ultimate issue in the case.[182] However, full and detailed reasoning based on the standards of the jurisdiction's insanity test should be discussed in the evaluator's report, unless instructed otherwise by the referring party. Testimony may also address the effects of the illness on behavior generally and on motivations other than the defendant's insanity. In addition to insanity defenses, abnormal mental states may be used in some jurisdictions as the basis of defenses asserting, lack of specific intent, diminished capacity or imperfect self-defense. This report does not address these special other defenses.

Opinions should be stated to a "reasonable degree of medical certainty" or a "reasonable degree of medical probability," depending on the jurisdiction. If the examiner is unable to form an opinion to a reasonable degree of medical certainty or probability, that fact should be stated. The jurisdiction's definition of reasonable medical certainty or probability should be discussed with the referring party.[183,184]

At times the examiner may be unable to answer whether the defendant suffered from a mental disorder or if he met the jurisdiction's test for being found not criminally responsible. If so, this should be clearly communicated in the report. The examiner might also state what additional data might help

form an opinion to a reasonable degree of medical certainty or probability.

IX. The Forensic Opinion

The forensic psychiatric opinion usually addresses three areas in the formulation or conclusion section. The first is the determination of mental disease or defect. The second is a clarification of the relationship between the mental disease or defect, if any, and the criminal behavior. The third assesses whether the defendant's mental state at the time of the crime satisfies the jurisdictional requirements for an insanity defense. This section reviews current practices in all three of these interrelated areas.

Establishing Mental Disease or Defect

Statutory tests for an insanity defense typically require the presence of mental disease or defect at the time of the crime. The statutes may or may not define the psychiatric equivalents of mental disease or defect. Consequently, the forensic psychiatrist should try to assess the presence or absence of mental illness at the time of the crime and describe it in the forensic opinion. In jurisdictions where mental disease is strictly defined as a severe mental disorder, the forensic psychiatrist may first have to determine if the mental illness meets that threshold before proceeding with the remainder of the analysis.

The exact definitions of mental disease and mental defect for some jurisdictions are found in statutes or case law. For example, some state's statutes define mental disease as a "serious mental illness." In other states, courts have determined that mental disease means a DSM disorder. Some jurisdictions specifically exclude all personality disorders or antisocial personality disorder. Voluntary intoxication with alcohol or other drugs may also be excluded, particularly in the absence of a co-morbid psychiatric diagnosis. The forensic psychiatrist must carefully review the statutory definitions and case law interpretations of mental disease or defect applicable to the case.

In jurisdictions where the mental disease or defect is not formally defined, the forensic psychiatrist may seek guidance from the referring attorney. The forensic psychiatrist may find it useful to review recent court decisions involving the insanity defense in the case's jurisdiction. The experience of other experts, case law, and statutes concerning the admissibility of expert opinions also may be considered.

The sections entitled "Introduction" and "Case Law Since Hinckley" review legal cases addressing the insanity defense. There are clear trends in the courts' acceptance of some diagnosable mental disorders and syndromes. Psychotic disorders such as schizophrenia, schizoaffective disorder, and mood disorders with psychotic features are diagnoses that typically qualify as serious or severe mental disorders or mental disease. Other diagnoses differ in outcome depending on the facts of the case, the degree and nature of the symptoms, and the jurisdictional precedent. For example, personality disorders, paraphilias, impulse control disorders, dissociative identity disorders and developmental disorders can vary widely in terms of acceptance. Certain cognitive disorders, such as dementia or delirium, may also qualify as mental disease or defect, depending on circumstances and jurisdiction. Courts also have considered, and some statutory language has suggested, that psychiatric syndromes and cognitive disorders not in the DSM or ICD, such as, battered woman syndrome, may constitute "mental disease" for purposes of an insanity defense.

Forensic psychiatrists take different approaches in relating clinical diagnoses to an insanity standard. Most experts consider mental disorders or their equivalents. Some consider only those conditions listed in the DSM or ICD in deciding whether an evaluee has a mental disease or defect. Some experts believe that a formally recognized diagnosis is not necessary when a narrative of the defendant's state of mind describes symptom clusters or syndromes that meet the jurisdictional requirement of mental disease or defect. DSM diagnostic disorders are often limited by strict time requirements and do not include newly emerging syndromes or illnesses. Most experts believe that a psychiatric diagnosis should be made whenever possible. For a discussion of the methodological value of psychiatric diagnoses in testimony, see The APA's *Task Force Report on The Use of Psychiatric Diagnoses in the Legal Process.*[185]

Existing case law may affect the admissibility of expert testimony on mental conditions. Jurisdictions apply either the Frye[186] or the Daubert/Kumho[187,188] test in determining admissibility. Under the Daubert/Kumho standard, the trial court considers several factors, such as testing with scientific methodology, peer review, rates of error, and acceptance within the scientific community. Some states still apply the Frye rule, which focuses specifically on "general accep-

tance" as the basis for proposed testimony. Jurisdictions typically articulate standards for the admission of expert testimony in either case law or statute.

In summary, the forensic psychiatrist should discuss the presence or absence of mental disease or defect in the conclusion of the report. Case law or statutes may specify jurisdictional definitions of mental disease or defect. In the absence of specific definitions, trends in case law and standards for the admissibility of expert testimony may provide guidance. Acceptable practices for the establishment of mental disease or defect should contain at least a narrative description of a scientifically based disorder, symptom cluster, or syndrome. Generally speaking, the use of specific diagnoses helps the expert organize patterns of symptoms and explain the conclusions drawn.

Establishing the Relationship Between Mental Disease or Defect and Criminal Behavior

Once the presence or absence of a mental disease or defect is established, the psychiatrist focuses on the relationship, if any, between the mental disease or defect and the alleged crime. The analysis of this relationship may focus on one or more of the following: the individual's severity of illness; history of illness; perception of reality; motivations, beliefs, and intentions; behavior and emotional state as related to the criminal behavior. (In states requiring severe mental illness, the severity of mental illness may be addressed more appropriately in the determination of mental disease or defect.) The relevance and importance of each of these factors will vary from case to case. The psychiatrist must carefully assess the credibility of the defendant's report in each of these areas.

The severity of an individual's illness or defect helps determine how the psychiatric symptoms led to the person's behavior. Severity of mental illness involves the nature, duration, frequency, and magnitude of psychiatric symptoms and how these symptoms impinge on the person's awareness, thinking, and functioning. Cognitive testing and/or the relationship of the impairment to the person's intellectual and adaptive functioning may help determine the severity of a mental defect.

The individual's history of mental illness or defect may be relevant in establishing the presence of a mental disease or defect at the time of the crime and substantiating the relationship of the individual's behavior to the reported symptoms. For example, an individual's report of assaultive behavior due to psychotic symptoms is more credible if psychiatric records document similar behavioral responses to psychotic symptoms before the crime took place. Although such a history may be relevant, the psychiatrist should state the limitations of rendering an insanity opinion based solely on that history.

