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I'm going to present a somewhat alternative point of view. In this panel, to this point, we've been talking about the relationship between the so-called forensic evaluator and the judiciary. I see my job, that of the forensic psychiatrist, as essentially that of a translator. Both fields, those of Mental Health and Law, both interested in the welfare of those with whom we come into professional contact, speak two different languages. Samarqandi, a Sufi sage once said,

> Different sections of the community are, to all realities, "nations."
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> . . . .
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> The clerics, doctors, literary men, nobles and peasants, really could be called nations; for each one has its own customs and casts of thought. To imagine that they are just the same as you simply because they live in the same country or speak the same language is a feeling to be examined.[1]

Half of us here speak an inductive language, half speak a deductive language. I remember a case called *Pennoyer v. Neff*,[2] hearing about two people who disappear from the case rapidly, but, from development of thought about the situation, as I understand it, concepts of jurisdiction arise. The medical model, following the presentation of a symptom in a case we may see, is that of approaching it in exactly the opposite way, beginning with the largest categories, then narrowing down consideration by exclusion or additional information, to arrive at a diagnosis.

It is because we speak a different language, have different "customs and casts of thought," that the task of the forensic psy-

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1. Samarqandi, *Class and Nation, in* CARAVAN OF DREAMS 166 (Idries Shah ed., 6th ed. 1988).

2. 95 U.S. 714 (1877).

chiatrist is that of translating the language of our medical field in a way that may be useful to the courts. For these purposes, I don't find presenting diagnoses useful, for the most part. I think they are more confusing than useful for legal purposes. Our job is to give opinion for a judge to consider. Diagnoses do not convey legal truth. Legal "truth" and scientific "truth" may have nothing to do with each other.

Think of the *Hinckley*[3] case as an example. In his attempt to kill President Reagan, Hinckley was found not guilty by reason of insanity.[4] Why? Jurors, polled after the verdict, said that psychiatrists for the defense said, during the trial, that the defendant had a mental disorder. And these jurors said that gave them reasonable doubt.[5] Legally, the "truth" is that he is insane. Insanity, as you know, is a legal term, not a psychiatric one.

In other cases, as with child custody and domestic violence, psychiatric diagnoses often are presented as weapons and established facts as conclusory testimony, rather than as opinion evidence, promoting the cause the psychiatrist wishes to promote.[6] Thus, a person may be called "narcissistic" or "schizoid" or "passive-aggressive," as if any of these diagnostic terms

3. *See* United States v. Hinckley, 525 F. Supp. 1342 (D.D.C. 1981).

4. The "not guilty by reason of insanity" defenses are well-presented as applied to *Hinckley*, in PETER W. LOW ET AL., A CASE STUDY IN THE INSANITY DEFENSE: THE TRIAL OF JOHN W. HINCKLEY, JR. 19-33 (2d ed. 2000).

5. *See generally Defendant Smiles, Jury is Impassive*, N.Y. TIMES, June 22, 1982, at D27 (quoting a juror: "[y]ou have to go by all the evidence. All the psychiatrists found there was a mental disorder. You have to go on the evidence, not your personal feelings. I felt he was a disturbed person mentally."); *2 Jurors Assert that Pressure Forced Them to Alter Votes*, N.Y. TIMES, June 23, 1982, at B6; Stuart Taylor Jr., *The Hinkley Riddle*, N.Y. TIMES, June 23, 1982, at D21 (quoting jurors that "[p]rofessional knowledge didn't prove either that [Hinkley] was insane or sane," and that some jurors found the prosecutions evidence of sanity was "not strong enough."); Mary Thorton, *Hinkley Jurors Critical of System*, WASH. POST, June 25, 1982, at A3 (quoting a juror "[e]veryone knew beyond a shadow of a doubt that he did it. He was guilty. But we had that mental problem to deal with.").

6. *See, e.g.*, United States v. Schatzle, 901 F.2d 252, 257 (2d Cir. 1990) (stating that while the Federal Rules of Evidence "do not bar all expert testimony concerning an ultimate issue, a district court may exclude ultimate issue testimony . . . when it is not helpful to the jury, or . . . when it may be unduly prejudicial."); United States v. Locascio, 6 F.3d 924, 939 (2d Cir. 1993) (reminding district courts that they are not required to admit expert testimony and when they do it should be "carefully circumscribed to ensure that the expert does not usurp either the role of the judge in instructing on the law, or the role of the jury in applying the law to the facts before it.").

presents a full view of the person. In my opinion, the task of the psychiatrist is to relate the psychiatric condition, whatever it is, to the question of concern to the court.

The basic issue is not that of diagnosis, but, again using custody as an example, the court needs an opinion as to which parent meets the child's emotional needs better then the other. In a domestic violence case, the question is that of behavior and responsibility for such behavior, even as it is in the criminal law. In an insanity or a partial insanity defense, the question for the finder of fact is that of the defendant's ability to reason or control his actions and conform to the requirements of law or not,[7] which may be independent of the diagnosis presented by the psychiatrist.

Such reports are often conclusory, presenting conclusions instead of descriptions or attempts to present the psychiatrist's understanding of the behavior. By way of contrast, in medical malpractice cases, I always suggest to the lawyers, "review the nurses' notes first." Don't read the residents' notes or the physicians' notes at the start. Nurses are trained to describe what they see. Residents draw conclusions. A resident writes of a woman that she is "seductive." The nurse writes, "this woman sits in the day room with her skirt up to her shoulders, exposing her undergarments." I know what that means. I don't know what the resident means by "seductive." So, if it's a question of conclusory material versus description, I would expect that the court would benefit most from the description.

I learned very quickly in training residents in psychiatry that we spend the whole first year teaching concepts of traditional psychiatric diagnosis. We spend the next three years ripping apart this concept because people don't fit into simple pigeonholes. Diagnoses are often situation-dependent also, and subject to change.

As an Army psychiatrist years ago, I saw soldiers unsuitable or unfit for military service, many of whom were discharged administratively because they were considered to have psychiatric diagnoses of "character disorders," having "passive-aggressive" character structures. It happened that I saw three of the

7. *See, e.g.*, People v. Almonor, 715 N.E.2d 1054, 1059 (N.Y. 1999) (citing N.Y. PENAL LAW § 40.15).

people I boarded out administratively years later, while I was in private practice in this area. At this later time, they weren't passive-aggressive. It finally occurred to me that the passive-aggressive response, for some, may be a normal response to the military. In this example, the characterological diagnosis is clearly situational, as it may be to the stress of litigation as well.

The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) states very clearly that it is not to be used for forensic purposes.[8] The fact is that lawyers in every court in which I have testified have brandished the volume, using it as a "paint by numbers" method of extracting a diagnosis from the witness. I suggest that this is not a proper function or use of the forensic psychiatrist. We in our field need more help from the judiciary to help us to help them in determining what is useful for the court in the interests of justice.

8. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR xxxii-xxxiii (4th ed. 2000).