# Mental Health & Experts Manual

## 8th Edition

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# Chapter 1:
# Mental Health Issues: The Heart of the Matter

**by Dick Burr**

**Thinking Comprehensively and Consistently About Mental Health Issues**

1. Prior to and independent of current offense
- Prior convictions
- Prior aggravating acts
- Prior attempts to obtain services

2. Prior to and related to current offense
- Crime derives from mental illness
- Crime occurs while client's behavior structured by illness

3. During current crime
- Ability to form specific or general intent, premeditate, implement a plan, have malice
- NGRI/Sanity
- Affirmative defenses (coercion, duress, domination by others)
- Self-defense and imperfect self-defense

4. Immediately following current crime
- Waivers of rights, consent to search
- Behavior alleged to be inculpatory, including statements or admissions to non-law enforcement

5. Interrogations
- Waiver of right to counsel
- Voluntariness of confessions or statements
- Reliability (8th amendment right) of confessions or statements

6. Custodial Behaviors
- Medication
- Custodial adjustment

7. Working with defense counsel/defense team
- Competence to assist counsel
- Ability to assist in defense
- Ability to understand

8. Entering plea
- Competence to enter a plea

9. Behaviors in court during trial
- What jury/judge sees
- Responding to witness testimony
- Client's Testimony
- Keep pace with courtroom proceedings

10. During sentencing
- Allocution

11. Post-conviction

**What We Need to Know and Do To Consider and Utilize Mental Health Issues**

1. We need to know something about relevant mental impairments

2. Those that compromise intellectual functioning
- mental retardation
- brain damage
- mental illness – psychosis, dissociation, physical illness

3. Those that produce loss of contact with reality
- psychosis – schizophrenia, depression, mania, bipolar, schizoaffective, PTSD
- dissociation – PTSD
- physical illness – fevers, diabetes, stroke, tumors

4. Those that produce a multitude of intellectual, emotional, and physical problems
- trauma – PTSD
- chronic maltreatment and neglect

5. We need to know the major risk factors that can produce mental illness and disorder
- Multigenerational mental illness and disorder
- Multigenerational exposure to trauma, maltreatment, and neglect
- Exposure to trauma, maltreatment, and neglect
- Closed head injuries
- Prenatal conditions – exposure to alcohol and drugs, maternal malnutrition and disease, maternal injury
- Perinatal conditions – loss of oxygen in birth process, head trauma from delivery process
- Exposure to environmental toxins
- Serious physical illness

6. We need to be attentive and perceptive in interactions and communications with the client

7. We need to investigate sufficiently to determine whether mental health assessment is warranted
- medical history and records
- mental health history and records
- social welfare agency records
- employment/military records
- school records
- prior criminal, prison, juvenile records
- history of family mental illness
  - multigenerational genetic history
  - diagnosed and undiagnosed illness and disorders
  - family dynamics
- interviews with family historian(s)

**It Is Our Duty to Assure Reliable Assessment**

1. Understanding the elements of reliable forensic mental health assessment
- psychosocial history, obtained from and independent of client
- medical examination
- mental status evaluation
- additional diagnostic procedures

2. Undertaking the investigation necessary for reliable assessment
3. Obtaining necessary investigative assistance
4. Obtaining necessary expert assistance
5. Working with investigators and experts

**The Common Pathway:**
**Maltreatment and Neglect**

1. Maltreatment deprives child of
- Important relationships
- Raw materials of self esteem
- Socialization necessary to become competent workers, parents, and citizens

2. Abuse and neglect impair the child
- Cognitively
- Emotionally
- Socially
- Physiologically

3. Maltreatment causes children to
- Be helpless
- Have no sense of self
- Be dominated by negative feelings
- Develop self defeating styles of relating to others
- Devote energy to managing danger rather than learning through love and play
- Have arrested and stunted development
- Develop either-or perspective
- Have difficulty concentrating
- Not understand the motives of others
- Have depressed verbal abilities
- Show increased arousal and insecurity

4. Lack of attachment due to chronic neglect
- Prevents child from developing a safe base from which to grow
- Dysregulates physiological and emotional states
- Causes child to be disoriented and confused
- Prevents children from learning how to interpret or express their own emotions and use emotions as guides for appropriate action
- Keeps children from forming secure attachments
- Makes children overreact to internal and external cues of terror & arousal

5. Children's responses to trauma depend on
- Source, nature and duration of the trauma
- Age when the trauma occurs
- How much social support is available
- How many other problems the child faces
- The presence of wise, caring adult
- Presence of mental illness in family
- Educational level of caretakers
- Supportive educational climate
- Early intervention
- Intelligence
- Good self esteem

**Presenting and Defending Mental Health Issues**

<u>Mental health as mitigation:</u>
In what manner did the client's mental and emotional functioning influence him in the commission of the crime?

**Goals of the presentation**
- To describe the experiences and disorders of the client that are relevant
- To use these experiences and disorders to explain why the crime was purposeful for the client – why, from the client's perspective, it happened
- To describe what could have prevented the crime from happening

<u>Direct Examination of the Defense Expert</u>
1 Credentials and experience – highlight those things that explain why this person's expertise will provide helpful information

2 Method of forensic evaluation and how followed here
- Focus of the evaluation
- Did you follow a particular methodology in conducting the evaluation?
- What are the steps that you followed?
- Why did you … [take each step]?
- How did you reach your conclusion?

Did you reach a conclusion concerning the effect of the client's emotional and mental functioning on the commission of the crime?

3. What is your conclusion …
- Concerning the client's mental and emotional functioning?
- And its effect on him at the time of the crime?

4. Explore the factual bases of the conclusions deriving from the client's life history, medical examination, clinical interview/mental status examination, and diagnostic studies
- Break into small questions and answers
- Testify in lay-friendly language
- Tie into lay testimony

- Explain the significance of each fact and how it links to other facts in supporting
- Bring out and explain contradictory facts as you go
- Use demonstrative evidence as much as possible – charts, videos of client, x-rays, CT scans, MRI's, excerpts from historical records, excerpts from movies showing the subjective experience of mental illness

5. In light of the client's mental and emotional functioning, explore whether anything could have been done to prevent the crime from happening

Cross Examination of the State's Expert

1. Investigation
- Credentials and experience
- Who s/he has worked for in other cases – conclusions
- Review prior testimony – learn style, biases, misconceptions, views on relevant issues
- Conduct thorough pretrial interview concerning information available, what considered significant, methodology, reasoning in support of conclusions

2. Develop strategy for cross
- Where is the expert vulnerable, where not vulnerable
- What can be accomplished to aid the defense case – don't overreach
- How to accomplish this

3. Go after the expert in terms that make sense to the fact finder

4. Don't engage in theoretical debates

5. Focus on fact-based matters as much as possible
- Relevant information known, not known
- Misinterpretation of information
- Use of diagnostic measures that do not support conclusions

Lay Witnesses – Direct Examination
- Establish relationship between client and witness – show how that provided good opportunity to come to know client
- Focus on events and incidents – tell the story of each in light of overarching themes
- Evoke emotional as well as narrative content
- Put into humanizing context – the witness's other experiences with client, impressions of client, knowledge of what kind of person client is

Lay Witnesses – Cross Examination of State's Witnesses

1. Investigate
- relationship with client
- biases toward client
- deals/favors
- content of testimony
- others who know the same content and can contradict

2. Limit the significance of the testimony
- not know much else about client
- embellishing what do know

I claim to be no more than an average man with less than average ability. Nor can I claim any special merit for such non-violence or continence as I have been able to reach with laborious research. I have not the shadow of a doubt that any man or woman can achieve what I have, if he or she would make the same effort and cultivate the same hope and faith. Work without faith is like an attempt to reach the bottom of a bottomless pit.

— Mahatma Ghandi

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# Chapter 2:
## Competency to Stand Trial, Criminal Responsibility, Mental Retardation, Extreme Emotional Disturbance, Guilty but Mentally Ill, Ethical Considerations When Representing Mentally Ill Clients

**by Leo Smith**

**I. COMPETENCY TO STAND TRIAL (Mental State at Time of Trial)**

A. Definition

1. RCr 8.06 - If upon arraignment or during the proceedings there are reasonable grounds to believe that the defendant lacks the capacity to appreciate the nature and consequences of the proceedings against him, or to participate rationally in his defense, all proceedings shall be postponed until the issue of incapacity is determined as provided by KRS 504.100.
2. KRS 504.060(4) - "Incompetency to stand trial" means that, as a result of mental condition, lack of capacity to appreciate the nature and consequences of the proceedings against one or to participate rationally in one's own defense.

B. Court's Right to Examination of Defendant

1. KRS 504.100(1) - If upon arraignment, or during any stage of the proceedings, the court has reasonable grounds to believe the defendant is incompetent to stand trial, the court shall appoint at least one (1) psychologist or psychiatrist to examine, treat and report on the defendant's mental condition.
2. Unlike criminal responsibility, there is no right of a prosecutor to have a defendant examined when competency to stand trial becomes an issue.

C. Caselaw

1. *Commonwealth v. Strickland*, 375 S.W.2d 701 (Ky. 1964). "[T]he test is whether he has substantial capacity to comprehend the nature and consequences of the proceeding pending against him and to participate rationally in his defense." *Id.* at 703. See also *Mattingly v. Commonwealth*, 878 S.W.2d 797 (Ky.App. 1993) and *Osborne v. Commonwealth*, 407 S.W.2d 406 (Ky. 1966) and *Gilbert v. Commonwealth*, 575 S.W.2d 455 (Ky. 1978), reiterating the test for competency to stand trial.
2. *Dusky v. United States*, 362 U.S. 480, 80 S.Ct. 788 (1960). It is not sufficient that a defendant is oriented to time and place and has some recollection of events. The test is "whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding - and whether he has a rational as well as factual understanding of the proceedings against him." 362 U.S. at 402, 80 S.Ct. at 789.
3. *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836 (1966). Constitutional rights violated by the failure to conduct an adequate hearing on defendant's competence to stand trial.
4. *Drope v. Missouri*, 420 U.S. 162, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975). "It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." 420 U.S. at 171, 95 S.Ct. at 903. The Court warned trial courts to be alert to indications that during trial a defendant's condition has changed. See also *Godinez v. Moran*, 509 U.S. 389, 113 S.Ct. 2680, 125 L.Ed.2d 321 (1993). A criminal defendant may not be tried unless he is competent.
5. *Medina v. California*, 505 U.S. 437, 112 S.Ct. 2572, 120 L.Ed.2d 353 (1992). "It is well-established that the Due Process Clause of the Fourteenth Amendment prohibits the criminal prosecution of a defendant who is not competent to stand trial. The issue in this case is whether the Due Process Clause permits a State to require a defendant who alleges incompetence to stand trial to bear the burden of proving so by a preponderance of the evidence." 112 S.Ct. at 2574. Statute placing burden of proof on issue of incompetency to stand trial in criminal case upon defendant did not violate defendant's federal procedural due process rights. Furthermore, statute providing that defendants are presumed to be competent to stand trial did not violate defendant's federal procedural due process rights.
6. *Cooper v. Oklahoma*, 517 U.S. 348, 116 S.Ct. 1373, 134 L.Ed.2d 498 (1996). Statute, which provided defendant was presumed to be competent to stand trial unless defendant proved incompetent by clear and convincing evidence, was held to violate right to due process under Fourteenth Amendment.
7. *Lear v. Commonwealth*, 884 S.W.2d 657 (Ky. 1994). Trial had been continued three times. Defendant moved to continue stating that on the morning of trial he was sedated and claimed incompetent to stand trial. The claim was found to have no merit. "Reasonable grounds must be called to the attention of the trial court or must be so obvious that the trial judge can-

not fail to be aware of them." *Id.* at 659.

8. *Gabbard v. Commonwealth*, 887 S.W.2d 547 (Ky. 1994). The issues in this case related to the proper procedures in a trial court's determination of a defendant's competency to stand trial. "[T]he presumption that a defendant is competent to stand trial disappears when there are reasonable grounds to hold a competency hearing." *Id.* at 551. "[T]he Commonwealth cannot rely on Dr. Dane's report without giving Gabbard the right to cross-examine him." *Id.* A conditional plea reserving the right to appeal under RCr 8.09 can be used to review further a finding of competent to stand trial.

**CRIMINAL RESPONSIBILITY**
**(Mental State at Time of Offense)**

A. Definition

1. KRS 504.020
   a. A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental illness or retardation, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.
   b. As used in this chapter, the term "mental illness or retardation" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

2. KRS 504.060(5) - "Insanity" means that, as a result of mental condition, lack of substantial capacity either to appreciate the criminality of one's conduct or to conform one's conduct to the requirements of law.

B. Written Notice Requirement of Expert Testimony to Prosecutor and Court

1. RCr 7.24(3)(B)(i)
   If a defendant intends to introduce *expert testimony* relating to a *mental disease or defect or any other mental condition* of the defendant *bearing* upon the issue of his guilt, he shall, at least *20 days* prior to trial, or at such later time as the court may direct, notify the *attorney for the Commonwealth* in *writing* of such intention and *file* a copy of such notice with the *clerk*. The court may for cause shown allow late filing of the notice or grant additional time to the parties to prepare for trial or make such other order as may be appropriate (emphasis added).
2. RCr 7.24(3)(C)
   If there is a failure to give notice when required by this rule or to submit to an examination ordered by the court under this rule, the court may exclude such evidence or the testimony of any expert witness offered by the defendant on the issue of his guilt.
3. RCr 7.24(3)(D)
   Evidence of an intention as to which notice was given pursuant to this rule, but later withdrawn, shall not be admissible, in any civil or criminal proceeding, against the person who gave said notice.

C. Written Notice Requirement of Defense
KRS 504.070(1)
A defendant who intends to introduce *evidence* of his *mental illness or insanity* at the *time of the offense* shall file *written notice* of his intention at least *twenty (20)* days before trial (emphasis added).