Understanding what motivates a person to behave criminally is important when studying the relationship between mental illness and criminal acts. Analyzing the criminal intent of defendants involves examining their awareness of what they were doing during the crime and what their motivations for actions taken were at that time. Indeed, analyzing the defendant's behavior before and after the crime may contribute greatly to the psychiatrist's overall understanding of the individual's mental states and how they bear on criminal intent. The psychiatrist determines whether the reported feeling states are consistent with the individual's psychiatric symptoms and behaviors.

The defendant's emotional state at the time of the crime helps to determine the relationship between a mental disease/defect and criminal behavior. In particular, the psychiatrist inquires as to how the defendant felt before, during, and after the criminal acts. The psychiatrist determines whether the reported feeling states are consistent with the individual's psychiatric symptoms and behavior.

Finally, the psychiatrist should carefully consider the possibility that defendants may, to avoid criminal prosecution, fabricate or exaggerate psychiatric symptoms and past psychiatric illness. They may misrepresent their motivations or intent regarding their criminal behavior, as well as any emotions they experienced while committing the crime. Conducting collateral interviews, reviewing collateral records, and administering appropriate psychological testing can assist in the clarification of possible malingering.

Since each case is unique, the importance, weight, and combination of each of the three areas of analysis will vary. That is why relying on just one factor may be inappropriate in certain situations. The forensic psychiatrist should strive for a consistent approach to the analysis to ensure a thorough review of all data and reliable testimony. The approach to and basis for the forensic psychiatrist's opinion should be explained clearly in the report and testimony.

Relationship Between Mental Disease or Disorder, Criminal Behavior, and the Legal Standard

In formulating the opinion, the psychiatrist considers to what degree the mental condition and its relationship to the alleged crime meet the legal standard for criminal responsibility. When an individual is charged with multiple offenses, the psychiatrist generally conducts the insanity analysis for each offense. Because the legal standards for determining insanity vary between states and the federal system, an individual could theoretically be found insane in one jurisdiction and sane in another.

As the definition of insanity is a legal one, it is important for psychiatrists to review their jurisdiction's insanity statute. In general, standards for an insanity defense include a cognitive and/or volitional prong in the form of the M'Naghten test, the ALI test, the irresistible impulse test, or modifications of all three. In addition, the precise wording of each test varies between jurisdictions. Regardless of the test used, psychiatrists should explain how they determined that the defendant did or did not meet the legal standard for insanity.

Cognitive Tests of Insanity

Cognitive tests of insanity focus on the relationship between the individual's cognitive impairments and the alleged crime. Such tests are part of the M'Naghten test, the first prong of the ALI test and variations of these two traditional standards. The M'Naghten standard (see "Review of State Statutes and Federal and Military Law" in Section I) serves as the basis for most insanity statutes with a cognitive component. The traditional M'Naghten cognitive prong focuses on whether individuals have a mental disorder that prevents them from "knowing the nature and quality of what they were doing and/or from knowing the wrongfulness of their actions." Some state statutes require both knowledge of behavior and knowledge of wrongfulness or criminality, whereas other states require only one of these components. Some states have substituted the word appreciate, understand, recognize, distinguish, or differentiate for know.

Jurisdictions vary in their interpretation of the M'Naghten standard and its modifications. The traditional standard is considered the hardest cognitive test to meet. Variations of the word know have led to different interpretations. For example, some insanity statutes use the word appreciate rather than know in reference to the defendant's understanding of wrongfulness. Some state courts have interpreted the word appreciate to represent a broader reasoning ability than know. Some state courts, however, have held to the strict M'Naghten standard despite the substituted language. Similarly, in some jurisdictions, a finding of insanity requires that defendants' mental disorders prevented them from knowing (or appreciating) the legal wrongfulness, whereas other states require only that the person's mental disorder prevented them from knowing (or appreciating) the moral wrongfulness of their behavior. The type of wrongfulness can be determined by statute or case law or left to the discretion of the jury.

In general, the cognitive prong of the ALI standard is considered easier to meet than the cognitive prong of the M'Naghten standard (or its variations). This prong of the ALI standard states that the person "lacks substantial capacity to appreciate the criminality of his conduct." Many courts have interpreted the "substantial capacity to appreciate" language as the broadest reasoning ability in cognitive tests of insanity. The interpretation, however, is specific to the jurisdiction, even though the general intent was to broaden the standard.

An example of the variations in interpreting know and appreciate is the contrasting testimony of Dr. Park Elliot Dietz and Dr. William T. Carpenter in the Hinckley trial. In the Hinckley trial, the applicable standard was whether the defendant lacked the substantial capacity to appreciate the wrongfulness of his conduct. The prosecution argued that the correct interpretation of appreciate was the consideration of cognitive function, excluding affective impairment or moral acknowledgment. The defense argued that appreciation went beyond the mere cognitive acknowledgment that the act was wrong and encompassed the "affective and emotional understanding of his conduct."[189]

Dr. Carpenter testified:

> . . . . So that I do think that he had a purely intellectual appreciation that it was illegal. Emotionally he could give no weight to that because other factors weighed far heavier in his emotional appreciation. And these two things come together in his reasoning processes, his reasoning processes were dominated by the inner state—by the inner drives that he was trying to accomplish in terms of the ending of his own life and in terms of the culminating relationship with Jodie Foster.

It was on that basis that I concluded that he did lack the substantial capacity to appreciate the wrongfulness of his acts (Ref. 189, p 56).

In contrast, Dr. Dietz testified:

Let me begin by saying that the evidence of Mr. Hinckley's ability to appreciate wrongfulness on March 30, 1981 has a background. That background includes long-standing interest in fame and assassinations. It includes study of the publicity associated with various crimes. It includes extensive study of assassinations. It includes the choice of Travis Bickle as a major role model, a subject I will tell you about when I describe "Taxi Driver." It includes his choice of concealable handguns for his assassination plans, and his recognition that the 6.5 rifle he purchased was too powerful for him to handle. It includes his purchase of Devastator exploding ammunition on June 18, 1980. It includes multiple writings about assassination plans.

Now on that backdrop we see specific behaviors involved in Mr. Hinckley's pursuit of the President. . . . He concealed successfully from his parents, his brother, from his sister, from his brother-in-law and from Dr. Hopper, including hiding his weapons, hiding his ammunition, and misleading them about his travels and plans. The concealment indicated that he appreciated the wrongfulness of his plans. . . .

Mind you, no single piece of evidence is determinative here. I am providing you with examples of kinds of evidence that, taken together, make up my opinion about his appreciation of wrongfulness. . . .

Finally, his decision to proceed to fire, thinking that others had seen him, as I mentioned before, indicates his awareness that others seeing him was significant because others recognized that what he was doing and about to do were wrong (Ref. 189, pp 63–5).

The importance of understanding the cognitive test and its jurisdictional interpretation is its relevance in forming an opinion. A strict M'Naghten standard sets a high threshold and may exclude individuals with major psychotic and/or mood disorders as defendants who may still possess sufficient cognition to know the nature and quality of their act. Conversely, the ALI cognitive test is generally felt to broaden the cognitive test to include, among other components, affect. This has the effect of lowering the threshold for a successful insanity defense. The forensic psychiatrist must investigate the interpretation of the cognitive prong on a case-by-case and jurisdiction-by-jurisdiction basis. The nuances of meaning for "know" or "appreciate" are subject to fierce legal battles, even in jurisdictions where statutes and case law appear to have provided clear definitions.

