The problems underlying a veridical determination of the insanity plea are sufficient to cause one to question the sanity of an author who would undertake this task. Nevertheless, this is what Dr. Rogers has attempted. He suggests that such a determination could be a more objective, orderly process than it usually is. Insanity pleas are one of those legal issues like capital punishment which, despite their comparative rarity, arouse highly emotional responses. Insanity pleas continue to plague the courts when they are offered and contested (it should be noted that these pleas are often agreed to by both prosecution and defense). Even though legal historians tell us that the courts have been wrestling with insanity pleas for several hundred years, there still appears to be little agreement on what constitutes insanity and the proof necessary to validate or invalidate the plea.

A number of difficulties underlie the determination and acceptance of the insanity plea. The great majority of psychiatrists and psychologists would probably agree that the severity of mental illness should be at the level of a psychosis for the plea to deserve serious consideration. However, agreement on whether a defendant has a psychosis or not is considerably less than perfect. For example, clinical studies of agreement on diagnosis rarely approach a level as high as 90%, even when the clinicians come from the same backgrounds. The issue of severity of mental illness is compounded by the fact that the insanity plea requires that illness be determined for a prior time and that the illness have particular effects on the commission of the unlawful act. The adversarial nature of our legal system poses difficulties even when the defense and the prosecuting attorneys agree on the basic nature of the mental illness. One of the best known incidents occurred in the trial of Sirhan Sirhan where both the defense and the prosecution essentially agreed that Sirhan had an underlying schizophrenia, but disagreed on whether or not his illness was of such severity as to render the assassin not guilty by reason of insanity. For the layman, many crimes, particularly those of a violent nature, make little sense, suggesting that many of the perpetrators are not entirely "in their right mind" during the commission of the crime. In these instances the line between sanity and insanity might be very difficult to discern. However, mental
hospitals cannot hold an individual once the illness has been "cured" or the individual is no longer deemed dangerous. (Criminals found not guilty by reason of insanity, in some instances, have been released after only a short stay and thus are popularly deemed to "have gotten away with their crime". Such a result might not be as upsetting to the layman if the perpetrator were to serve a definite minimum term in a mental hospital or other locked facility.

As would be expected, Dr. Rogers begins with a discussion of the various standards which have been applied to the insanity plea. These standards include McNaghten, The New Hampshire Rule, Irresistible Impulse, The Durham Rule, The American Law Institute (ALI) Standard, The Guilty but Mentally Ill (GBMI) Plea as well as the Federal Insanity Reform Act of 1984. He discusses problems with the terms used in these standards such as the word "knowing" and the question of whether this is cognitive or emotional understanding or both. With the ALI Standard the term "lack of substantial capacity" leaves open the question of how disorganized one must be (e.g., psychotic?), how much distortion might be operative (e.g., paranoia?), or how episodic this lack might be (e.g., circular manic-depressive illness). He also discusses the question of whether the prosecution should bear the burden of proof that the defendant is sane or whether the defendant should bear the burden of proof of insanity. The discussion of these issues, while brief, is well organized and to the point.

The evaluation process involves a number of issues for the clinician. Where are the clinician's loyalties? Should this expert be impartial or be an advocate? What are the limits on expertise? What are the problems inherent in an adversarial relationship? He discusses the need for informed consent of the defendant and argues that the clinician should give a complete report concerning the evaluation including the conclusion, "sane or not sane." And this report, with its strengths and weaknesses, should be presented to both the defense and prosecuting attorneys. Malingering and deception by defendants is always a difficulty in adversarial proceedings. For example, he cites figures indicating that 20% of those found to be sane were suspected of malingering (perhaps not surprising), but 7 1/2% of those found to be insane were so suspected (suggesting uncertainty even in this group). He discusses various indicators to detect malingering such as the issue of the subtlety and the consistency of symptoms and the degree of memory impairment. In a military hospital it was found that 41 out of 98 cases of memory impairment were feigned, while 13 cases with genuine symptoms had exaggerated them. He noted 35% of sane individuals and 37% of insane defendants had histories of alcoholism. He studied the degree of social responsibility exhibited by defendants and found almost half of both sane and insane defendants had a mild to moderate lack of