D. Reciprocal Discovery
RCr 7.24(3)

E. Prosecutor or Court's Right to Examination of the Defendant

1. RCr 7.24(3)(B)(ii) (Intent to Introduce Expert Testimony) (On Prosecutor's Motion) When a defendant has filed the notice required by paragraph (B)(i) of this rule, the court may, *upon motion of the attorney for the Commonwealth*, order the defendant to submit to a mental examination. No statement made by the defendant in the course of any examination provided for by this rule, whether the examination be with or without the consent of the defendant, shall be admissible into evidence against the defendant in any criminal proceeding. No testimony by the expert based upon such statement, and no fruits of the statement shall be admissible into evidence against the defendant in any criminal proceeding except upon an issue regarding mental condition on which the defendant has introduced testimony (emphasis added).
2. KRS 504.070(2) (Intent to Use Defense) (On Prosecutor *or* Court's Motion)
   The prosecution shall be granted reasonable time to move for examination of the defendant, or the court may order an examination on its own motion.

F. Burden of Proof

1. KRS 504.020(3) -"A defendant may prove mental illness or retardation, as used in this section, in exculpation of criminal conduct."
2. *Tunget v. Commonwealth*, 303 Ky. 834, 198 S.W.2d 785, 788 (1947). Defendant has to "prove by a preponderance of the evidence."
3. "Preponderance" should not be defined in the instructions. However, "counsel [is] free to ar-

gue the preponderance burden to the jury." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 247 (1996).

4. Introduction of proof of insanity by defense does not shift burden to prosecution to prove the defendant was sane, but, defense is then entitled to jury instruction on the issue. See *Wiseman v. Commonwealth*, 587 S.W.2d 235 (Ky. 1979), and *Edwards v. Commonwealth*, 554 S.W.2d 380 (Ky. 1977), and *Cannon v. Commonwealth*, 777 S.W.2d 591, 594 (Ky. 1989).

G. Instructions

RCr 9.55 was amended effective October 1, 1994. It states:

*On request of either party* in a trial by jury of the issue of absence of criminal responsibility for criminal conduct, the court *shall* instruct the jury at the guilt/innocence phase as to the dispositional provisions applicable to the defendant if the jury returns a verdict of not criminally responsible by reason of mental illness *or* retardation, *or* guilty but mentally ill (emphasis added).

H. Kentucky Caselaw

1. *Edwards v. Commonwealth*, 554 S.W.2d 380, 383 (Ky. 1977).
   "[P]resentation of evidence merely proving the defendant to be suffering from some form of mental illness at the time of the offense, without also proving him unable to appreciate the wrongfulness of his conduct or to resist his impulse to commit the illegal deed due to the perceived mental disease or defect, will not relieve him from the consequences of his criminal act." See *Newsome v. Commonwealth*, 366 S.W.2d 174, 177 (Ky. 1962).
2. Under *Payne v. Commonwealth*, 623 S.W.2d 867, 870 (Ky. 1981), neither prosecutor, defense counsel, nor court may comment about consequences of not guilty by reason of insanity verdict. Additionally, defense not entitled to jury instruction as to consequences of verdict of not guilty by reason of insanity. *Edwards v. Commonwealth*, 554 S.W.2d at 383-384. However, RCr 9.55, which became effective on November 15, 1991, appears to override the *Payne* and *Edwards* decisions.
3. *Jewell v. Commonwealth*, 549 S.W.2d 807 (Ky. 1977). (Overruled on other grounds in *Payne v. Commonwealth*, Ky., 623 S.W.2d 867 (1981)).
   a. Trial court erroneously excluded certified copy of judgment of another court finding defendant mentally ill. Id. at 811-812. See also *Smedley v. Commonwealth*, 138 Ky. 1, 127 S.W. 485, 488-489 (1910).
   b. Brother and sister should have been allowed to in effect testify that defendant did not know right from wrong at time of killing.
   c. Wide latitude must be given to lay opinion on issue of insanity. *Jewell v. Commonwealth*, 549 S.W.2d at 811.
4. "[T]his Court has long allowed lay testimony in cases involving the sanity of the defendant." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 248 (1996).
5. "Oftentimes, lay witnesses testifying as to the customary conduct of an accused more nearly reflect his mental capacity than the high sounding names tagged to imaginary self-induced complaints." *Wiseman v. Commonwealth*, 587 S.W.2d 235, 238 (Ky. 1979).
6. Even though a psychologist does not personally interview a defendant, he may testify at trial. The jury determines how much weight to give the testimony. "[A]n expert may testify as to what a third party said as long as that expert customarily relies upon this type of information in the practice of his or her profession." *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 247 (1996).
7. Evidence of mental condition before and after crime is admissible on issue of insanity. See *Moore v. Commonwealth*, 92 Ky. 630, 18 S.W. 833 (1892), and *Smedley v. Commonwealth*, 138 Ky. 1, 127 S.W. 485 (1910), and *Montgomery v. Commonwealth*, 88 Ky. 509, 11 S.W. 475, 476-477 (1889); *Buckler v. Commonwealth*, 541 S.W.2d 935 (Ky. 1976) and *Sharp v. Commonwealth*, 308 Ky. 765, 215 S.W.2d 983 (1949).
8. If there is any evidence of insanity, even that of lay witnesses, a jury instruction on insanity must be given. *Cannon v. Commonwealth*, 777 S.W.2d 591, 593 (Ky. 1989).
9. "We agree with the dissent and overrule *Corder v. Commonwealth* to the extent that it, even inferentially, requires evidence of insanity to be pinpointed at the moment of the crime before it can be submitted to the jury for decision." *Cannon v. Commonwealth*, 777 S.W.2d 591, 594 (Ky. 1989).
10. Convictions for assault in the third degree, wanton endangerment second degree, and resisting arrest were reversed. "Wyatt presented evidence that he was basically unconscious during this episode. Although extreme emotional disturbance may not mitigate a reckless assault on a policeman, even recklessness requires some intent. If there was insufficient mental capacity or no intent, there could be no violation of KRS 508.025, or any other offense requiring intent.... Under the instructions given by the court, the jury would have had to have found Wyatt guilty of the charges without regard to whether he was con-

scious of his acts. We find this unconscionable. If on retrial the evidence is practically the same, the court should submit to the jury an instruction, whereas the jurors may find Wyatt not guilty, if they believe from the evidence that he was indeed unconscious of his acts." *Wyatt v. Commonwealth*, 738 S.W.2d 832, 834-835 (Ky.App. 1987).

11. *Tibbs v. Commonwealth*, 138 Ky. 558, 128 S.W. 871 (1910). Evidence that defendant was a somnambulist and while in such state was without self-control and committed acts of which he had no recollection. Appropriate to give insanity instruction. See also *Watkins v. Commonwealth*, 378 S.W.2d 614 (Ky. 1964).
12. *Cooley v. Commonwealth*, 459 S.W.2d 89 (Ky. 1970). Defendant suffered epileptic seizures for eight years prior to the stabbing and was taking medication and undergoing treatment for this condition. Psychiatrist testified defendant suffered from psychomotor epilepsy. One stage is a state of automatism during which the subject of the attack is not aware of his actions and of which he later has no memory. This state may last for a matter of seconds to a matter of days. No specific instruction on epilepsy was required as long as a general instruction on insanity adequately presented the issue.
13. *Smith v. Commonwealth*, 268 S.W.2d 937, 938 (Ky. 1954). "It is a well-recognized principle of criminal law that, if a person is unconscious at the time he commits a criminal act, he cannot be held responsible."
14. *Jacobs v. Commonwealth*, 870 S.W.2d 412, 419 (Ky. 1994). "In spite of courtroom amusement, we fail to determine how asking a qualified expert witness in the field of psychiatry questions concerning belly dancing is relevant to the issues of this case and would have a bearing upon the expert's credibility as to her medical training and ability or the competency of the examination performed upon appellant... The Commonwealth's purpose of instituting this line of questioning and interjecting such trivia undermined the appellant's right to a fair trial... Such prosecutorial misconduct does not equate to properly disqualifying but only demeaning the defense expert in the minds of the jury."
15. *Sanborn v. Commonwealth*, 754 S.W.2d 534, 544 (Ky. 1988). "The prosecutor questioned an expert witness called by the defense about his fee, stating: 'and that's what you want the court to direct Henry County to pay you?' Such evidence served only to prejudice the jurors, citizens of Henry County, against appellant."
16. *Mattingly v. Commonwealth*, 878 S.W.2d 797, 800 (Ky.App. 1993). (Case ordered published by the Supreme Court on June 15, 1994.) Prosecutor misstated the test for insanity as being whether the defendant knew right from wrong *generally*, as opposed to whether she appreciated the wrongfulness of posing her daughter for photographs. The misstatement was magnified by the prosecutor's references to defendant's law-abiding life. Prosecutor argued that showed "[s]he had apparently known the difference between right and wrong."
17. *Tate v. Commonwealth*, 893 S.W.2d 368 (Ky. 1995). Defendant was convicted of possession of controlled substance, robbery, and of being a persistent felony offender. The issued addressed by the Court was "whether drug addiction is a mental disease, defect or illness for purposes of KRS 504.020." The Court held, "[a]s there is dissension in the medical community as to whether addiction is a mental disease or whether it is merely a physical craving, appellee did not meet the initial burden showing that his criminal conduct was the result of mental illness or retardation as required under KRS 504.020(1)." *Id.* at 371. "We hold that a mere showing of narcotics addiction, without more, does not constitute 'some evidence' of mental illness or retardation so as to raise the issue of criminal responsibility, requiring introduction of the expert's controversial testimony or an instruction to the jury on that issue. Due to the fact that *no evidence was presented that Tate was in need of a fix at that time, there was an absence of the requisite evidence that at the time of the act charged*, Tate had an abnormal condition of the mind which substantially impaired his behavior. In this case, the weight of the evidence was to the contrary as appellee's attempt to obtain money legally and the arresting officers' testimony showed appellee's lucidity at time of arrest." *Id.* at 372 (emphasis added). "Therefore, the trial court did not err in excluding Dr. Pelligrini's testimony on the grounds of lack of relevancy as no *probative* evidence was offered from which a jury could reasonably infer that at the time of the criminal act, *as a result of mental illness or retardation*, appellee lacks substantial capacity to either appreciate the criminality of his acts or to conform his conduct to the requirements of the law." *Id.* at 373.
18. *Cecil v. Commonwealth*, 888 S.W.2d 669 (Ky. 1995). Clinical psychologist allowed to give opinion that defendant "intentionally shot the victim." *Id.* at 674. He went on to state that the defendant "would not have shot the victim if a police officer had been standing at her elbow (a classic test for the "irresistible impulse" or temporary insanity claim)." *Id.* The Court refers to KRE 702.

Furthermore, "Expert witnesses such as Dr. Noonan can properly state opinions which are admissible concerning the sanity or insanity of criminal defendants." *Id.* at 675.

19. *Port v. Commonwealth*, 906 S.W.2d 327 (Ky. 1995). The defendant was convicted of intentional murder but mentally ill, criminal attempt to commit murder but mentally ill, and wanton endangerment in the first degree but mentally ill. A defendant is entitled to directed verdict on defense of insanity if it would be clearly unreasonable for jury to find against the defendant on the issue of insanity. The mere presence of any evidence that defendant was sane at time the offense was committed does not necessarily enable issue of sanity to be submitted for jury determination; rather, evidence must be taken as a whole. Under the facts of this case the court found that it was not clearly unreasonable for any jury to find the defendant was sane at the time he entered the restaurant and shot two people. Witnesses testified that the defendant appeared to be in control during the shootings, police testified that the defendant acted rational when he was apprehended, and the defendant testified, that he chose to shoot the victims because they caused his frustration. See also *Brown v. Commonwealth*, Ky., 934 S.W.2d 242, 246-247 (1996).

## II. MENTAL RETARDATION

A. Definition - KRS 504.060(7)

"Mental retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period and is a condition which may exist concurrently with mental illness or insanity.

B. Capital Cases

1. Federal Law

Eighth Amendment to the United States Constitution does not prohibit execution of mentally retarded individual. Sentencers may consider mitigating evidence of mental retardation in imposing sentence. *Penry v. Lynaugh*, 492 U.S. 302, 109 S.Ct. 2934, 106 L.Ed.2d 256 (1989).

2. Kentucky Law

a. KRS 532.130 - Definitions for KRS 532.135 and 532.140

(1) An adult, or a minor under eighteen (18) years of age who may be tried as an adult, convicted of a crime and subject to sentencing, is referred to in KRS 532.135 and 532.140 as a defendant.

(2) A defendant with significant sub-average intellectual functioning existing concurrently with substantial deficits in adaptive behavior and manifested during the developmental period is referred to in KRS 532.135 and 532.140 as a seriously mentally retarded defendant. "Significantly sub-average general intellectual functioning" is defined as an intelligence quotient (I.Q.) of seventy (70) or below.

b. KRS 532.135 - Determination by court that defendant is mentally retarded

(1) At least thirty (30) days before trial, the defendant shall file a motion with the trial court wherein the defendant may allege that he is a seriously mentally retarded defendant and present evidence with regard thereto. The Commonwealth may offer evidence in rebuttal.

(2) At least ten (10) days before the beginning of the trial, the court shall determine whether or not the defendant is a seriously mentally retarded defendant in accordance with the definition in KRS 532.130.

(3) The decision of the court shall be placed in the record.

(4) The pretrial determination of the trial court shall not preclude the defendant from raising any legal defense during the trial. If it is determined the defendant is a seriously mentally retarded offender, he shall be sentenced as provided in KRS 532.140.

c. KRS 532.140 - Mentally retarded offender not subject to execution; authorized sentences

(1) KRS 532.010, 532.025, and 532.030 to the contrary notwithstanding, no offender who has been determined to be a seriously mentally retarded offender under the provisions of KRS 532.135, shall be subject to execution. The same procedure as required in KRS 532.025 and 532.030 shall be utilized in determining the sentence of the seriously mentally retarded offender under the provisions of KRS 532.135 and 532.140.

(2) The provisions of KRS 532.135 and 532.140 do not preclude the sentencing of a seriously mentally retarded offender to any other sentence authorized by KRS 532.010, 532.025, or 532.030 for a crime which is a capital offense.