Volitional Tests of Insanity

Volitional tests of insanity focus on how defendants' mental disorders affect their ability or capacity to control their behavior. This test has been called both the irresistible impulse test and the volitional prong of the ALI test. Insanity statutes vary regarding the degree of mental disorder necessary to show that behavioral control was impaired. For example, some statutes require that the person's mental disorder render them "unable" to control their behavior. Other jurisdictions allow an insanity defense if defendants "lacked substantial capacity to control their behavior" as a result of a mental disorder. In conducting this type of analysis, psychiatrists should consider the possibility that defendants chose not to control their behavior for reasons unrelated to a mental disorder. Currently, since an expert's ability to measure the incapacity to control behavior are limited, opinions expressing high degrees of confidence in this area are generally not warranted.

Since legal tests of insanity do vary among jurisdictions, as noted earlier, it is possible for an individual to meet the criteria for insanity under one test but not another.

To illustrate, consider a woman who suffers from the obsession that she is contaminated with germs whenever she leaves her house. To combat her fear that she will bring the contamination into her home, she feels compelled to completely undress and wash with soap and water outside her house before going inside. She may know, understand or appreciate the nature and quality of her actions, and may have a cognitive awareness that her behavior violates the law against public nudity. Therefore, she would likely not meet a cognitive test for insanity. However, because her compulsion renders her unable to refrain from her behavior, she may meet a volitional test of insanity.

A person suffering from severe mania provides a further example where impairments in volitional control may exist despite the person's cognitive awareness of their behavior and its wrongfulness. For example, consider a man on an inpatient psychiatric unit with severe mania. He has not responded to mood stabilizers or electroconvulsive therapy. He remains extremely hypersexual and recurrently exposes himself to female staff and patients. Although the patient knows what he is doing and can articulate that it is wrong, he nevertheless continues his behavior. Under a volitional test of insanity, the trier of fact may consider the possibility that this man's mania resulted in an inability to control his behavior.

The Product Test

A rare insanity standard, known as the product test, is still used in New Hampshire and the Virgin Islands. New Hampshire's standard is cited as "whether the defendant was insane and whether the crimes were the product of such insanity are questions of fact for you (the jury) to decide." This test does not include either a cognitive or a volitional prong. Under this test, the psychiatrist describes the person's mental disorder and how this disorder affects the individual's behavior. The trier of fact then determines if the person's alleged criminal behavior resulted from the mental disorder described by the psychiatrist.

Summary

In formulating the opinion regarding a defendant's sanity at the time of the act, the psychiatrist determines the presence or absence of a mental disorder; discusses the relationship, if any, of the mental disorder to the alleged criminal behavior; and determines if such a relationship meets the jurisdictional standard for insanity. Federal law and some state laws preclude an expert from testifying to so-called ultimate issues, such as whether or not the defendant actually meets the jurisdictional standards for the defense. However, there is nothing to prevent its inclusion in a report.

X. Summary

The insanity defense is a legal construct that excuses certain mentally ill defendants from legal responsibility for criminal behavior. This practice guideline has delineated the forensic psychiatric evaluation of defendants raising the insanity defense. The document describes acceptable forensic psychiatric practices. Where possible, standards of practice and ethical guidelines have been specified. And where appropriate, the practice guideline has emphasized the importance of analyzing the individual case, the jurisdictional case law and the state (or federal) statute.

This practice guideline is limited by the evolving case law, statutory language and legal literature. The authors have emphasized the statutory language of current legal standards, as well as the state or federal courts' interpretation of those standards because the same statutory language has been interpreted differently in different jurisdictions. Similarly, this practice guideline has reviewed the state and federal trends that determine which diagnoses meet the criteria for mental disease or defect. These trends yield to jurisdictional court interpretations.

Finally, the authors hope this practice guideline has begun the dialogue about formulating a forensic psychiatric opinion by surveying the various approaches used to analyze case data. The forensic psychiatrist's opinion in each case requires an understanding of the current jurisdictional legal standard and its application, as well as a thorough analysis of the individual case. The psychiatrist's analysis and opinion should be clearly stated in the forensic psychiatric report. It should be noted that the role of a psychiatric expert witness in the criminal justice system is predicated on the law's interest in individualizing the criteria of mitigation and exculpation. Forensic psychiatric analyses and formulations of opinions are, therefore, subject to change as the legal guidance changes.

The Insanity Defense: State and Federal Standards, (2000–2001)*

State	Source of Law	Standard	Cognitive Prong	Volitional Prong	Strict ALI	Strict M'Naghten	Variation	M'Naghten Variant	ALI Variant	Abolished Defense
Alabama	Ala. Code § 13A-3-1 (1988)	Affirmative defense if the defendant "as a result of severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of his acts"	Yes	No	No	No	Addition of "severe" and "appreciate"	Yes		
Alaska	Alaska Stat. § 12.47.010 (1982)	Affirmative defense that defendant was "unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct"	Yes	No	No	No	No M'Naghten wrongfulness language and use of "appreciate"	Yes		
Arizona	Ariz. Rev. Stat. Ann. § 13-502 (1993)	Person "guilty except insane" if "afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong" (this is not a GBMI verdict)	Yes	No	No	No	No M'Naghten "nature and quality" language	Yes		
Arkansas	Ark. Code Ann. § 5-2-312 (1975)	Affirmative defense that defendant "lacked capacity, as a result of mental disease or defect, to conform his conduct to the requirements of the law or to appreciate the criminality of his conduct"	Yes	Yes	No	No	No "substantial" capacity		Yes	
California	Cal. Penal Code § 25 (1982)	Not guilty by reason of insanity only if accused was "incapable of knowing or understanding the nature and quality of his or her act and of distinguishing right from wrong at the time of the commission of the offense"	Yes	No	No	Yes	No			
Colorado	Colo. Rev. Stat. § 16-8-101.5 (1995)	"A person who is so diseased or defective in mind at the time of the commission of the act as to be incapable of distinguishing right from wrong with respect to that act is not accountable. . . . A person who suffered from a condition of mind caused by mental disease or defect that prevented the person from forming a culpable mental state that is a essential element of the crime charged [is not accountable]."	Yes	No	No	No	No M'Naghten "nature and quality" language and includes a mens rea element as part of insanity	Yes		
Connecticut	Conn. Gen. Stat. Ann. § 53a-13	Affirmative defense that "the defendant. . .lacked substantial capacity, as a result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law"	Yes	Yes	Yes	No	Uses "control" instead of "conform"			
Delaware	Del. Code Ann. tit. 11, § 401(a) (1982)	"[I]t is an affirmative defense that, at the time of the conduct charged, as a result of mental illness or mental defect, the accused lacked substantial capacity to appreciate the wrongfulness of the accused's conduct."	Yes	No	No	No	Dropped the volitional prong of ALI		Yes	

(table continues)

The Insanity Defense: State and Federal Standards, 2000–2001 (continued)