(3) The provisions of KRS 532.135 and 532.140 shall apply only to trials commenced after July 13, 1990.

C. DSM-IV

1. "The essential feature of Mental Retardation is

significantly sub-average general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system. (p. 39 of DSM-IV)

2. IQ of 70 or below is required to be considered "[s]ignificantly sub-average intellectual functioning". Taking into account possibility of measurement error an IQ of 70 represents a range of 65 to 75. (p. 39 of DSM-IV)
3. Four Degrees of Mental Retardation
   a. Mild - IQ ranges from 50-55 to approximately 70 (85% of mentally retarded)
   b. Moderate - IQ ranges from 35-40 to 50-55 (10% of mentally retarded)
   c. Severe - IQ ranges from 20-25 to 35-40 (3%-4% of mentally retarded)
   d. Profound - IQ below 20 or 25 (1%-2% of mentally retarded)

D. Evidence of defendant's mental retardation is admissible in a prosecution for reckless homicide. *Robinson v. Commonwealth*, 569 S.W.2d 183 (Ky.App. 1978).

## III. EXTREME EMOTIONAL DISTURBANCE

A. Statutes
1. Murder - KRS 507.020(1)(a)
2. Assault - KRS 508.040(1)

B. Requirement of Written Notice

1. KRS 504.070(1) (notice of defense) does not specifically include extreme emotional disturbance.
2. RCr 7.24(3)(B)(i) (notice of expert testimony) does not specifically include extreme emotional disturbance.
3. But see *Coffey v. Messer*, Ky., 945 S.W.2d 944 (1997). The Court held that "[w]hen the defendant intends to introduce *expert mental health evidence* to prove that defense, the provisions of RCr 7.24(3)(B)(I) and (ii) are triggered." *Id.* at 946-947 (emphasis added).
4. See also *Stanford v. Commonwealth*, 793 S.W.2d 112 (Ky. 1990). Court agreed trial court properly excluded from guilt phase "certain evidence relevant to the mitigating factor of extreme emotional disturbance" due to failure to comply with notice requirements of KRS 504.070 (1). The evidence excluded was that defendant had a long-term history of depression, paranoid schizophrenia and borderline personality disorder. Court noted that this was a death penalty case and that "much of the testimony excluded during the guilt phase" was admitted during the penalty phase. 793 S.W.2d at 115.

C. Definition

1. *McClellan v. Commonwealth*, 715 S.W.2d 464, 468-469 (Ky. 1986). "Extreme emotional disturbance may reasonably be defined as follows: Extreme emotional disturbance is a temporary state of mind so enraged, inflamed, or disturbed as to overcome one's judgment, and to cause one to act uncontrollably from the impelling force of the extreme emotional disturbance rather than from evil or malicious purposes. It is not a mental disease in itself, and an enraged, inflamed, or disturbed emotional state does not constitute an extreme emotional disturbance unless there is a reasonable explanation or excuse therefore, the reasonableness of which is to be determined from the viewpoint of a person in the defendant's situation under circumstances as defendant believed them to be." See also *Hudson v. Commonwealth*, Ky., 979 S.W.2d 106, 108 (1998) and *Dean v. Commonwealth*, 777 S.W.2d 900, 909 (Ky. 1989).
2. *Stanford v. Commonwealth*, 793 S.W.2d 112, 115 (Ky. 1990). "These cases teach that extreme emotional disturbance is not established by evidence of insanity or mental illness, but require a showing of some dramatic event which creates a temporary emotional disturbance as opposed to a more generalized mental derangement."

D. Expert Testimony
Defense expert failed to define what she meant by extreme emotional disturbance. "Unless such testimony is directed to the concept of extreme emotional disturbance as defined by Kentucky law, as expert's opinion in his regard does not 'assist the trier of fact to understand the evidence or to determine a fact in issue,'" *Talbott v. Commonwealth*, Ky., 968 S.W.2d 76, 85 (1998).

E. Caselaw

1. "We have also held that mental illness and extreme emotional disturbance are not the same thing..." *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991).
2. "Evidence of mere 'hurt' or 'anger' is insufficient to prove extreme emotional disturbance." *Talbott v. Commonwealth*, Ky., 968 S.W.2d 76, 85 (1998).

3. "The Commonwealth still has the burden of proof, but in order to justify an instruction on the lower degree there must be something in the evidence sufficient to raise a reasonable doubt whether the defendant is guilty of murder or manslaughter." *Gall v. Commonwealth*, 607 S.W.2d 97, 108 (Ky. 1980). See also *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991).
4. Extreme emotional disturbance is not a defense to wanton murder. *Todd v. Commonwealth*, 716 S.W.2d 242, 246 (Ky. 1986).
5. The absence of extreme emotional disturbance is not an element of the crime of murder. See *Wellman v. Commonwealth*, 694 S.W.2d 696, 697 (Ky. 1985), and *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (Ky. 1991). However, "once evidence of EED is introduced, the absence thereof becomes an element of the offense of murder." *Coffey v. Messer*, Ky., 945 S.W.2d 944, 946 (1997).
6. "Extreme emotional disturbance, if present, merely mitigates a charge of murder, but permits an instruction on voluntary manslaughter, and should be left to the jury." *Morris v. Commonwealth*, 766 S.W.2d 58, 60 (Ky. 1989). See also *Haight v. Commonwealth*, Ky., 938 S.W.2d 243, 248-249 (1997).
7. Instruction on extreme emotional disturbance may be waived by trial *counsel. Davis v. Commonwealth*, Ky., 967 S.W.2d 574, 578 (1998).
8. It is wholly insufficient for accused defendant to claim defense of extreme emotional disturbance based on gradual victimization from his or her environment, unless additional proof of triggering event is sufficiently shown. The event which triggers the explosion of violence must be sudden and uninterrupted. *Foster v. Commonwealth*, 827 S.W.2d 670 (Ky. 1992).
9. Extreme emotional disturbance required jury to place themselves in actor's position as he believed it to be at the time of the act, and if jury finds existence of extreme emotional disturbance, offense of murder is reduced to manslaughter in the first degree. *Holbrook v. Commonwealth*, 813 S.W.2d 811, 815 (Ky. 1991) (overruled on other grounds in *Elliott v. Commonwealth*, Ky., 976 S.W.2d 416 (1998).
10. Separate instruction on extreme emotional disturbance and definition of extreme emotional disturbance are necessary. *Holbrook v. Commonwealth*, 813 S.W.2d 811, 815 (Ky. 1991).
11. Defendant was convicted of assault in the third degree, wanton endangerment in the second degree, and resisting arrest. "KRS 508.040 allows mitigation for those offenses involving intentional conduct as described under KRS 508.010, 508.020, or 508.030 (first-, second-, and fourth-degree assault). It is clear that the legislature in enacting 508.025, coupled with 508.040, did not intend to allow for mitigation for assaulting a peace officer while under extreme emotional disturbance." *Wyatt v. Commonwealth*, 738 S.W.2d 832, 834 (Ky.App. 1987).
12. *Morgan v. Commonwealth*, 878 S.W.2d 18 (Ky. 1994). Defendant convicted of murdering his wife. Trial court refused to give instruction on extreme emotional disturbance. Conviction affirmed. Defendant did not testify. "There was no evidence that at the time of the act of homicide, there was some event, some act, some words, or the like to arouse extreme emotional disturbance which is absolutely necessary. ...[A]n extreme emotional disturbance instruction is justified 'when there is probative, tangible and independent evidence at the time of the [defendant's] act which is contended to arouse extreme emotional disturbance.'" *Id.* at 21. See also *Hudson v. Commonwealth*, Ky., 979 S.W.2d 106, 109 (1998), and *Tamme v. Commonwealth*, Ky., 973 S.W.2d 13, 36-37 (1998).
13. *Hunter v. Commonwealth*, 869 S.W.2d 719 (Ky. 1994). Amount of evidence necessary to warrant penalty phase instruction on extreme emotional disturbance is lower than amount necessary for guilt phase instruction on the same point. *Id.* at 726 (see also KRS 532.025(2)(b) (2)).
14. *Whitaker v. Commonwealth*, 895 S.W.2d 953 (Ky. 1995). The defendant was convicted of murdering his wife. Evidence indicated that the defendant had gone to his wife's place of employment, asked her to sign some tax documents, and then shot her in the head at close range. The defendant claimed at trial that he could not recall the actual shooting. Instructions on extreme emotional disturbance and first-degree manslaughter were rejected by the trial court. As to the denied instructions the court found no error. The court found that there was no evidence to indicate the defendant was under the influence of extreme emotional disturbance or that any circumstances existed at the time of the killing to provoke such a disturbance. "Evidence of extreme emotional disturbance must be definite and nonspeculative." *Id.* at 954. The court stressed that there "must be an event triggering the explosion of violence on the part of the defendant." *Id.*

## IV. GUILTY BUT MENTALLY ILL

A. Definition - KRS 504.060(6)
"Mental illness" means substantially impaired capacity to use self-control, judgment or discretion in the conduct of one's affairs and social relations, associ-

ated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior, or emotional symptoms can be related to physiological, psychological or social factors.

B. Written Notice Requirement of Expert Testimony to Prosecutor and Court
   - see II(B) of this outline

C. Written Notice Requirement of Defense
   - see II(C) of this outline

D. Reciprocal Discovery
   RCr 7.24(3)

E. Prosecutor or Court's Right to Examination of the Defendant - see II(E)(1) and (2) of this outline

F. Burden of Proof
   - see KRS 504.130(1)(b)

G. Instructions
   - see II(G) of this outline

H. Kentucky Caselaw
   1. The Supreme Court is "concern[ed] with the constitutionality and effectiveness of the GBMI verdict." *Brown v. Commonwealth*, 934 S.W.2d 242, 245 (Ky. 1996). "[I]t appears that the time may have arrived for this Court to evaluate that statute." *Id.* "We caution, however, that this decision does not put to rest the issues of the constitutionality of the GBMI statute and the content of the instructions – especially with regard to treatment – to be given to the jury in a GBMI case." *Id.* at 249. See the opinion for the arguments to make as well as the type of proof the Court is requiring.
   2. Mental illness and extreme emotional disturbance are not the same thing. See *Sanders v. Commonwealth*, 801 S.W.2d 665 (Ky. 1991), and *Wellman v. Commonwealth*, 694 S.W.2d 696 (Ky. 1985).
   3. Instructions need not inform jury of the consequences of a verdict of guilty but mentally ill. See *Sanders v. Commonwealth*, 801 S.W.2d 665, 679 (1991). Additionally, under *Mitchell v. Commonwealth*, 781 S.W.2d 510, 512 (Ky. 1989), defense counsel may not comment on the result of a guilty but mentally ill verdict. However, see RCr 9.55 which became effective on November 15, 1991, and appears to override the *Sanders* and *Mitchell* cases.
   4. A task force on "law, violent crime and serious mental illness" has proposed repeating guilty but mentally and deleting it from KRS 504.120(4), KRS 504.130, KRS 504.140, and KRS 504.150.

## V. EXPERTS

A. Sufficient Showing by Trial Counsel

Mental Health Consultant

1. *Binion v. Commonwealth*, 891 S.W.2d 383 (Ky. 1995). Prior to trial, the defendant indicated that he was going to present an insanity defense. The trial judge ordered that Kentucky Correctional Psychiatric Center conduct an examination to determine if defendant was competent to stand trial. The examining psychologist found the defendant competent to stand trial and then the trial judge ordered another evaluation to determine if the defendant was criminally responsible at the time of the crimes. "The trial judge indicated that if it was determined that a question existed regarding Binion's sanity at the time of the crimes, he would grant the motion to provide a defense mental health consultant." *Id.* at 384. Later, "the trial judge overruled Binion's request for an independent defense mental health consultant. The trial judge ultimately determined that Binion had been provided with a neutral examination which he considered sufficient to meet due process requirements." *Id.* at 385. The appellate court first held that, "the trial judge properly required Binion to submit to an initial evaluation through KCPC." *Id.* The KCPC report "cataloged a variety of mental problems and experiences in the mental history of the defendant." *Id.* The appellate court went on to hold that, "the appointment of Dr. Smith as a *neutral mental health expert was insufficient* to satisfy the constitutional requirement of due process because the services of a mental health expert should be provided so as to permit that expert to conduct an appropriate examination and assist in the evaluation, preparation and presentation of the defense. The benefit sought was not only the testimony of a mental health professional, but also, the assistance of an expert to interpret the findings of the expert used by the prosecution and to aid in the presentation of cross-examination of such an expert. The defendant was deprived of his right to a fundamentally fair trial and due process without such assistance... [Due process] also means that there must be an appointment of a psychiatrist to provide assistance to the accused to help evaluate the strength of his defense, to offer his own expert diagnosis at trial, and to identify weaknesses in the prosecution's case by testifying and/or preparing counsel to cross-examine opposing experts." (emphasis added) *Id.* at 386. See also *Harper v. Commonwealth*, Ky., 978 S.W.2d 311, 314 (1998).
2. *DeFreece v. State*, 848 S.W.2d 150 (Tex.Cr.App. 1993). Even if harmless error analysis applied, failure to appoint psychiatrist to assist murder

defendant in preparing defense was not harmless where assistance of expert to interpret voluminous medical records could have assisted defense counsel in cross-examining state witness, only contested issue at trial was sanity, and jury deliberated for five hours before convicting defendant.

3. Electroencephalogram (EEG)
*United States v. Hartfield*, 513 F.2d 254 (9th Cir. 1975). Defense in this attempted armed robbery case was entitled to money to have an EEG run when the defendant's defense "turned on his mental condition." *Id.* at 258.

B. Insufficient Showing by Trial Counsel

1. *Simmons v. Commonwealth*, 746 S.W.2d 393 (Ky. 1988). In this case, on a joint motion, the appellant was transferred to the Kentucky Correctional Psychiatric Center for an evaluation. A psychiatrist found the appellant to be competent to stand trial. The psychiatrist testified in behalf of appellant at the guilt phase of the trial and a social worker testified at both the guilt and the sentencing phase. "Appellant requested that funds be provided for the appointment of two independent psychiatrists, two independent psychologists, and one licensed clinical social worker to examine him." The court held that, "the appellant failed to show a necessity for the expert assistance he requested. He stated in general terms only that expert assistance was needed to prepare adequately for trial and possible sentence hearing. He did not state the names of any doctor or social worker that he desired to examine him, nor did he furnish any estimate of the costs. He further did not state what he expected to show or in what manner the requested assistance would be of any specific benefit to him. He made no challenge to the competency of Dr. Ravani or that Dr. Ravani was uncooperative with him or was not available for consultation. The only objection that he made to the examination by Dr. Ravani, pursuant to the court order, was that the information given to Dr. Ravani would not be treated with confidentiality but, nevertheless, he used Dr. Ravani as a witness in his behalf. The Commonwealth presented no psychiatric evidence in support of any aggravating factor in his capital murder cases." The court held "that appellant was provided competent expert psychiatric and social worker assistance, which he utilized in his trial and that he failed to establish that further expert assistance was reasonably necessary for his defense."
2. *Smith v. Commonwealth*, 734 S.W.2d 437 (Ky. 1987). The trial judge denied funds to the defendant to hire a defense pathologist and for a crime scene or ballistics expert. "Here Smith seeks to prove his mental state by the testimony of either a ballistics expert or a crime scene reconstruction witness... We do not believe that the expert assistance Smith claims he needed had anything to do with his defense which was that the murders were wanton, rather than intentional. The evidence he believed he needed was available through the use of state experts and facilities. He did not take advantage of the assistance available. At trial he cross-examined both the firearms examiner and the police sergeant in charge of the investigation of the homicides. The firearms examiner indicated that he had discussed the case with and cooperated with the defense attorney. Under the circumstances, it does not appear that the services of an independent ballistics expert were reasonably necessary." *Id.* at 447- 448. Additionally, there was no reversible error due to the denial of funds to obtain the testimony of a psychologist regarding the defendant's intelligence. "Nothing in his behavior or in the content of his confession indicates his inability to understand. There was no showing that the assistance of an expert would produce anything that was reasonably necessary for his defense." Id. at 450. The court went on to point out that the defendant "did not rely on or pursue an insanity defense and the record is devoid of any indication of mental disease or defect." Id. at 450.
3. *Todd v. Commonwealth*, 716 S.W.2d 242 (Ky. 1986). Defendant was indicted for *wanton* murder. Intoxication is not a defense to wanton murder. Therefore, a defendant does not have a right to an independent psychiatrist to aid in presenting defense or mitigation of intoxication. Extreme emotional disturbance is not a defense to the crime of wanton murder. Therefore, the defendant did not have the right to an independent psychiatrist to aid in presenting mitigation of extreme emotional disturbance. The court pointed out that nothing had been filed by the appellant to indicate that he intended to raise insanity as a defense. The defendant "had a history of treatment for mental health problems. *He could have submitted those records to have established before the lower Court a definite proclivity towards possible insanity*; however, instead on his own request these were filed on a sealed basis, to be opened only for appellate review. Nevertheless, we cannot review these records and make a determination on the factual matter of Mr. Todd's history when the trial court has not had the similar prior opportunity; this is axiomatic of appellate practice." (emphasis added) *Id.* at 247. The defendant had been examined in the Kentucky Correctional Psychiat-

ric Center. The court pointed out that the defendant had also failed to seek that the Kentucky Correctional Psychiatric Center report be expanded to include the specific finding on the question of sanity. "The absence of this information does not in and of itself automatically trigger the need for a *second* evaluation by an independent agency." *Id.* at 247.

4. *Rackley v. Commonwealth*, 674 S.W.2d 512 (Ky. 1984) (overruled on other grounds in *Beddl v. Commonwealth*, Ky., 870 S.W.2d 779 (1994). "Appellant moved for further psychiatric examination because the report indicated that the appellant had stated that he had blackout spells when he drank to excess (hardly a rare malady). The further reason given was that the attorney for the appellant felt that his client was 'psychologically weak.' ...This assertion of error is without merit." *Id.* at 514.
5. *Kordenbrock v. Commonwealth*, 700 S.W.2d 384 (Ky. 1985). "From a perusal of the hearing and other statements, it appears that the underlying basis for psychiatric testimony was primarily for the penalty phase of the trial... We do not believe a defendant in a case such as this has a right to a psychiatric fishing expedition at public expense, or an in-depth analysis on *matters irrelevant to a legal defense* to the crime." (emphasis added) *Id.* at 387.

C. Continuance for Examination

*Hunter v. Commonwealth*, 869 S.W.2d 719 (1994). "The first issue is the trial court's denial of defense motions for continuances, resulting in insufficient time for appellant to be examined thoroughly by a mental health expert. This violation of due process deprived appellant of the opportunity to explore fully (a) present competency, (b) possible guilt phase defenses, (c) penalty phase medication evidence, and/or (d) possible exemption from the death penalty because of mental retardation." *Id.* at 720.

D. Necessary Expense

*McCracken County Fiscal Court v. Graves*, 885 S.W.2d 307 (Ky. 1994). This case was a capital murder case. Time spent by defendant's psychologist in hallway outside courtroom, waiting for opportunity to give testimony by avowal outside the presence of jury was not chargeable to county as a necessary expense because it was reasonable to assume that the avowal would not occur until the end of the jury's normal day, and the psychologist could have returned to his office until that time. However, the time spent by the defendant's psychologist, observing as the defendant was interviewed by the prosecution's psychiatrist, was a necessary expense required to be paid by the county. Under KRS 504.080(5), the defendant's expert had a right to participate in the state's examination and, therefore, the defendant's availing himself of what the law provided in his interest must be considered a necessary expense. The court "believed [t]hat whether a defendant avails himself of this opportunity is strictly a matter of legal strategy to be decided by defendant and his counsel. It is not a question for the defense expert to decide; nor is it a question for the trial court." *Id.* at 313.

E. *Ex Parte* Procedure

1. KRS 500.070(2) - "No court can require notice of a defense prior to trial time."
2. *Ake v. Oklahoma*, 470 U.S. 68, 105 S.Ct. 1087, 84 L.Ed.2d 53 (1985). "When the defendant is able to make an *ex parte* threshold showing to the trial court that his sanity is likely to be a significant factor in his defense, the need for the assistance of a psychiatrist is readily apparent." 470 U.S. at 82-83, 105 S.Ct. at 1096, 84 L.Ed.2d at 66.
3. In Jefferson County, "counsel for a person who is financially unable to pay for…experts…may request funds for those services in an *ex parte*, in camera application to the judge…." JRP 604B. In Fayette County, "a defendant in a pending criminal proceeding, who is a needy person as defined by KRS Chapter 31, may apply ex parte to the Court for the payment of…expert… services necessary for an adequate defense." RFCC 8B.
4. *Brooks v. State*, 385 S.E.2d 81 (Ga. 1989). "While exercising that right, a defendant also has the right to obtain that assistance without losing the opportunity to prepare the defense in secret. Otherwise, the defendant's 'fair opportunity to present his defense,' acknowledged in *Ake*, will be impaired... It is clear that in making the requisite showing defendant could be placed in a position of revealing his theory of the case. He therefore has a legitimate interest in making that showing *ex parte*... We find, further, that under ordinary circumstances, the trial court can evaluate the necessity for expert assistance without the benefit of cross-examination of the defendant by the state. We affirm the trial court's order that an application for funds be presented to the court in chambers. The matter will be heard *ex parte*. The state may submit a brief, which will be considered at the time of the *ex parte* hearing. The *ex parte* proceeding shall be reported and transcribed as part of the record but shall be sealed in the same manner as are those items examined *in camera*." *Id.* at 84.
5. *McGregor v. Oklahoma*, 733 P.2d 416 (Okl., 1987). In this case, an evidentiary hearing was scheduled to determine whether the defendant

was entitled to a court-appointed psychiatrist under the holding of *Ake v. Oklahoma*. The defendant filed a motion requesting the district court to hold the hearing *ex parte*. The trial court overruled the motion and the defendant petitioned the appellate court for a writ prohibiting inclusion of the district attorney at the hearing and ordering the district court to conduct the evidentiary hearing *ex parte*. The court stated, "we are compelled to agree with the petitioner's assertion that there is no need for an adversarial proceeding, that to allow participation, or even presence, by the State would thwart the Supreme Court's attempt to place indigent defendants, as nearly as possible, on a level of equality with non-indigent defendants." *Id.*

6. *Corenevsky v. Superior Court*, 204 Cal.Rptr. 165 (Cal., 1984). The court held that counsel for the county funding source for expert funds was not entitled to be present at the *ex parte* hearing. Such a "procedure would create unnecessary conflicts of interest; in any event, county counsel's presence cannot be permitted because such petitions are entitled to be confidential." *Id.* at 172.
7. *United States v. Sutton*, 464 F.2d 552 (5th Cir. 1972) The purpose of the *ex parte* motion for funds is to "insure that the defendant will not have to make a premature disclosure of his case." *Id.* at 553.
8. *Marshall v. United States*, 423 F.2d 1315 (10th Cir. 1970). "The manifest purpose of requiring that the inquiry be *ex parte* is to insure that the defendant will not have to make a premature disclosure of his case." *Id.* at 1318.

F. Presence of Defense Expert During Examination by Prosecution's Expert

*Sanborn v. Commonwealth*, Ky., 975 S.W.2d 905 (1998). The court noted approvingly that defense counsel obtained a court order requiring presence of the defense expert during the interviews conducted by the prosecution's expert.

## VI. POTENTIAL SOURCES OF EVIDENCE FOR DEFENSE

A. Records of Prior Hospitalizations
Example - Central State Hospital, Our Lady of Peace, Kentucky Correctional Psychiatric Center

B. School Records - Typically these contain an IQ score - may be best source since the records go a long way in rebutting claim by prosecutor of malingering.

C. Mental Health Professionals
1. Psychiatrist
2. Psychologist - Use of psychological testing
3. Social Worker

D. Family, Friends, Teachers, and Neighbors - Case of *Jewell v. Commonwealth*, 549 S.W.2d 807 (Ky. 1977) (overruled on other grounds in *Payne v. Commonwealth*, Ky., 623 S.W.2d 867 (1981)), allowed opinion evidence by lay witnesses, defendant's brother and sister, on issue of sanity.

E. Arrest Slip
Example - An arrest slip-stating defendant is "slow."

F. Jail Records
Example - Medication records

G. Defense Attorney's Investigator
Example - An investigator transports a defendant to and from court. Investigator develops sufficient contact with a defendant to describe his mental condition.

H. Pretrial Report
Example - The report has notation that defendant was incoherent and unable to complete the interview.

I. Social Security Records
Example - Report of Administrative Law Judge finding defendant to be schizophrenic and qualifying for disability payments.

J. Juvenile Court Records
Example - Psychological testing. Evidence of abuse from parent or other family member.

K. Discovery
Example - Investigative letter describing interview by detective with neighbor who details bizarre behavior of the defendant.

L. Booking Photo

M. Medical screening form at time of arrest

N. Psychiatric/psychological records of immediate family members

O. Audiotape of district court arraignment
Example - Defendant rambling that he is "Jesus."

P. Videotape of circuit court arraignment

## VII. ETHICAL CONSIDERATIONS WHEN REPRESENTING MENTALLY ILL CLIENTS

A. Kentucky Rules of Professional Conduct (KRPC)

1. RULE 1.14 CLIENT UNDER A DISABILITY
   a. When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of [minority] age, mental disability or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal cli-

ent-lawyer relationship with the client.

b. A lawyer may seek the appointment of a guardian or take other protective action with respect to a client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest.

2. Comment 2 to RPC 1.14 - "...If the person has no guardian or legal representative, the lawyer often must act as de facto guardian...".
3. Comment 2 to RPC 1.2 - "In a case in which the client appears to be suffering mental disability, the lawyer's duty to abide by the client's decision is to be guided by reference to Rule 1.14."

B. Model Code of Professional Responsibility - EC 7-12

"Any mental or physical condition of a client that renders him incapable of making a considered judgment on his own behalf casts additional responsibilities upon his lawyer. Where an incompetent is acting through a guardian or other legal representative, a lawyer must look to such representative for those decisions which are normally the prerogative of the client to make. *If a client under disability has no legal representative, his lawyer may be compelled in court proceedings to make decisions on behalf of the client.* If the client is capable of understanding the matter in question or of contributing to the advancement of his interests, regardless of whether he is legally disqualified from performing certain acts, the lawyer should obtain from him all possible aid. *If the disability of a client and the lack of a legal representative compel the lawyer to make decisions for his client, the lawyer should consider all circumstances then prevailing and act with care to safeguard and advance the interests of his client.* But obviously a lawyer cannot perform any act or make any decision which the law requires his client to perform or make, either acting for himself if competent, or by a duly constituted representative if legally incompetent" (emphasis added).

C. Right of Defendant to Waive Insanity Defense

1. *Dean v. Commonwealth*, 777 S.W.2d 900 (Ky. 1989).
   a. "[C]ounsel must respect the defendant's authority to make critical decisions concerning his defense." Id. at 908. Court cited as authority EC 7-7 of the *Code of Professional Responsibility* which had been adopted by SCR 3.130 and was in effect at the time the case was decided.
   b. "[T]he decision to assert the defense of insanity may seriously compromise a defendant's chosen alternative defense, as well as threaten his liberty and reputational interests and other legal rights." 777 S.W.2d at 908.
   c. "If, after counsel has fully informed the defendant of relevant considerations bearing on the decision to forego the insanity defense, the defendant insists on an ill-advised course of action, counsel should bring the conflict to the attention of the trial court by seeking a determination of whether the accused is capable of voluntarily and intelligently waiving the defense." *Id.*
   d. "Even if a defendant is found competent to stand trial, he may not be capable of making an intelligent decision about his defense." *Id.*
   e. "If the trial judge determines the defendant is incapable of voluntarily and intelligently waiving the defense of insanity, counsel must proceed as the evidence and counsel's professional judgment warrant." *Id.*
   f. "If the defendant is found capable of waiving the defense, both counsel and the trial court must proceed according to the defendant's wishes." *Id.*

2. *Jacobs v. Commonwealth*, 870 S.W.2d 412, 418 (Ky. 1994). "Therefore, we hold that upon retrial, should there be a conflict between Jacobs and defense counsel concerning asserting the defense of insanity, and should there be a question as to Jacobs' mental capacity, although found competent to stand trial, the trial court shall hold a hearing as to Jacobs' ability to voluntarily and intelligently understand and waive such defense, and such hearing shall be on the record, and upon the finding of the trial court as to Jacobs ability to voluntarily and intelligently understand and waive such defense, defense counsel shall be bound. Said otherwise, on this particular issue, it is the trial court who shall determine if the defendant is the master of his own defense and pilot of the ship."