State	Source of Law	Standard	Cognitive Prong	Volitional Prong	Strict ALI	Strict M'Naghten	Variation	M'Naghten Variant	ALI Variant	Abolished Defense
Florida	Case law, e.g., Davis v. State, 32 So. 822 (Fla. 1902)	Not criminally responsible if "the defendant, by reason of a mental disease or defect, (1) does not know of the nature or consequences of his or her act; or (2) is unable to distinguish right from wrong"	Yes	No	No	Yes	No			
Georgia	Ga. Code Ann. §§ 16-3-3 (1968); 16-3-2 (1968)	Not guilty when "the person, because of mental disease, injury, or congenital deficiency, acted as he did because of a delusional compulsion as to such act which overmastered his will to resist committing the crime"; or when "the person did not have mental capacity to distinguish between right and wrong"	Yes	Yes	No	No	M'Naghten plus volitional prong variant	Yes		
Hawaii	Haw. Rev. Stat. § 704-400 (1972)	Not responsible if "as a result of physical or mental disease, disorder, or defect the person lacks substantial capacity either to appreciate the wrongfulness of the person's conduct or to conform the person's conduct to the requirements of the law"	Yes	Yes	Yes	No	No			
Idaho	Idaho Code § 18-207 (1982)	Mental condition not a defense to any charge of criminal conduct	N/A	N/A	N/A	N/A	N/A			Yes
Illinois	720 Ill. Comp. Stat. 5/6-2(a) (1995)	Not criminally responsible if "as a result of mental disease or defect, [actor] lacks substantial capacity to appreciate the criminality of his conduct"	Yes	No	No	No	Dropped the volitional prong of ALI		Yes	
Indiana	Ind. Code § 35-41-3-6(a) (1984)	Not criminally responsible if "as a result of mental disease or defect, [actor] was unable to appreciate the wrongfulness of the conduct"	Yes	No	No	No	Dropped the volitional prong and "substantial capacity" of ALI		Yes	
Iowa	Iowa Code § 701.4 (1984)	No conviction if "the person suffers from such a disease or deranged condition of the mind as to render the person incapable of knowing the nature and quality of the act the person is committing or incapable of distinguishing between right and wrong in relation to that act"	Yes	No	No	Yes	No			
Kansas	Kan. Stat. Ann. § 22-3220 (1995)	Mental disease or defect not a defense unless because of such disease or defect person lacked mental state required as element of offense	N/A	N/A	N/A	N/A	N/A			Yes

Kentucky	Ky. Rev. Stat. Ann. § 504.020(1) (1988)	Not responsible if "as a result of mental illness or retardation, [actor] lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law"	Yes	Yes	Yes	No	No		
Louisiana	La. Rev. Stat. Ann. § 14 (1942)	Exempt from criminal responsibility if "because of a mental disease or mental defect the offender was incapable of distinguishing right from wrong with reference to the conduct in question"	Yes	No	No	No	No M'Naghten "nature and quality" language	Yes	
Maine	Me. Rev. Stat. Ann. tit. 17-A, § 39 (1985)	Not criminally responsible if "as a result of mental disease or defect, [actor] lacked substantial capacity to appreciate the wrongfulness of his conduct"	Yes	No	No	No	Dropped volitional prong of ALI		Yes
Maryland	Md. Code Ann. § 12-108 (1984); substantially the same in 1967	Not criminally responsible if "the defendant, because of a mental disorder or mental retardation, lacks substantial capacity: (1) To appreciate the criminality of that conduct; or (2) To conform that conduct to the requirements of the law"	Yes	Yes	Yes	No	No		
Massachusetts	Case law, e.g., Commonwealth v. McHoul, 226 N.E.2d 556 (Mass. 1967)	Not responsible if "as a result of mental disease or defect [actor] lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law"	Yes	Yes	Yes	No	No		
Michigan	Mich. Comp. Laws § 768.21a(1) (1994)	Affirmative defense if "as a result of mental illness. . .or. . .being mentally retarded. . .that person lacks substantial capacity either to appreciate the nature and quality or the wrongfulness of his or her conduct or to conform his or her conduct to the requirements of the law"	Yes	Yes	Yes	No	No		
Minnesota	Minn. Stat. § 611.026 (1971)	Excused from criminal liability if "the person was laboring under such a defect of reason, from [mental illness or mental deficiency], as not to know the nature of the act, or that it was wrong"	Yes	No	No	Yes	No		
Mississippi	Case law, e.g., Laney v. State, 421 So. 2d 1216 (1982)	Test is "ability of the accused to realize and appreciate the nature and quality of his deeds when committed and the ability to distinguish between right and wrong"	Yes	No	No	No	Substitutes "realize" and "appreciate" for "know"	Yes	
Missouri	Mo. Ann. Stat. § 552.030 (1994)	Not responsible for criminal conduct if "as a result of mental disease or defect such person was incapable of knowing and appreciating the nature, quality, or wrongfulness of such person's conduct"	Yes	No	No	No	Adds "appreciate" to M'Naghten	Yes	

(table continues)

The Insanity Defense: State and Federal Standards, 2000–2001 (continued)

State	Source of Law	Standard	Cognitive Prong	Volitional Prong	Strict ALI	Strict M'Naghten	Variation	M'Naghten Variant	ALI Variant	Abolished Defense
Montana	Mont. Code Ann. § 46-14-102 (1979)	Evidence of mental disease or defect admissible only to prove that defendant did not have state of mind that is element of offense	N/A	N/A	N/A	N/A	N/A			Yes
Nebraska	Case law, e.g., State v. Hurst, 592 N.W.2d 303 (Neb. 1999)	Elements of insanity defense are that defendant had mental disease and did not understand the nature and consequences of his actions or did not know the difference between right and wrong with respect to what he was doing	Yes	No	No	Yes	No			
Nevada	Nev. Rev. Stat. Ann. 174.035 (1995)	A defendant may plead not guilty, guilty, guilty but mentally ill, or with the consent of the court, *nolo contendre.*	N/A	N/A	N/A	N/A	N/A			Yes
New Hampshire	Case law, e.g., Abbott v. Cunningham, 766 F. Supp. 1218 (D.N.H. 1991)	No definition of insanity; jury decides whether defendant was insane. "Whether the defendant was insane and whether the crimes were the product of such insanity are questions of fact for you (the jury) to decide."	No	No	No	No	"Product" test			
New Jersey	N.J. Stat. Ann. § 2C:4-1 (1979)	Not criminally responsible if "laboring under such a defect of reason, from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know, that he did not know what he was doing was wrong"	Yes	No	No	Yes	No			
New Mexico	Case law, e.g., State v. White, 270 P.2d 727 (N.M. 1954)	No criminal responsibility if "as a result of disease of the mind [the defendant] (a) did not know the nature and quality of the act or (b) did not know that it was wrong or (c) was incapable of preventing himself from committing it"	Yes	Yes	No	No	Adds irresistable impulse to M'Naghten	Yes		
New York	N.Y. Penal Law § 40.15 (1984)	No criminal responsibility if "as a result of disease or defect, he lacked substantial capacity to know or appreciate either (1) the nature and consequences of such conduct or (2) that such conduct was wrong"	Yes	No	No	No	Dropped volitional prong of ALI		Yes	
North Carolina	Case law, e.g., State v. Bonney, 405 S.E.2d 145 (N.C. 1991)	Not criminally responsible if "laboring under such a defect of reason, from disease or deficiency of the mind as to be incapable of knowing the nature and quality of his act, or if he did know this, of distinguishing between right and wrong in relation to such act."	Yes	No	No	Yes	No			