**NOTE:** In same case Kentucky Supreme Court later granted defendant's request for a writ of prohibition which reversed trial court's ruling that the hearing need not be *ex parte*. Unfortunately the opinion is unpublished. ■

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# Chapter 3: Mental Health Problems

by Roger Gibbs

## Competency to Stand Trial

1. You're in Circuit Court, and you meet a client for the first time at arraignment when the Public Defender's Office is appointed to represent him or her. After arraignment, client's sister advises you of the following:

   a. That your client has had problems with his "nerves" for a long time;

   b. That he is taking some medication from a doctor, but she's not sure what it is, and;

   c. That your client is not very smart and dropped out of school when he was 16.

   What do you need to do?

2. You're in Circuit Court at arraignment, and the Court is inquiring of your client as to his eligibility for a Public Defender. When he asks your prospective client if he's employed, he says, "yes." When the Judge says, what does he do? He responds, "I am king of the world."

   What are your obligations for this client?

   What are the Court's obligations?

   What are possible strategies to employ regard-ing the appointment of counsel, the Court's ordering the defendant to KCPC, and the prosecutor being involved in any further conversations with this defendant?

   Does it make a difference if your client is charged with a serious homicide?

3. You made a motion in Circuit Court for your client to be evaluated at KCPC. However, be-cause your county has a contract with the local Comp Care, Seven Counties, or other mental health associations, the competency evaluation of your client was done in the local jail, and he was never sent to KCPC. The report has come back finding your client competent to stand trial.

   What do you do?

## Criminal Responsibility

1. You're in your office and you receive a phone call from a person's sister. This person is housed in your local jail. This person stands accused of having shot their neighbor. The sister asks that you go and immediately speak to this person. Pursuant to Chapter 31, you go to the jail to speak to the person. When you're there, you find the following:

   a. That the jail has isolated this person, and removed belts, shoe strings, pillow cases, etc., and tells you that this - person is suicidal;

   b. The jail also says they've had a long history of problems with this particular person, and;

   c. When you actually meet with this client, it appears that he or she is babbling.

   What should you do under these circumstances?

2. You have received from KCPC a report. The report is divided into two parts. The examining doctor at KCPC has found that your client is now competent to stand trial. However, this doctor says that your client was not criminally responsible for his acts at the time they were committed.

   What are your obligations in regards to the criminal responsibility report which was sent exclusively to you?

   What is your strategy?

   What things do you think you need to know before you pursue any type of strategy?

3. Your client has a factual defense to the offense charged. He also has a long history of verifiable mental illness, and a report from a KCPC doctor that says that it is highly possible that he was not criminally responsible at the time of his acts.

   Your client wants to pursue the factual defense. You, after consultation with other attorneys and brainstorming the case, feel that an insanity defense is your best option.

   What do you do?

   What are your obligations?

   What are the rights of your client?

### Mental Retardation

1. You have just received a case from a private attorney who is relieved from the case be-cause your client's family was unable to afford to continue to retain him. The attorney tells you that this client is slow. However, he did make all of his office appointments, and has been able to communicate about witnesses, dates, etc.

   At the client's first meeting with you, it ap-pears that the private attorney's advice to you that this client was slow was correct. However, he did make his appointment with you and make it in a punctual manner. He can talk about the case with you.

   What issues present themselves with this client?

   What are your obligations?

   What is it that you need to know about this client?

### Extreme Emotional Disturbance

1. Your client has a verifiable history of mental illness. He is accused of coming home and finding his wife in bed with another lover. He shoots, seriously injuring, both of them, but both of them live.

   What problems and possibilities do you see?

   Do you have your client testify?

2. Your client is arrested for shooting his brother. When the police arrive at the home they shared in common, they found it to be in a state of upheaval, with things strewn every-where, with lights broken, doors kicked in, etc. The brother was found in his own bed, shot one time in the head. Your client gives no statement. Police gunshot residue test, ballistics test, etc., point to your client as the shooter. Your client has a felony record.

   Do you have him testify?

3. Under the facts of the first question in this section, you have your client evaluated for competency/insanity. Your independent expert advises you that you have a good argument for extreme emotional disturbance. She could testify and has test data and interviews to support her position. With proper medication, your client is now competent and insanity may be a tough call for the jury.

   Do you use your expert?

   Do you give notice of your intention to use extreme emotional disturbance? Of your intention to use an expert?

   Will your client have to submit to an evaluation by the state's doctor?

### Guilty But Mentally Ill

1. Your client has a history of mental illness. The prosecutor tells you that the victim's family is aware of this history, and would be willing to settle your client's case on a plea of guilty but mentally ill so that your client can get treatment in the prison system.

   Your response to the prosecutor is what?

   What do you need to advise your client?

   Is this a good deal?

2. The prosecutor, before trial, advises the Court that based upon your filing of a Notice of In-sanity that he wishes to seek jury instructions for guilty but mentally ill.

   Is he entitled to do so?

   What should your response be?

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# Chapter 4:
# Updating Approaches to Client Competence:
## Understanding the Pertinent Law and Standards of Practice

**By John T. Philipsborn**

In 2000, a federal district court in Louisiana wrote one of the most extensive and thoughtful rulings on trial competence available today. The court's ruling in *U.S. v. Duhon* responded to a government agency recommendation for a finding of restoration to competence of an accused who had undergone extensive evaluation, had been found mildly mentally retarded, and had undergone competence "training" while in federal custody.[1]

*Duhon* is notable in at least two ways. First, the court discussed at length the fabric of the case law that defines the meaning of competence to stand trial, and also what it means to be truly restored to competence. Second, the court detailed the various categories of evidence that might be considered in a competence assessment. These ranged from the specific testing processes, to the meaning of the data obtained in testing, through the role played by lay persons' observations, and to the value of an attorney-expert's views on an accused's competence. The discussion includes consideration of the strengths and limitations of the various approaches taken by mental health professionals in assessing and "treating" Duhon.

From NACDL's point of view, the case is distinguished by the fact that the district court chose to rely, in passing, on an article published in *The Champion* describing the limitations inherent in a mental health expert's capabilities of assessing the ability to assist counsel.[2] It is nice to know that a federal district court judge may have been impressed enough by a piece in *The Champion* to have relied upon it – no doubt at the urging of a thorough and imaginative defense lawyer.

On the other hand, the citation is symptomatic of a problem in the competence assessment process. There are few authoritative guides on the standards of practice for both mental health experts and defense counsel in approaching competence assessment.

The dearth of published and accepted standards of practice for lawyers in competence assessments is arguably one of the many causes of the unevenness in the approaches to competence issues.[3] There are few sources to assist lawyers in deciding when, how, and with what approach to raise (or to choose not to raise) a competence to stand trial question in a given case.

Indeed, the courts have been extremely uneven in dealing with the definitions of competence (particularly where state statutes are far afield from U.S. Supreme Court decisions); what categories of evidence should be deemed reliable and valid where competence is at issue; what type of expertise should be relied upon by the trier of fact; what role the appointed or retained trial counsel should play in informing the court (and/or the experts) of the bases for a competence (or incompetence) adjudication; and how the approaches to competence assessments accepted in the mental health community can, and should, be integrated into the judicial findings about an individual's trial competence.

This article discusses some of the approaches experienced criminal de-fense lawyers have used in dealing with competence issues, especially since the previously mentioned article was published in *The Champion* in June 1998.[4]

Insofar as competence questions are among the "standard" mental health questions that arise in criminal cases, an effort is made to review the discussion of these questions offered in the current mental health literature on competence to stand trial questions.[5] This article also urges the leading criminal defense organizations to be more attentive to the development of standards of practice, and to provide more training and continuing education for criminal defense lawyers on trial competence issues. This is not only so that we, as a group, can do a better job in performing our duties, but also so that we can encourage the courts to do a better job of showing the fundamental respect for persons charged with crimes that is the basis for the requirement that a person be com-petent to stand trial.

### Competence And Incompetence Revisited

[If] a Man in his Sound Memory Commits a Capital Offense. . .[a]nd if, After he has Pleaded, the Prisoner Becomes Mad, he Shall not be Tried, for How can he Make his Defence?" Blackstone, *Commentaries* XXIV

In 1960, the United States Supreme Court announced in a simple, one-page opinion what is generally considered the modern statement of the requirement of competence in *Dusky v. United States*.[6] The requirement of competence to stand trial is "rudimentary," and it must be clear that ". . .the trial of an incompetent defendant violates due process."[7], [8] *Dusky* set out what are today generally considered the three basic elements of competence. The accused must: (1) be rational; (2) have a sufficient present ability to consult with counsel with a "reasonable degree" of rational understanding; and (3) have both a rational and factual understanding of the proceedings.[9] Fifteen years after *Dusky*, the Supreme Court decided *Drope v. Missouri*, which added what some commentators consider to be the fourth element of the competence test. This additional element requires that the accused have the ability to assist counsel in preparing his or her defense.[10]

In the years that followed *Dusky* and *Drope*, the techniques and approaches to assessing trial competence were of continuing interest to a specific community of mental health and legal scholars who focused on mental health issues in the criminal courts generally. As has tended to be true about issues involving the intersection of mental health and the law, the "line" defense bar seems to have given the development of standards of practice surrounding the evaluation, assessment, and litigation of competence a fairly wide berth. A review of the draft "ABA Standards on the Prosecution Function and Defense Function," dating back to the decade after the decision in *Dusky,* reveals no specific discussion about competence *per se*.

By 1986, however, the ABA *Criminal Justice Mental Health Standards* addressed a wide variety of mental health and criminal case issues, including competence to stand trial. Anecdotal evidence suggests that these ABA standards were not regularly covered during continuing education programs for the criminal defense bar until the increase in sophistication in the training for death penalty defenders took hold over the last 25 years. Indeed, some otherwise extremely skilled and knowledgeable defense lawyers informally polled during the writing of this piece indicated that they have never received any training on competence assessments.

Since 1986, the United States Supreme Court has decided several cases of importance to our current understanding of competence. Two of these rulings occurred in the early 1990s. The first is *Medina v. California.*[11] There, the Court affirmed a decision of the Supreme Court of California, which had noted in language that has made all too little of an impression on the criminal defense bar that ". . . one might reasonably expect that the defendant and his counsel would have better access than the People [prosecution] to the facts relevant to the court's competency inquiry."[12] In additional language that was anointed by the United States Supreme Court's affirmance, the California Supreme Court had noted that with respect to the ". . .defendant's possible inability to cooperate with his counsel in establishing his incompetence: Counsel can readily attest to any such defect or disability."[13]

This state court *dicta* underscores the value of information possessed by the criminal defense lawyer. This lawyer-based information is something that mental health professionals have integrated into their published approaches to competence assessments — at least at the high end. The assessment of an accused's competence is not a task that should be undertaken without the participation of that client's lawyer — and the *dicta* quoted above supports this view. This truism has been commented on both in published decisions and in the professional literature, in part because only defense counsel in a given case can provide a description of how the lawyer and client are actually interacting, in contrast to what interaction is actually needed in the case context. "One of the most evident issues is whether the assessing professional, usually a psychiatrist or psychologist, really knows what would normally go into the defense of the case."[14]

Indeed, without finding out from counsel of record what the nuances of the charges and available defenses are, and how the accused is interacting with counsel, how does a mental health professional gauge both situational awareness of rights and procedures, and the ability to assist counsel in conducting the defense? Yet, even today, anecdotal evidence suggests that neither mental health experts nor defense counsel participate in this recommended interaction — often out of sheer ignorance of the case law and literature.

Where the question of competence involves the nature, quality, and characteristics of communication (or lack of communication) between counsel and client, defense counsel will often be the best source of information.[15] In a standard work on mental health and the courts, the authors make a succinct point. "The clinician also needs to obtain information from the attorney. . . more important, only the attorney can provide the clinician with information about the length, substance, and nature of previous attorney-client contacts."[16] This practice note should be emphasized to the criminal defense bar and mental health experts.

The second significant U.S. Supreme Court case from the early 1990s was the 1993 decision in *Godinez v. Moran*.[17] For practitioners who want real familiarity with the Court's definition of competence, *Godinez* is a "must read." *Godinez* is really the only case in which the Court has discussed the combination of the characteristics of competence to stand trial and the attributes of the accused who is competent. The *Godinez* court sets out its expectations of the situational awareness that the accused should have of his or her procedural rights, as well as the decisional abilities that are expected to flow from the accused's understanding of the case, and interaction with counsel.

In *Godinez*, the Supreme Court ruled that there was no difference between being competent to plead guilty and being competent to stand trial. The Court emphasized that there are certain decisions that any competent accused will be assumed to have the ability and capacity to make, regardless of whether that person is going to plead guilty or stand trial. The breadth of the abilities and capacities that the court attributes to a competent accused come as a surprise to numerous lawyers and mental health professionals:

"In sum, all criminal defendants — not merely those who plead guilty — may be required to make important decisions once criminal proceedings have been initiated . . . these decisions include whether to waive the privilege against self incrimination, whether to take the witness stand, whether to waive the right to trial by jury. . .whether to decline to cross-examine certain witnesses, whether to put on a defense, and whether to raise one or more affirmative defenses."[18]

Some of the sophisticated recent mental health literature covering competence acknowledges the importance of *Godinez*.[19]

There are other significant trial competence rulings from the U.S. Supreme Court handed down beginning in 1996. In *Cooper v. Oklahoma*, the Court decided that the standard of proof placed on the accused who is attempting to prove his incompetence cannot be so high as to violate the Due Process Clause of the U.S. Constitution.[20] Oklahoma's "clear and convincing" standard proved too high. The *Cooper* opinion reviews the history of the requirement of competence in the Anglo-American legal tradition, and the court rejects a burden of proof by clear and convincing evidence based in part on what it found to be the vagaries of the competence assessment process, on the one hand, balanced against the need for courts to be assured that they are only trying competent people, on the other.

One can read into the *Cooper* decision the view that the mental health assessment sciences have not yet reached a point at which it makes sense to require high standards of proof. Because of the premium put on competence, requiring only proof by a preponderance of the evidence of incompetence will decrease the risk of erroneous findings of competence.

In 2003, the Court reconsidered psychoactive medication and competence in *Sell v. United States*, a decision that builds on the Court's first such decision, *Riggins v. Nevada*.[21], [22] These two decisions will continue to be of great importance, particularly as the mental health professions in state and federal institutions administer psychotropic medications with accuseds facing trial. These cases guide the discussion in any case in which a client facing trial has been administered psychotropic medications, and particularly anti-psychotic drugs that are known, in the literature and/or in the case law, to have extensive side effects. Indeed, there is an entire body of federal and state court case law discussing the level of due process that attends the administration of anti-psychotic medication to persons in custodial settings, some of which serves as a useful backdrop to the litigation of concerns about the effects of anti-psychotics generally.[23]

A secondary but extremely important reason for defense counsel to be familiar with the body of law that regulates the administration of psychotropics to potentially incompetent accuseds is to ensure that trial courts properly consider all factors required by *Sell* before allowing the trial of a person medicated with, or in need of, certain classes of psychotropics to go forward.

One additional recent ruling warrants comment here. It is from the U.S. Court of Appeals for the Ninth Circuit, and involved a non-communicative death row inmate. In *Rohan ex rel. Gates v. Woodford*, the Ninth Circuit decided, first, that an accused must be competent when pursuing federal habeas relief. Second, the Court noted that the competence element requiring the ability for rational communication now has an expanded definition.[24]

As the Court noted, it is no longer only the capacity to communicate rationally that characterizes the compete defendant — it is also, in a larger sense the ability to assist in one's own defense. This is a point worthy of consideration since few competence evaluations are based on examination of the latter ability. Many examiners would not know (without being informed) what goes into the defense of the case at issue. The change in the case law's focus is a subtle elaboration. For example, a mentally retarded or disordered person may have the ability to communicate rationally on basic subjects without having a real ability to assist counsel in the conduct of the defense of a complex case. The same may be true of persons with a wide range of disorders. More generally, this means that competence assessments that focus merely on the *ability to interact* do not measurably advance an understanding of an accused's trial (or post conviction) competence.

**Case Law Yields Variable Assessment Practices**

One is hard pressed to find the United States Supreme Court making reference to the many scholarly articles on the competence assessment protocols, tools, techniques, and instruments available. The reason for mentioning the value of the ruling in *U.S. v. Duhon* in the introduction is that it is one of the very few cases reflecting judicial commentary on what seemed defensible, or indefensible, in a particular competence assessment process. The exception is where the courts discuss questions of "medication into competence" under *Riggins* and *Sell* by urging a combination of methodical fact finding and caution — making note of the literature on the effects of certain classes of psychoactive medications that have yet to be fully understood in the mental health sciences.

However, we have yet to read a decision from the Court dealing with competence issues that goes as far as the Court's 2002 landmark decision in *Atkins v. Virginia* in referring to what might be considered authoritative mental health literature and standards that lower courts and legislatures might consider when establishing statutory requirements for competence adjudications.[25]

In several respects, requiring trial competence without providing anything but a legal definition of the concept has resulted in the absence of precise guidance on how to evaluate and adjudicate competence. This means that there are numerous options open, and the quality of practice has suffered as a result. In essence, the state of the law is such that, at the low end, the litigation practice embodies the *dictum* that "if you don't know where you're going, any road will get you there." The California Supreme Court indirectly acknowledged this problem in commenting on the value of expert testimony specific to competence:

"The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion . . . it does not lie in his mere expression of conclusion."[26]

Reviewing courts rarely address competence questions by expressing concern either at the inadequacy of the lawyering related to a competence issue or on the poverty of an expert's approach that compromised the integrity of proceedings. It is understood that lawyering that is measurably departing from the ABA standards, and what is locally accepted as effective lawyering, may cause reversal of a conviction or death sentence.[27] Since the court's ruling in *Strickland v. Washington*, it has generally been understood that while not controlling, the ABA standards will be viewed as indicative of the standard of practice for lawyers defending criminal cases.[28]

While the federal courts have not issued notable decisions in which ineffective lawyering was viewed as the cause for the poor handling of the accused's possible incompetence to stand trial, there have been a few cases in which the courts were presented with sufficient post-conviction evidence of incompetence that cases have been remanded for a retrospective competence assessment. These are cases in which the question is not whether there was ineffective representation that caused a prejudicial error warranting reversal, but rather whether there is sufficient evidence of incompetence of the accused in the record that there might have been a violation of due process in that an incompetent person was subjected to trial and punishment. These retrospective competence cases give us a type of backward description of what post-conviction courts have viewed as useful sources of information on competence.

The retrospective competence inquiry process first appeared to be disfavored by the United States Supreme Court, which warned that there would be "the difficulty of retrospectively determining an accused's competence to stand trial. . ."[29] However, over time, federal and state reviewing courts have remanded so that trial courts could revisit competence questions. For example, when the Ninth Circuit remanded *Odle v. Woodford* for a retrospective competence hearing, it did so with instructions to the state trial court to determine whether "the record contains sufficient information upon which to base as reasonable psychiatric judgment" the accused's competence to stand trial many years before.[30] Because neither the trial judge nor defense counsel had raised a competence question, the *Odle* court's "recipe" for the determination was extremely basic, encouraging inquiry into the availability of information from the record, any experts, and the lawyers, or investigators who might still be available.

Other courts have issued similarly basic orders for a retrospective competence assessment hearing, noting the expectation that lawyers and examining experts may have useful material available to assist in the retrospective assessment.[31] Significantly, while trial competence standards are described as exclusively legal, in retrospective competence assessment cases, courts have used the "reasonable psychiatric judgment" test to gauge the existence of post-conviction evidence of trial incompetence.[32]

### Understanding of Law Necessary To Comprehend Literature

Because competence to stand trial is a legal requirement, an understanding of the case law and statutes that make up the legal framework of competence is itself an essential foundation for a criminal defense lawyer's reading of the pertinent mental health literature. Dr. Thomas Grisso, one of the leading scholars on the subject of evaluating legal competencies, has written several works that confirm the value of knowing the legal framework of competence to stand trial as a basis for planning, and indeed evaluating, a competence assessment process.

In his recently updated *Evaluating Competencies: Forensic Assessments and Instruments*, Dr. Grisso begins the discussion of the evaluation of competence to stand trial by reviewing the legal standards.[33] This recent discussion of the legal construct of competence is much more extensive than the one contained in his well-known early work on the subject.[34]

Drs. Melton and Poythress, who are mental health experts, joined law professors Petrila and Slobogin to publish their well-known *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers*, which is in its second edition.[35] These authors also set out certain key legal definitions as part of their discussion of legal competencies, including the competency to stand trial.[36] They set forth useful but very brief discussions of the controlling law to introduce legal concepts of importance.

The same is true, though in a different way, of the ABA/SJI *National Benchbook on Psychiatric and Psychological Evidence and Testimony,* which was published in 1998.[37] As with *Melton, et al.*, the *Benchbook* covers a great many topics in the intersection between the mental health sciences and the law. The *Benchbook* also offers some discussion of the salient cases, while not dwelling on the textual analysis of significant United States Supreme Court opinions. The practitioner needs to understand what these good sources of information offer, and what he or she needs to have sought elsewhere.

What emerges from a review of the analysis of the law offered to us by these well-known experts in the field of competence assessments, and forensic mental health assessments generally, is the understanding that they opt for synthesis and a succinct statement of their views on the legal structure and definition of competence. They do not offer a lawyer preparing a case a detailed dissection of the law.

Thus, there is no substitute in this area for a thorough reading and understanding of the pertinent case law. This is not to attack the mental health literature — the manuals written exclusively for lawyers present similar problems. This holds true even though a different approach has been taken in some of the practice manuals that have been developed for the capital defense bar. For example, in the long published *Califor-nia Death Penalty Defense Manual*, the emphasis tends to be on an updating of the case law related to mental health cases. In a section on mental health experts, the *Manual* offers a discussion of recent decisions pertinent to certain mental state mitigation, mental state defense, and competence issues in conjunction with a discussion of some of the pertinent scientific literature.[38]

Admittedly, death penalty defense publications may not be a useful *litmus* of the practice guides available for the criminal defense bar, as death penalty defense is highly specialized. However, death penalty defenders in general are expected to have greater expertise on mental health issues than many of their colleagues. But even a knowledgeable reader of the *Death Penalty Manual* will need to review the relevant cases in approaching a competence inquiry.

A knowledge of the case law exposes those areas in the mental health literature that may need to be reviewed carefully with an examining expert. For example, *Melton, et al.*, discuss "competency to plead guilty" under the rubric of "criminal competencies." As they point out certainly in enough detail to remind the knowing lawyer (and expert), in *Godinez v. Moran* the Supreme Court held ". . . with the majority of federal courts that a person who is competent to stand trial is also competent to plead guilty."[39]

But then, they point out that not all jurisdictions follow *Godinez*.[40] That observation on their part might shock some experts on criminal procedure, in that it is not at all clear that the United States Supreme Court decision in *Godinez* allows the states to require differing standards in the definition of competence to plead guilty versus competence to stand trial. Moreover, the mental health expert who has relied upon *Melton, et al.* to define competence to plead guilty as a separate category from "competence to stand trial," may be open to cross-examination on this point.

This remark is not meant as a criticism of *Melton, et al.*, whose works are well-respected and much cited. However, it is meant to illustrate that in the absence of the acquisition of a good working knowledge of the case law, a lawyer seeking a quick fix of overall competence knowledge might accept as completely defensible a viewpoint stated by authors whose analysis of the law might, at least in the respect just used as an example here, be taken as a minority view.

Therefore, the practice note here is that lawyers approaching a competence assessment should review the applicable case law, concentrating on decisions that cover both the big picture and case specific issues.[41]

**Leading Mental Health Literature Addressing Competence**

When the United States Supreme Court concluded that it is not constitutionally acceptable for the mentally retarded to be executed in *Atkins v. Virginia*, the Court relied in part on the definition of mental retardation found in Sadock and Sadock's, *Comprehensive Textbook of Psychiatry* (7th ed.).[42] That work is cited here because it is an example of a useful text for lawyers seeking to learn about a variety of mental health issues. Its editors deal with competency in a relatively brief section of the book, correctly noting that "legal criteria, not medical or psychiatric diagnoses, govern competency."[43] Their book is filled with cross-references, and the editors steer readers towards well-known sources in the mental health literature on competence to stand trial, including Dr. Thomas Grisso, and Melton, *et al*.[44]

Sadock and Sadock outline the diagnostic criteria for various mental disorders, conditions and issues, while also covering the basic treatment approaches. The book is written as a reference work for mental health professionals. Importantly, since part of what lawyers are concerned about in understanding the mental health professional's approach to competence assessment are the various protocols and guidelines for forensic examinations, the editors provide brief but useful references to the literature, including the guidelines for forensic psychiatric examinations.[45]

Melton, *et al.*, *Psychological Eval-uations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (2d. ed.) has previously been mentioned. This book covers a lot of territory in addition to competence to stand trial. However, it specifically provides a series of useful observations and bits of information that should be known to lawyers approaching competence assessments.

The authors dissect the definition of competence in such a way as to allow a lawyer to understand what a qualified mental health examiner should know about competence. For example, they make the point that "With respect to the first prong of the competency test, for instance, a level of capacity sufficient to understand simple charges. . . may be grossly insufficient when a more complicated offense is involved..."[46] This is a significant point, since many competence examiners do not appear to consider that the nature and complexity of the charge is a consideration in a competence assessment. Lawyers approaching competence assessments need to be thoroughly familiar with literature such as this, which supports the notion that competence assessments are conducted in a context — a point also made by Dr. Grisso, as will be further noted below.

Helpfully, *Melton, et al.* review what is now a somewhat dated list of the various structured evaluation formats and testing protocols available for use by mental health professionals in competence assessments. *Id*. at 139. These include the Competency Screening Test; the Competency

Assessment Instrument; the Interdisciplinary Fitness Interview; the two versions of the Georgia Competency Test; the Computer-Assisted Competency Assessment Tool; the MacArthur Competence Assessment Tool; and the Competence Assessment for Standing Trial for Defendants with Mental Retardation.

Importantly, for our purposes, the authors focus on what mental health professionals need to understand about the attorney-client relationship and attorney-client communications. As previously noted, they, among others, place among the "required" inquiries to be made by the assessing mental health professionals an interview with the defense attorney concerning the length, substance, and nature of previous attorney-client contacts.[47] They make the following important observation:

"Points of misunderstanding about charges and the legal process will be interpreted differently depending on whether they occur after hours of counseling from the lawyer or, as may often be the case given the press of dockets and lawyers' caseloads, after a five-minute meeting at a preliminary hearing. And, as noted previously, information about the quality of the relationship is crucial in addressing this second *Dusky* prong and in fulfilling the consultation role."[48]

Another source that defense counsel should be thoroughly aware of in approaching competence assessments are the pertinent works of Dr. Thomas Grisso. His 1988 workbook entitled *Competency to Stand Trial Evaluations: A Manual for Practice* is useful, though now not only supplanted by some of his own work, but that of other reputable scholars as well. The 1988 work includes a few important observations, particularly where a lawyer is preparing to cross-examine a mental health examiner who has performed a "drive by" examination — characterized by a brief review of a few records, and by one relatively quick interview with the accused, which may or may not have included some competence-specific assessments.