North Dakota	N.D. Cent. Code § 12.1-04.1-01 (1985)	Not criminally responsible if "as a result of mental disease or defect. . .[t]he individual lacks substantial capacity to comprehend the harmful nature or consequences of the conduct, or the conduct is the result of a loss or serious distortion of the individual's capacity to recognize reality, and it is an essential element of the crime that the individual act willfully"	Yes	No	No	No	Substantially different from M'Naghten and ALI, but broadly, and includes a *mens rea* element		Yes
Ohio	Ohio Rev. Code Ann. § 2901.01(A)(14) (1990)	Not guilty only if "the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts"	Yes	No	No	No	No M'Naghten "nature and quality" language	Yes	
Oklahoma	Okla. Stat. Ann. tit. 21, § 152 (before 1901)	Legally insane if "suffering from a mental disease or defect rendering him unable to differentiate between right and wrong, or unable to understand the nature and consequences of his act"	Yes	No	No	Yes	No		
Oregon	Or. Rev. Stat. § 161.395 (1971)	Guilty except for insanity if "as a result of mental disease or defect. . . . The person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of the law"	Yes	Yes	Yes	No	No		
Pennsylvania	18 Pa. Cons. Stat. Ann. § 315(b) (1982)	Insane if "laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing or, if the actor did know the quality of the act, that he did not know that he was doing was wrong"	Yes	No	No	Yes	No		
Rhode Island	Case law, e.g., State v. Johnson, 399 A.2d 469 (R.I. 1979)	Not responsible if "as a result of mental disease or defect, his capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law is so substantially impaired that he cannot justly be held responsible"	Yes	Yes	Yes	No	Similar language to ALI but adopts British "justly responsible"		
South Carolina	S.C. Code Ann. § 17-24-10 (1984)	Affirmative defense if the defendant "as a result of mental disease or defect, lacked the capacity to distinguish moral or legal right from moral or legal wrong or to recognize the particular act charged as morally or legally wrong"	Yes	No	No	No	No M'Naghten "nature and quality" language; uses language of moral wrongfulness	Yes	
South Dakota	S.D. Codified Laws § 22-1-2(20) (before 1910)	Insanity is "the condition of a person temporarily or partially deprived or reason, upon proof that. . .he was incapable of knowing the wrongfulness of his act"	Yes	No	No	No	No M'Naghten "nature and quality" language	Yes	

(table continues)

The Insanity Defense: State and Federal Standards, 2000–2001 (continued)

State	Source of Law	Standard	Cognitive Prong	Volitional Prong	Strict ALI	Strict M'Naghten	Variation	M'Naghten Variant	ALI Variant	Abolished Defense
Tennessee	Tenn. Code Ann. § 39-11-501 (1995)	Affirmative defense that "the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature or wrongfulness of such defendant's acts"	Yes	No	No	No	Substitutes "appreciate" for "know"	Yes		
Texas	Tex. Penal Code Ann. § 8.01 (1983)	Affirmative defense that "the actor, as a result of mental disease or defect, did not know that his conduct was wrong"	Yes	No	No	No	No M'Naghten "nature and quality" language	Yes		
Utah	Utah Code Ann. § 76-2-305 (1983)	Defense that defendant "as a result of mental illness, lacked the mental state required as an element of the offense charged"; mental illness not otherwise a defense	N/A	N/A	N/A	N/A	N/A			Yes
Vermont	Vt. St. Ann. title 13, § 4801 (1957)	Not responsible for criminal conduct if "as a result of mental disease or defect [the actor] lacks adequate capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law"	Yes	Yes	No	No	"adequate capacity" substituted for "substantial capacity"		Yes	
Virginia	Case law, e.g., Bennett v. Commonwealth, 511 S.E.2d 439 (Va. 1999)	Insane if "the accused's mind has become 'so impaired by disease that he is totally deprived of the mental power to control or restrain his act,' " or "he or she did not understand the nature, character, and consequences of his or her act, or was unable to distinguish right from wrong"	Yes	Yes	No	No	M'Naghten plus irresistable impulse	Yes		
Washington	Wash. Rev. Code Ann. § 9A.12.010 (1975)	Defense of insanity if "as a result of mental disease or defect, the mind of the actor was affected to such an extent that: (a) He was unable to perceive the nature and quality of the act with which he is charged; or (b) He was unable to tell right from wrong with reference to the particular act charged"	Yes	No	No	Yes	No			
West Virginia	Case law, e.g., State v. Grimm, 195 S.E.2d 637 (W. Va. 1973)	Not held criminally responsible if, because of a mental disorder, the defendant lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law	Yes	Yes	Yes	No	No			
Wisconsin	Wisc. Stat. Ann. § 971.15 (1969)	Not responsible for criminal conduct if "as a result of mental disease or defect the person lacked substantial capacity either to appreciate the wrongfulness of his or her conduct or conform his or her conduct to the requirements of law"	Yes	Yes	Yes	No	No			

Wyoming	Wyo. Stat. Ann. § 7-11-305(b) (1975)	Defense if defendant "as a result of mental illness or deficiency. . .lacked capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law"	Yes	Yes	No	No	No "substantial" capacity	Yes
U.S. Military	10 U.S.C.A. § 850a (1986)	Affirmative defense that 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"	Yes	No	No	No	Substitutes "appreciate" for "know"	No / Yes
U.S. Federal	18 U.S.C.A. § 17 (1984)	Affirmative defense that 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"	Yes	No	No	No	Substitutes "appreciate" for "know"	No / Yes
Total			44 States + Federal and Military	16	10	10	15 states	9 / 5

Date following statute indicates year statute or standard was adopted in substantially the same form. Some statues or case law have been amended as of this publication, and thus this summary should not be relied upon for current standards. The wording of several standards combines language from different tests so as to make characterization of the test somewhat arbitrary in a few cases.

References

1. Bonnie R: The moral basis of the insanity Defense. ABAJ 69: 194, 1983
2. Bonnie R: Morality, equality, and expertise: renegotiating the relationship between psychiatry and the law. Bull Am Acad Psychiatry Law 12:5–21, 1984
3. Fingarette H: The Meaning of Criminal Insanity. Berkeley: University of California Press, 1972
4. Durham v. U.S., 214 F.2d 862 (D.C. Cir. 1954)
5. Diamond B: On the spelling of Daniel M'Naghten's name, Ohio State Law J 25:84–8, 1964
6. Platt AM, Diamond B: The origins and development of the "wild beast" concept of mental illness and its relation to theories of criminal responsibility. J Hist Behav Sci 1:355–66, 1965
7. Quen JM: Anglo-American criminal insanity—an historical perspective. J Hist Behav Sci 10:31, 1974
8. Walker N: Crime and Insanity in England ("From unpublished correspondence in the Royal Archives at Windsor, which is published by gracious permission of HM the Queen"). Edinburgh: Edinburgh University Press, 1979
9. Maeder T: Crime and Madness: The Origins and the Evolution of the Insanity Defense. New York: Harper and Row, 1985
10. Bolland WC, Maitland FW, Harcourt LW (editors): Year Books of Edward II, Year Book Series (vol 5). London: Selden Society, 1909
11. Arnold's Case, 16 Howell St. Tr. 695, 764 (1724)
12. Ray I: A Treatise on The Medical Jurisprudence of Insanity. Boston: Charles Little and James Brown, 1838
13. Regina v. Oxford, Car. & P. 9:525, 546, 173; Eng. Rep. 941, 950 (1840)
14. Bonnie RJ, Jeffries JC, Low PW: The Trial of John W. Hinckley, Jr: A Case Study in the Insanity Defense. New York: Foundation Press, 1986
15. M'Naghten's Case, 10 Cl. & F. 200, 8 Eng. Rep. 718 (H.L. 1843)
16. Steadman HJ, McGreevy MA, Morrissey JP, *et al*: Before and After Hinckley: Evaluating Insanity Defense Reform. New York: Guilford Press, 1993
17. State v. Pike, 49 N.H. 399 (1870)
18. State v. Jones, 50 N.H. 369 (1871)
19. Durham v. United States, 214 F.2nd 862 (D.C. Cir. 1954)
20. McDonald v. United States, 312 F.2nd 851 (D.C. Cir. 1962)
21. Washington v. United States, 390 F.2nd 444 (D.C. Cir. 1967)
22. United States v. Brawner, 471 F.2nd 969 (D.C. Cir. 1972)
23. Government of the Virgin Islands v. Henry Knight, 26 V.I. 396 (1991)
24. Parsons v. State, 81 Ala. 577, 596, 2 So. 854, 866 (1886)
25. ALI Model Penal Code, § 4.01 (1985)
26. Rosenberg C: The Trial of the Assassin Guiteau: Psychiatry and the Law in the Gilded Age. Chicago: University of Chicago Press, 1995
27. Pub. L. No. 98–473, 98 Stat. 2057 (1984)
28. 18 U.S.C.A. § 20(a) (West Supp. 1985)
29. 18 U.S.C.A. § 4242(b) (West Supp. 1985)
30. S. 1762, 98th Cong., 1st Sess. (1983)
31. H.R. 2151, 98th Cong., 2d Sess. (1984)
32. 2 Paul H. Robinson, Criminal Law Defenses § 173(a), at 282 n.4 (1984)
33. Note, The Proposed Federal Insanity Defense: Should the Quality of Mercy Suffer for the Sake of Safety? 22 Am Crim Law Rev 49, 55 n.42 (1984)
34. United States v. Lyons, 731 F.2d 243, 248 (5th Cir. 1984), cert. denied, 105 S. Ct. 323 (1984)