One characteristic of a "drive by" of this type is that often the examiners neither taperecord the sessions nor use a methodical way of documenting both their competence-pertinent questions and the specific answers given. Often, these "drive bys" contain a brief summary of the charges, some anecdotal patient history, notations concerning any records reviewed, and a series of observations about competence. As Dr. Grisso points out, they may not even have a specific methodology that will allow their opinion to be compared with those of other examiners. The end product of these sad professional exercises is a conclusion by the examiner largely based on a statement of the examiner's professional qualifications, and an "I know it when I see it" type of assessment.

Noting that mental health professionals have an obligation to keep themselves informed of new developments that arise in their field of practice,[49] Dr. Grisso points out that a defendant may be legally competent for one purpose but not for another, and that the examiner must be careful to have used a method that can be validated for the competence inquiry to which it has been applied.[50]

Thus, in this early work, Dr. Grisso noted that a competency assessment might include five objectives, focused on the description of the defendant's strengths and deficits; a causal explanation for the deficits in abilities that are known to define legal competence to stand trial; a description of mental disorder; possible causes of incompetence, including malingering, or the purposeful faking or exaggerating of deficiencies; the establishment of a relationship between the causal conditions and the deficits in competency abilities; and the interactive significance of deficits in competence abilities.

Dr. Grisso has pointed at one of the great deficits in the competence assessment process, which is that mental health examiners are not held, even in their professional circles, to particular methodologies in competence to stand trial procedures. Thus, it is rare that two examiners use the same methodologies, questions, response formats, and ways of evaluating the examinee's responses.[51]

In a more recent work published in 2003, Dr. Grisso wrote that while mental health professionals have contributed to some improvements in the assessment of legal competencies, there continues to be a level of ignorance of the legal standards, the relevant professional literature that leads to irrelevance in courtroom testimony. At the same time, because courts and lawyers are often not sufficiently knowledgeable about competence issues, they allow the intrusion of psychiatric and psychological concepts into legal matters such as the definition of competence. Dr. Grisso observed that there is still a problem with the sufficiency and credibility of information provided to the courts to allow reliable competence assessments, while applauding the fact that there are guidelines published by various mental health profession groups that should help improve the panorama.[52] From a practitioner's viewpoint, there are a number of useful points made in Dr. Grisso's work that should be of value to lawyers of all levels of experience. For example, he reiterates the distinction between "screening evaluations," which may consist of an interview, or the administration of one test, and assessments conducted over time, noting the quality and extent of data that one might get through various in-patient or extended out-patient assessment processes.[53]

Moreover, he makes a point that is of great significance, particularly where the objective of the cross-examination is to point out the inherent problems in the competence assessment process. He observes that "little is known empirically about the methods that clinicians actually use in collecting data for competence to stand trial evaluations."[54] There are still a significant number of areas in which the mental health professions have yet to achieve consensus, which result in a lack of standardization and approaches to

report writing on the one hand, or the assessment process on the other.[55]

Grisso repeats the area in which "...[a]lmost all texts describing pre-trial competence evaluations have agreed [, which is] that examiners need structure and a clear conceptualization of their objective, as well as appropriate methods, in order to perform evaluations that will have clinical quality, legal relevance, and practice utility to the courts." *Id*. at 82.

Helpfully, especially for lawyers, Grisso outlines his view of how the various available forensic instruments relate to the assessment process as he understands it. From defense counsel's viewpoint, he offers a very useful "critique" of a number of the standard instruments.[56]

In addition to the several already discussed, there are a number of other valuable works that address competence to stand trial and competence assessments. Well-known scholars have been working in the area for some time. For example, Professors Golding and Bonnie have separately published a number of works pertinent to competence, as have several researchers who have worked on the various MacArthur mental health projects, some of whom have addressed competence issues over the years. Bruce Winnick has for years dealt with various competence assessment issues. He wrote some of the scholarship that dealt with medication and competence issues dating back to the 1970s, and continues to publish today.

Dr. Richard Rogers' work on the assessment of malingering, and on forensic assessments generally, is reflected in several well-received books that he has authored. He has developed and recently published an approach to competence assessment. In addition, several researchers have been working on the issue of competence regarding juveniles, and the need to address (and for lawyers to understand) the important differences between the assessment of adult and juvenile competence. Look for a new Rogers book in 2005 that will offer a very useful addition to the literature on competence assessments.

As a number of mental health professionals point out to lawyers, studies funded by the MacArthur Foundation have produced valuable literature.[57]

### Strengths And Limitations Of Competence Assessment Devices

There are several sources that discuss the generally accepted structured interviews, assessment inventories, and instruments specific to the assessment of competence to stand trial. A number of these have been described, at least by name, in the above review of the pertinent literature. Moreover, these items are all best seen in their original formats, and are more knowledgeably commented upon by the authors whose works have been mentioned at some length in this piece than they are by the present author.

For example, it does not take a great deal of time to review the Competency Screening Test, or any of the other much used competence assessment tools. What is commonly known as "The MacArthur" is an example of a "new generation" assessment tool that requires the uninitiated lawyer to be briefed by a mental health professional who has both the manual and knowledge of the relevant literature, as well as a copy of the screening device available.[58]

The MacArthur uses scenarios presented to the examinee to elicit responses, which are then integrated into the assessment process. The MacArthur Competence Assessment Tool is described as divided conceptually into what the law might describe as separate capability or ability areas, allowing the examinee to be assessed in those specific areas as he or she navigates various scenarios presented.

A number of the older assessment devices clearly concentrate on situational awareness, emphasizing questions such as What does the judge do?, Who is the judge?, What does the jury do?, What does your lawyer do?, etc.

There are new assessment devices being published, and in use, constantly. There are in-patient programs whose clientele involves a large number of persons there for competence assessment, or competence restoration, that have adapted and "retooled" a number of the published instruments and assessment devices. Thus, a practitioner who acquires an understanding of the panorama of assessment tools and devices from the literature may be surprised to find that at a given state hospital, the competence inventory administered for a "situational awareness" is not one of the "standard" and well-known devices.

Not all useful competence assessment inventories are extremely recent. For example, some time ago, Dr. Stephen Lawrence from Southern California, developed what he called the "Lawrence Psychological-Forensic Examination for Use within the Criminal Justice System." This structured interview was designed for a California competence inquiry, but it is well suited, from a lawyer's viewpoint, to help organize a number of areas that involve or implicate competence to stand trial.[59] This instrument is mentioned here as an example of a useful tool that is, in a sense, "off the radar" of mainstream mental health competence assessment tools, but useful for lawyers to review. It is certainly not unique, in that sense. Other experts have also developed worthy materials. It is an example of an inventory that a lawyer can use to gauge how thorough a competence assessment process has been in a given case.

From a lawyer's viewpoint, an examiner's use of a given competence-specific assessment device is only part of the concern. Given that the case law and literature encourage trial lawyers to have input into a client's competence assessment, it makes little sense for lawyers to defer the responsibility of a competence assessment exclusively to a mental health expert. Moreover, as pointed out above, it is

unclear that such experts have any foundation for opining on the significance of attorney-client communications in the absence of consultation with trial counsel.

Without counsel's input, mental health professionals can only provide general information on the accused's "ability to assist in the defense" and, indeed, most mental health professionals do not inquire sufficiently into the characteristics of a given case, the nature of attorney-client communications, and the specific defense strategies (and legal defenses) available, to understand the accused's situational awareness and ability to assist.

It is for this reason, as previously indicated, that it is important for lawyers to understand the accepted protocols for competence assessments, *including* the place that specific competence assessment tools, structured interviews, and situational awareness "tests" used by mental health experts should occupy. No one test or structured interview device is going to provide a sufficient basis for a defensible competence assessment. A competence assessment is contextual, and counsel should treat it as such. Counsel should certainly interact with competence examiners to have input on the elements of a given competence assessment.

### Developing A Client — And Case — Specific Competence Approach

While the case law places *at least* the ability to monitor competence (and in some states, the responsibility to monitor competence) on defense counsel, it is relatively rare for a defense lawyer to have developed a defensible understanding of what goes into a competence assessment. Here, the understanding referred to is not what a mental health professional does in assessing competence, but rather what defense counsel needs to know to assess whether, when, and how to raise the question of a client's incompetence.

A number of well-qualified and well-intentioned lawyers will point out that there are a variety of strategic and tactical reasons for not "fronting" a client's incompetence where there would, in general, be some case-related "loss" for the client. This view is legitimate in the following respects. First, it may be that an amazingly good settlement opportunity is being presented to a client who, in a lawyer's judgment, is marginally competent. The settlement possibility will be eclipsed if a competence question is raised, and therefore, with the long view in mind, the lawyer decides not to raise the issue.

There may be other serious concerns about raising competence questions. For example, in a death penalty case, or in other cases involving mental state issues, raising a competence question will give both the trial court and the prosecution, insight into a client that neither would normally have. In some jurisdictions the prosecution is able to essentially control the nature and extent of the competence assessment. Therefore, a competence inquiry amounts to a combination prosecutorial discovery and prosecution evidence, notwithstanding the rules of judicial immunity that may limit the collateral uses of a client's statements during a competence assessment. Careful planning of a prosecution competence assessment may allow the prosecutor to assemble ammunition to rebut a mental state defense, and perhaps also in a death case, to assemble facts in aggravation, or rebut an *Atkins* claim.

Indeed, because of the U.S. Supreme Court's ruling in *Atkins*, there are even more refined questions asked of a capital case defender today than previously. For example, it may be that the lawyer who suspects that his or her client is likely both mentally retarded and incompetent will feel that the presentation of a competence question will trigger an examination of the client intended to neutralize defense evidence of mental retardation. Thus, a death penalty defense team might delay the raising of the competence question until the assessment, and even the adjudication, of the *Atkins* issue takes place — knowing that such an adjudication may actually have a bearing (either useful or useless) on the later competence adjudication. Indeed, there has already been litigation on the type of protocol that should be used in an *Atkins* examination to differentiate such an assessment from a competence assessment.

Undoubtedly, from a practitioner's viewpoint, outcome-oriented, competence-related decision making is legitimate, and discarding a competence question in favor of obtaining what is defined as a "better" outcome for a client is difficult to argue against. Moreover, it may be that the defenders will be guided by the viewpoint that in any event a competence claim cannot really be waived. This is a risky outlook, however. Indeed, some of the retrospective competence assessment cases demonstrate how difficult it is to prove a client's incompetence during a trial that occurred several and, in some cases, many years ago, especially where trial counsel did little to document the evidence of incompetence. For that reason, especially where the competence "punch" is being pulled, counsel should carefully think through how to memorialize concerns about incompetence so that if a case "blows up," the reality of the client's incompetence is not lost.

### A Competence Issues Checklist

Assuming that the lawyer has arrived at the conclusion that the competence issue must be raised, a number of attendant questions need to be answered. First, in addition to collecting the relevant case law and mental health literature, counsel should begin to define whether the competence question centers around situational awareness, including awareness of procedural and substantive rights, case outcomes, and the like, or the ability to communicate with, and assist counsel, or both.

Second, while considering the practical and strategic issues involved in the release of various forms of client history, counsel should outline what in the available records, including the available medical, psychological and psychiatric treatment records (if there are any), institutional behavior, and attorney-client related interaction records, may either support or undermine a claim of incompetence.

Third, counsel should identify *all* persons who are possible sources of information, and available witnesses, on competence questions, including family, friends, custodial personnel, medical personnel, court staff, and jail visitors.

Fourth, together with one or more mental health professionals, the lawyer should arrive at an understanding of what testing and assessment protocols are indicated, including whether basic psychological testing is needed; whether some understanding of the implications of medication or medical/psychiatric issues is required; and how the examiners propose to use the broad range of competence assessment tools available.

Fifth, the lawyer also should consider what position he or she needs to occupy in the proceedings — whether to remain as counsel of record, or essentially to become a witness. Obviously, there are some dangers in selecting the latter course, but note: the literature on competence clearly assigns an information sharing role to the lawyer of record. Moreover, at the high end, lawyers who have litigated competence issues where the issue centers on attorney-client communication and ability to assist are aware that counsel of record's input is critical.

A lawyer's role can be variable. On the one hand, it can involve discussions with a designated attorney-expert who becomes the lawyer's surrogate (and is a likely witness) during the course of the litigation of the competence question. There is a wide variety of formats used in connection with this type of approach. Counsel of record may allow the attorney expert (who is retained or appointed solely for that purpose) to communicate directly with the client, or to communicate with the client, lawyer, and a wide range of sources of information. In the alternative, counsel of record may use the attorney-expert only to explain: the duties of defense counsel; the requirement of competence and the attributes of competence; how a competent client and defense counsel interact in the defense of that particular type of case. Often the in-court examination of such an attorney-expert involves a series of hypothetical questions.

Sixth, counsel of record must not only plan how his or her own information will be presented to the trier of fact, but also how to interact with mental health professionals on the case. There are a number of different formats that have been used in this respect. Some lawyers have gone so far as to videotape their interaction with the client, knowing that the video tape would be produced to the prosecution, and eventually to the court. However, the videotape, usually covering a discussion involving both situational awareness and ability to communicate issues, provides a unique insight into the nature of the communication problems that may be raised in a given case.

In other settings, counsel have provided experts with a diary, or chronicle of communication issues and problems, together with jail records evidencing a client's psychological deterioration, and increasingly incoherent conversations and statements. A clear record of the transmission of these materials is made so that when mental health professionals testify in proceedings, and essentially base their views on material other than that, counsel can successfully examine to point out that sources of information acknowledged both in U.S. Supreme Court opinions (remember *Medina v. California*), and accepted mental health literature clearly delineate and define the defense lawyer as a valuable front line source of information on trial competence.

Elsewhere, it has proven possible for a mental health professional to essentially serve as the surrogate for the lawyer, by not only using the arsenal of tools available to mental health professionals, but also by videotaping interaction with the client that involves a carefully planned set of questions designed to demonstrate the client's responses to questions involving situational awareness, and ability to assist in the conduct of the defense. On occasion, incidentally, the record of either attorney meetings, or mental health professional meetings, has proven to be extremely long — in part in order to assure the trier of fact that the possibility or hypothesis of malingering, and exaggeration of symptoms was considered.