35. S. Rep. No. 225, 98th Cong., 2d Sess. 225–29; reprinted in U.S. Code Cong & Admin News 3182, 3407–11 (1984)
36. H.R. Rep. No. 577, 98th Cong., 1st Sess. 12 (1983)
37. American Bar Association: Criminal Justice Mental Health Standards. Washington, DC: ABA, 1989, pp 321–94
38. Simon RJ, Aaronson DE: The Insanity Defense: A Critical Assessment of Law and Policy in the Post Hinckley Era. New York: Praeger, 1988
39. Fed. R. Evid. 704(b) (1984)
40. Slovenko R: Psychiatry and Criminal Culpability. New York: John Wiley, 1995
41. State v. Hartfield, 300 S.C. 469; 388 S.E.2d 802 (1990)
42. Brunner v. State, 683 So.2d 1129 (Fla. Dist. App., 1996)
43. Commonwealth v. Tate, 893 S.W.2d 368 (Ky. 1995)
44. Bieber v. People, 856 P.2d 811 (Colo. 1993), cert. denied, 114 S. Ct. 716 (1994)
45. Hassman PE: Effect of voluntary drug intoxication upon criminal responsibility. 73 A.L.R.3d 98, §2a (1976; 1998 supplement)
46. Porreca v. State, 433 A.2d 1204 (Md. App. 1981)
47. People v. Conrad, 385 N.W.2d 277 (Mich. App. 1986)
48. People v. Kelly, 10 Cal. 3d 565, 516 P.2d 875 (1973)
49. State v. Wilcox, 436 N.E.2d 523, 530 (Ohio 1982)
50. State v. Cooey, 544 N.E.2d 895 (Ohio 1989)
51. State v. Solomon, 570 N.E.2d 1118 (Ohio 1991)
52. U.S. v. Knott, 894 F.2d 1119 (9th Cir. 1990), cert. denied, 498 U.S. 873 (1990)
53. U.S. v. Knott, 894 F.2d 1119 at 1122 (9th Cir. 1990)
54. U.S. v. Frisbee, 623 F. Supp. 1217 (N.D. Cal. 1985)
55. Montana v. Engelhoff, 518 U.S. 37 (1996)
56. United States, v. F. D. L. and R. L. R., 836 F.2d 1113 (1988)
57. Gilcrist v. Kincheloe, 589 F Supp. 291 (ED Wash, 1984), aff'd 774 F.2d 1173 (9th Cir, 1985)
58. Gilcrist v. Kincheloe, 589 F Supp. 294
59. State v. Lucas, 368 N.W.2d 124 (Iowa 1985)
60. Minnesota v. Altimus, 306 Minn. 462; 238 N.W.2d 851 (1976) (en banc)
61. State v. Mriglot, 15 Wash. App. 446; 550 P.2d 17 (1976), aff'd 88 Wash. 2d 573; 564 P.2d 784 (1977) (en banc)
62. 73 A.L.R. 3d 203–4 (1976) (cases cited therein)
63. Boswell v. State, 610 So.2d 670 (Fla. 4th DCA 1992)
64. Melton BG, Petrila J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers (2nd ed). New York: Guilford Press, 1997, pp 187–8
65. Perlin ML: Myths, realities, and the political world: the anthropology of insanity defense attitudes. Bull Am Acad Psychiatry Law 24:5–26, 1996
66. Perlin ML: The Jurisprudence of the Insanity Defense. Durham, NC: Carolina Academic Press, 1994, pp 331–77
67. Perlin ML: Mental Disability Law —Civil and Criminal (1989 and 1999 supplement). Charlottesville, VA: Lexis Law Publishing, § 15.29 *et seq.*
68. Note, Vietnam Stress Syndrome and the Criminal Defendant. 19 Loy LA Law Rev 473, 478 (1985)
69. U.S. v. Crosby, 713 F.2d 1066, 1076–7 (5th Cir. 1983)
70. Miller v. State, 338 N.W.2d 673, 678 (S.D. 1983)
71. Perlin ML: Mental Disability Law—Civil and Criminal. LEXIS Publishing (1989 and 1997 cumulative supplement), § 15.32
72. U.S. v. Rezaq, 918 F Supp. 463, 467 (D.D.C., 1996)
73. State v. Felde, 422 So.2d 370, 393 (1982); rehearing denied, 422 So.2d 370 at 398 (1982)
74. Bouchillon v. Collins, 907 F.2d 589, 597 (5th Cir. 1990)
75. Miller v. State, 338 N.W.2d 673, 676–7 (S.D., 1983)
76. Blair D: The medicolegal aspects of automatism. Med Sci Law 17:167, 1977
77. Black's Law Dictionary (ed 6). 1990, p 134
78. Bratty v. Attorney-General of Northern Ireland, 3 All E.R. 523, 527 (1961)
79. Eichelberger EA: Annotation, Automatism or Unconsciousness as Defense to Criminal Charge. 27 A.L.R. 4th 1067 (1984)
80. Davidson MJ, Walters S: *United States v. Berri:* the automatism defense rears its ugly little head. Army Law, pp 17–26 (1993)
81. 27 A.L.R. 4th 1067
82. McClain v. Indiana, 678 N.E.2d 104 (1997)
83. Pope HG Jr, Oliva PS, Hudson JI, Bodkin JA, Gruber AJ: Attitudes toward DSM-IV dissociative disorders diagnoses among board-certified American psychiatrists. Am J Psychiatry 156: 321–3, 1999
84. Behnke SH. Assessing the criminal responsibility of individuals with multiple personality disorder: legal cases, legal theory. J Am Acad Psychiatry Law 25:391–9, 1997
85. State v. Grimsley, 444 N.E.2d 1071 (Ohio App. 1982)
86. Kirkland v. State, 304 S.E.2d 561 (Ga. App. 1983)
87. Commonwealth v. Roman, 606 N.E.2d 1333, 1336 (Mass. 1993)
88. State v. Rodrigues, 679 P.2d 615 (Haw. 1984), cert. denied, 469 U.S. 1078 (1984)
89. U.S. v. Denny-Shaffer, 2 F.3d 999 (10th Cir. 1993)
90. State v. Wheaton, 850 P.2d 507 (Wash. 1993)
91. State v. Greene, 984 P.2d 1024 (Wash. 1999)
92. Burger v. State, 163 S.E.2d 333, 335 (Ga. App. 1968)
93. Ariz. Rev. Stat. § 13-502 (2001)
94. U.S. Navy-Marine Corps Court of Military Review, 34 M.J. 745 (1991)
95. Robey v. State, 456 A.2d 953 (Md. App. 1983)
96. State v. Smith, 217 A.D.2d 221; 635 N.Y.S.2d 824 (N.Y. App. 1995)
97. State v. Filiaggi, 714 N.E.2d 867 (Ohio 1999)
98. State v. Ellis, 963 P.2d 843 (Wash. 1998)
99. State v. Wiley, 185 Ill. App. 3d 1097; 541 N.E.2d 1345, 1352 (Ill. App. 1989)
100. State v. Grice, 121 Ill. App. 3d 567; 459 N.E.2d 1122, 1125 (Ill. App. 1984)
101. Hanover Fire Ins. Co. v. Argo, 251 F.2d 80 (Ga. App. 1957)
102. Durham v. United States, 237 F.2d 760 (D.C. App. 1956)
103. Toole v. State, 479 So.2d 731 (Fla. 1985)
104. Faulkenberry v. State, 649 P.2d 951 (Alaska App. 1982)
105. State v. Talley, 702 P.2d 353 (N.M. App. 1985)
106. People v. Burress, 272 N.E.2d 390 (Ill. App. 4th Dist. 1971)
107. Briscoe v. U.S., 102 U.S. App. D.C. 145; 251 F.2d 386 (D.C. App. 1958)
108. U.S. v. Lewellyn, 723 F.2d 615, 618–20 (8th Cir. 1983)
109. U.S. v. Gould, 731 F.2d 45, 50–52 (4th Cir. 1984)
110. U.S. v. Gillis, 773 F.2d 549, 556–9 (4th Cir. 1985)
111. U.S. v. Davis, 772 F.2d 1339, 1344–7 (7th Cir. 1985)
112. State v. Lowitzki, 285 Ill. App. 3d 770; 674 N.E.2d 859 (1996), appeal denied, 172 Ill. 2d 560, 679 N.E.2d 383 (1997)
113. U.S. v. Torniero, 735 F.2d 725 (2nd Cir. 1984), cert. denied, 469 U.S. 1110 (1985)
114. U.S. v. Torniero, 570 F. Supp., 721 at 734 (1983)
115. U.S. v. Torniero, 570 F. Supp. 721 at 732 (1983)
116. State v. Lafferty, 189 Conn. 360; 456 A.2d 272 (Conn 1983)
117. Conn. Gen. Stat. Ann. § 53a-13(c)(2) (West 1985)
118. Kansas v. Hendricks, 521 U.S. 346 (1997)
119. Kansas v. Hendricks, 521 U.S. 346 at 371 (1997)
120. In re Linehan, 594 N.W.2d 867 (Minn. 1999)
121. People v. Mawhinney, 622 N.Y.S.2d 182, 186 (1994)
122. U.S. v. Benedict, 27 M.J. 253 (Ct. Mil. App. 1988)
123. State v. Mace, 921 P.2d 1372 (Utah 1996)
124. Parrish v. Colorado, 78 F.3d 1473 (10th Cir. 1996)

125. Osborn v. Psychiatric Security Review Board, 934 P.2d 391 (Ore. 1997)
126. Rios v. Psychiatric Security Review Board, 325 Ore. 151; 934 P.2d 399 (Ore. 1997)
127. State v. Simants, 248 Neb. 581; 537 N.W.2d 346 (Neb. 1995)
128. Commonwealth v. Rodriquez, 418 Mass. 1, 633 N.E.2d 1039 (1994)
129. People v. Torres, 488 N.Y.S.2d 358, 363 (1985)
130. Masson EM: Admissibility of expert or opinion evidence of battered-woman syndrome on issue of self-defense. 58 A.L.R. 5th 749 (1998)
131. State v. Kelly, 102 Wash. 2d 188, 685 P.2d 564 (1984)
132. Ewing CP: Psychological self-defense: a proposed justification for battered women who kill. Law Hum Behav 14:579–94, 1990
133. Morse S: The misbegotten marriage of soft psychology and bad law: psychological self-defense as a justification for homicide. Law Hum Behav 14:595–618, 1990
134. State v. Moore, 568 So.2d 612 (La. Ct. App. 1990)
135. People v. Saiz, 923 P.2d 197 (Colo. App. 1995), as modified on denial of reh'g (Feb. 1, 1996) and cert. denied (Sept. 3, 1996); cert. denied, 519 U.S. 1069 (1997)
136. Ohio Revised Code, Section 2945.392 (2001)
137. Commonwealth v. Hall, 45 Mass. App. Ct. 146, 696 NE.2d 151 (1998)
138. United States v. Johnson, 956 F.2d 894, 899–900 (9th Cir. 1992)
139. People v. Aris, 215 Cal. App. 3d 1178, 1194 (1989)
140. State v. Borrelli, 227 Conn. 153, 169 n.13 (1993)
141. Bechtel v. State, 840 P.2d 1, 7 (Okla. Crim. App. 1992) (see also United States v. Marenghi, 893 F. Supp. 85, 91 n.10 (D. Me. 1995))
142. State v. Riker, 123 Wash. 2d 351, 359 (1994), quoting from State v. Janes, 121 Wash. 2d 220, 233 (1993) (see People v. Christel, 449 Mich. 578, 588 n.15 (1995); Commonwealth v. Stonehouse, 521 Pa. 41, 62 (1989); State v. Bednarz, 179 Wis. 2d 460, 467 (Ct. App.))
143. United States v. Alvarez 519 F.2d 1036 (1975)
144. Maryland v. Pratt 284 Md. 516; 398 A.2d. 421 (1979)
145. United States v. Rezaq, 918 F.Supp. 463, 467 (D.D.C., 1996)
146. Jacobs v. Commonwealth of Kentucky, 870 S.W.2d 412 (1994)
147. Cohn: Offensive use of the insanity defense: imposing the insanity defense over the defendant's objection. 15 Hastings Const Law Q 295, 212–318 (1988)
148. The right and responsibility of a court to impose the insanity defense over the defendant's objection. 65 Minn Law Rev 927, 944–946 (1981)
149. Treece v. Maryland, 313 Md., 665, 547 A.2d 1054 (1988)
150. Jacobs v. Commonwealth of Kentucky, 870 S.W.2d 412 at 418 (1994)
151. Ake v. Oklahoma, 470 U.S. 68 (1985)
152. Diamond BL: The forensic psychiatrist: consultant versus activist in legal doctrine. Bull Am Acad Psychiatry Law 20:119–32, 1992
153. Janofsky JS, Dunn MH, Roskes EJ, Briskin JK, Rudolph MS: Insanity defense pleas in Baltimore City: an analysis of outcome. Am J Psychiatry 153:1464–8, 1996
154. Slobogin C: Mental illness and the death penalty, Ment Phys Disabil Law Rep 24:667–77, 2000
155. Slobogin C: Symposium: law and psychiatry. Part I: Estelle v. Smith: the constitutional contours of the forensic evaluation. 31 Emory Law J 71–138 (1982)
156. Appelbaum PS: The parable of the forensic psychiatrist: ethics and the problem of doing harm. Int J Law Psychiatry 13:249–59, 1990
157. American Academy of Psychiatry and the Law: Ethical Guidelines for the Practice of Forensic Psychiatry. Section III: Consent. Adopted May 1987, revised October 1989, 1991, and 1995
158. Miller RD, Maier GJ, Kaye M: The right to remain silent during psychiatric examination in civil and criminal cases—a national survey and an analysis. Int J Law Psychiatry 9:77–94, 1986
159. American Bar Association: Criminal Justice Mental Health Standards. Washington, DC: ABA, 1989
160. American Academy of Psychiatry and the Law: Ethical Guidelines for the Practice of Forensic Psychiatry. Adopted May 1987, revised October 1989, 1991, and 1995
161. American Medical Association: Current Opinions of the Council on Ethical and Judicial Affairs. Section 9.07. Washington, DC: AMA, 1995
162. American Medical Association: Code of Medical Ethics, Current Opinions with Annotations. Principle IV. Washington, DC: AMA, 2000, p xiv
163. Weinstock R, Leong G, Silva J: The role of traditional medical ethics in forensic psychiatry, in Ethical Practice in Psychiatry and the Law. Edited by Rosner R, Weinstock R. New York: Plenum Press, 1990, pp 31–51
164. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Section 4, Annotation 13. Washington, DC: APA, 2001
165. Miller R: Ethical issues involved in the dual role of treater and evaluator, in Ethical Practice in Psychiatry and The Law. Edited by Rosner R, Weinstock R. New York: Plenum Press, 1990, pp 129–50
166. Simon RI, Shuman DW: Conducting forensic examinations on the road: are you practicing your profession without a license? J Am Acad Psychiatry Law 27:75–82, 1999
167. American Psychiatric Association: Practice Guideline for Psychiatric Evaluation of Adults. Am. J Psychiatry 152 (suppl): 63–80, 1995
168. Resnick PJ: The detection of malingered psychosis. Psychiatric Clin North Am 22:159–72, 1999
169. Rogers R, Salekin RT, Sewell KW, Goldstein A, Leonard K: A comparison of forensic and nonforensic malingerers: a prototypical analysis of explanatory models. Law Hum Behav 22:353–67, 1998
170. Rogers R: Structured interviews and dissimulation, in Clinical Assessment of Malingering. Edited by Rogers R. New York: Guilford Press, 1988, pp 250–69
171. Zonana, H, Bradford J, Giorgi-Guarnieri D, *et al*: Videotaping of forensic psychiatric evaluations. J Am Acad Psychiatry Law 27:345–58, 1999
172. Rogers R (editor): Clinical Assessment of Malingering and Deception (ed 2). New York: Guilford Press, 1997
173. Resnick PJ: Malingering, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. New York: Chapman and Hall, 1994, pp 417–26
174. Rock v. Arkansas, 483 U.S. 44 (1987)
175. State v. Hurd, 414 A.2d 291 (1980)
176. Rogers R, Shuman D: Conducting Insanity Evaluations (ed 2). New York: Guilford Press, 2000
177. Rappeport JR: Differences between forensic and general psychiatry. Am J Psychiatry 139:331–4, 1982
178. Code Ann. § 19.2-169.5 (2001)
179. Group for the Advancement of Psychiatry: The Mental Health Professional and the Legal System. New York: Brunner/Mazel, 1991, pp 92–101
180. Melton GB, Petrila J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts (ed 2). New York: Guilford Press, 1997, pp 547–613
181. Noffsinger SG, Resnick PJ: Insanity Defense Evaluations. Directions Psychiatry 19:325- 38, 1999
182. U.S.C.S. Fed Rules Evid R 702, 704 (2000)

183. Rappeport JR: Reasonable medical certainty. Bull Am Acad Psychiatry Law 13:5–15, 1985
184. Lewin J: The genesis and evolution of legal uncertainty about "reasonable medical certainty." 57 Md Law Rev 380, 1998
185. American Psychiatric Association: Task Force Report on The Use of Psychiatric Diagnoses in the Legal Process. Washington, DC: APA, 1991
186. Frye v. United States, 54 App. D.C. 46, 47, 293 F.1013, 1014 (1923)
187. Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993)
188. Kumho Tire Co. v. Carmichael, 526 U.S. 137; 119 S. Ct. 1167 (1999)
189. Bonnie RJ, Jeffries JC, Low PW: The Trial of John W. Hinckley Jr.: A Case Study in the Insanity Defense (ed 2). New York: Foundation Press, 2000, pp 12–14, 49, 50

Volume 30, Number 2 Supplement 2002

The Journal of the American Academy of Psychiatry and the Law