**Some Pertinent Legal Issues**

At the beginning of this writing, emphasis was placed on the usefulness of the district court's restoration to competence-related ruling in *U.S. v. Duhon*.[60]

For those whose cases involve presentation of evidence under the guidance of the Federal Rules of Evidence or similar rules, the reality is that psychological or psychiatric evidence often falls into a "soft science" area. For example, in federal courts, since *Daubert*, there have been a number of rulings on the threshold for the admission of psychological or psychiatric evidence that is not itself dependent on some new technique.[61]

Under *Daubert*, a central question was "whether the reasoning or methodology underlying the testimony is scientifically valid and whether that reasoning or methodology properly can be applied to the facts in issue."[62] Several federal courts have indicated that the "non-scientific expertise" threshold for the presentation of expert testimony found in *Kumho Tire* is applicable to psychological, psychiatric, and social sciences.[63] Indeed, during the years between *Daubert* and *Kumho Tire*, several circuit courts had already decided that psychological and psychiatric

testimony was really "specialized expertise" rather than testimony that was the product of a specific scientific theory.[64]

Thus, in a number of jurisdictions, where psychiatric and psychological expertise is at issue, the question is whether the expert has the appropriate qualifications; sufficient special knowledge, skill, experience and training to formulate the competence opinion; and generally employed methodologies and techniques that render the evidence sufficiently reliable to be proffered.[65]

Thus, in addition to having reviewed the literature on competence, and competence-specific definitions, counsel should be acquainted with the evidentiary tests, thresholds, and standards applicable to the introduction of expert testimony on competence — carefully differentiating those instances in which an examiner is relying on "a classic" combination of interviews and assessment devices that are recognized in the pertinent literature from those instances in which the examiner has either clearly done insufficient work (according to the literature) or has combined techniques, methods, and tests in a way that is novel and not supported in the literature.

A basic survey of reviewing court decisions where competence was at least one of the issues considered indicates that it is rare that counsel will have made an extremely thorough record where "bad science" has been involved. Thus, we have few opinions that cover research specific to the admission of psychological and psychiatric testimony in a given competence assessment process.

**Every Case**

In 2004, the United States Supreme Court unexpectedly issued a ruling (*Blakely v. Washington*) that has raised substantial questions about sentencing processes around the United States, and may change the way that criminal trials are conducted in certain instances, as well.[66] While astute commentators and scholars may well have predicted that after the seminal *Apprendi* ruling, the Court would be headed towards *Blakely*, before 2004 most practitioners certainly were not litigating their cases as though *Blakely* was looming large on the legal horizon. [67]

It is unclear whether the United States Supreme Court intends to tinker much with the current definition of trial competence, or with the procedures for the assessment of competence. Nonetheless, in subtle ways, since the Court's ruling in *Godinez v. Moran*, it has grown increasingly expansive in its dealings with certain aspects of trial competence. But, the criminal defense bar has continued to treat trial competence almost as a passing matter, a question that is easily addressed. Indeed, there are probably more opportunities for criminal defense lawyers to be trained on the vicissitudes of fingerprint examination than on the requirement of each and every client's competence to stand trial.

With competence, we have used a sort of "learn as we go" approach. Unless a lawyer has taken an accidental interest in learning about competence, or is faced with a competence assessment requiring a fast self-study course on competence issues, many lawyers remain barely acquainted with what competence means, how it should be assessed, and when a client's incompetence should be raised.

The requirement of competence is sufficiently important that we should be learning about it at the same time that we learn trial techniques and the basic skills of criminal defense lawyering. Unlike many aspects of the lawyer's case-specific knowledge, knowing about competence is not something that may be of benefit in only one case in a lifetime. Knowledge of competence and incompetence to stand trial is a factor that plays a part in every case that we handle.

**EndNotes**

1. *U.S. v. Duhon*, 104 F.Supp.2d 663 (W.D. La. 2000).
2. 104 F.Supp.2d 663 at 668, n. 21, citing Burt and Philipsborn *Assessment of Client Competence, A Suggested Approach*, 22 The Champion 18 (June 1998).
3. As used throughout this article, the word "competence" means competence to stand trial, unless otherwise indicated.
4. See n.3 above.
5. There are many types of legally recognized "competencies." As used in this article, the word "competence" means only competence to stand trial in a criminal case.
6. Dusky v. United States, 362 U.S. 408 (1960) *per curiam*.
7. *See Riggins v. Nevada*, 504 U.S. 124, 139-40 (1992), Kennedy, J., concurring.
8. *See Medina v. California*, 505 U.S. 437, 553 (1992).
9. *Dusky v. United States, supra*, 362 U.S. 408.
10. *Drope v. Missouri*, 420 U.S. 162, 171 (1975). The court described these as the basic tests in use today in *Medina v. California, supra*, 505 U.S. 437, 452.
11. 505 U.S. 437 (1992).
12. *People v. Medina*, 51 Cal.3d 870 (1991), *affirmed* in *Medina v. California, supra*, 505 U.S. 437.
13. *People v. Medina, supr*a, at 884-85.
14. *U.S. v. Duhon, supra*, 104 F.Supp.2d 663 at 668, n.21, citing Burt and Philipsborn, *supra*.
15. As noted, this truism is recognized in the mental health literature per Dr. Thomas Grisso, Evaluating Competencies: Forensic Assessments and Instruments, (2d. ed.) Kluwer Academic Publishers (2003). Note that Dr. Grisso points out: the *Godinez* Court included decision-making abilities within the *Dusky* standard." *Id.* at 73.
16. *Id.* at p. 150.
17. 509 U.S. 389 (1993).
18. 509 U.S. 389, 398.
19. A good example of the understanding that an experienced mental health expert brings to this matter is found in Dr. Thomas Grisso, Evaluating Competencies: Forensic

Assessents and Instruments, (2d. ed.) Kluwer Academic Publishers (2003). Note that Dr. Grisso points out: the Godinez Court included decision-making abilities within the Dusky standard." *Id*. at 73.

20. 517 U.S. 348 (1996).
21. *Sell v. United States*, 539 U.S. 166 (2003).
22. *Riggins v. Nevada*, *supra*, 504 U.S. 127.
23. *See Washington v. Harper*, 494 U.S. 210 (1990), a case that discusses the hearing requirements for the involuntary administration of anti-psychotics to a prisoner.
24. 334 F.3d 803, 808 (9th Cir. 2003): "Capacity for rational communication once mattered because it meant the ability to defend oneself [citations omitted] . . . while it now means the ability to assist counsel in one's defense. . ." [further citations omitted]
25. *Atkins v. Virginia*, 536 U.S. 304 (2002).
26. *People v. Lawley*, 27 Cal.4th 102, 132 (2004).
27. *Wiggins v. Smith*, 539 U.S. 510 (2003).
28. *Strickland v. Washington*, 466 U.S. 668 (1984).
29. *Drope v. Missouri*, *supra*, 420 U.S. 162, 182-83.
30. *Odle v. Woodford*, 238 F.3d 1084, 1089 (9th Cir. 2001).
31. *See U.S. v. Mason*, 52 F.3d 1286, 1293 (4th Cir. 1995); *U.S. v. Renfroe*, 825 F.2d 763, 767-68 (3d Cir. 1987); *U.S. v. Johns*, 728 F.2d 953, 957-58 (7th Cir. 1984); *Bolius v. Wainwright*, 597 F.2d 986, 988 (5th Cir. 1979).
32. *People v. Ary*, 118 Cal.App.4th 1016 (2004).
33. *Grisso*, Evaluating Competencies: Forensic Assessment and Instruments,
34. 2d ed., *supra*, at p. 70.
35. *Grisso*, Competency to Stand Trial Evaluations: A Manuel for Practice (Professional Resource Exchange, 1988).
36. 2d Ed.
37. *See Melton*, *et al.*, Ch. 6 and 7.
38. Reference is to the American Bar Association/State Justice Institute National Bench Book on Psychiatric and Psychological Evidence and Testimony (ABA, 1998). The section of the ABA that contributed to the work was the Commission on Mental and Physical Disability Law.
39. This manual, published by the California Public Defenders Association and California Attorneys for Criminal Justice, has been used as a model in various parts of the country. A new edition has been published this year under the editorship of Michael Ogul, who has taken over from well respected death penalty defense counsel, Michael Burt. Burt edited the manual for years prior to the current edition. Thankfully, both Michael Burt and Michael Ogul have a great interest in mental health and the law, and have developed the publication accordingly. The present author has co-authored the sections on mental health experts with Michael Burt and Jennifer Friedman.
40. *Melton*, *et al.*, 2d. ed., at 163.
41. *Ibid.*
42. For example, a lawyer wishing to review an approach to competence assessment and malingering should become familiar with the tortured history of *U.S. v. Gigante*, 982 F. Supp. 140 (E.D.N.Y. 1997) and *U.S. v. Gigante*, 996 F. Supp. 194 (E.D.N.Y. 1998) and Gigante's eventual admission of malingering.
43. This well-respected work is actually published today under the names Kaplan and Sadock. The Comprehensive Textbook covers a wide spectrum of subjects that may arise in criminal cases, and is certainly a compendium well worth knowing.
44. *Id.* at 3285.
45. *Id.* at 3285, 3289.
46. *Id* at 3289 citing Simon, Wettstein, et al. "toward the development of guidelines for the conduct of forensic psychiatric examinations," 25 Journal of American Academy of Psychiatry and Law 17 (1997).
47. *Id*. at 122.
48. Page 150.
49. *Id.* at 150.
50. Introduction, p. xvi.
51. At page 4.
52. Grisso deals with this issue at p. 25 of his 1988 pamphlet.
53. The comments made in the foregoing paragraph are based on Dr. Grisso's writings in Evaluating Competencies: Forensic Assessments and Instruments (2d ed.) at pp. 10-11. Readers should be aware that the writer of this piece has mixed his own commentary with that of Dr. Grisso, who may not view the foregoing text as representative of his thinking.
54. *Id*. at 79.
55. *Id*. at 79-80.
56. Page 81.
57. *Id*. beginning at 89.
58. See the compendium of recent literature produced the MacArthur Adjudicative Competence Study updated through May 2004 at www.macarthur.virginia.edu. For understandable reasons, however, at least some of the emphasis of the MacArthur work, which has included well known mental health experts such as Drs. Bonnie, Monahan, Poythress, Otto, and others focus on the interests of the group of mental health experts who have worked together on, among other things, the MacArthur competence assessment tools such as the MacCAT-CA.
59. A number of mental health professionals will not share a competence assessment tool, or any other kind of an instrument, with a lawyer whose case is pending, and whose client may be "briefed" or otherwise impacted by the lawyer's acquired understanding of the materials reviewed. That said, a number of qualified mental health professionals are more than willing either during training sessions, or on a one-on-one basis, to brief lawyers with whom they are working for any number of valid and useful reasons.
60. The author thanks Michael Burt, his periodic co-author, and occasional co-counsel, and a well-recognized capital case defender from San Francisco for pointing out Dr. Lawrence's work.
61. *Supra*, 104, F.Supp.2d 663.
62. *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993).

63. *Id.* at 592-94.
64. *See Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 150-51 (1999).
65. *See U.S. v. Bighead*, 128 F.3d 1329, 1330 (9th Cir. 1997).
66. *See* a discussion in *U.S. v. Hankey*, 203 F.3d 1160, 1168 (9th Cir. 2000). *See, also, Wilson v. Woods*, 163 F.3d 935 (5th Cir. 1999). *See also* the Second Circuit's opinion in *U.S. v. Hall*, 93 F.3d 1337 (2d Cir. 1996) involving testimony about the symptoms of PTSD. But see, as well, rulings like *Usher v. Lakewood Engineering and Manufacturing Co*., 158 F.R.D. 411, N.D. Ill., 1994) holding results of an MMPI-2 inadmissible because of insufficient correlation and validity proof.
67. *Blakely v. Washington*, 124 S.Ct. 2531 (2004).

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# Chapter 5: Mental Health Issues in Criminal Cases:

## The Elements of a Competent and Reliable Mental Health Examination

by John Blume


- Introduction: Competent Mental Health Evaluations are Critical
- The Constitutional Framework
- The Elements of a Complete, Competent and Reliable Mental Health Evaluation
- Common Deficiencies in Forensic Evaluations
- Choosing Experts
- Meaningfully Presenting Expert Testimony
- Attacking Anti-Social Personality Disorder
- Considering Prior Diagnoses
- Don't be Fooled by the Client
- Essential References
- Conclusion: Complete, Competent, Reliable Evaluations


### I. Introduction: Competent Mental Health Evaluations are Critical

A persistent problem in the defense of criminal (and especially capital) cases, is incomplete, inadequate and unreliable evaluations regarding the defendant's mental state at the time of the offense and at trial. I constantly review trial records where a mental health professional, called by the state (or even at times by the defense), testifies that a defendant was competent to stand trial, not insane at the time of the offense, not under the influence of an extreme emotional disturbance and met all the criteria for the diagnosis of antisocial personality disorder. Another frequent scenario I encounter is to review a trial record where no mental state evidence was put on at all by the defense at trial. Then, either in reviewing trial counsel's file or in talking to trial counsel, I learn that no evidence was presented because there was a "bad" pretrial mental health evaluation.

Over the years, I have learned through experience to view with skepticism all previous mental health evaluations and expert trial testimony. I do so for the simple reason that many of the conclusions reached are either incomplete or wrong. The errors occur because, as will be discussed shortly, these evaluations do not meet existing standards in the mental health profession delimiting the adequacy of forensic mental state examinations. However, as tragic as the consequences of an incomplete or incompetent mental state evaluation might be, the situation is not necessarily irredeemable. An unreliable mental health evaluation often serves as the basis for a constitutional violation with a legal remedy. Furthermore, bringing the true facts to light regarding your client's mental impairments in post-conviction proceedings may establish a viable claim of ineffective assistance of counsel as well as other federal constitutional violations.

The importance of a competent mental health evaluation in criminal and capital litigation cannot be overestimated. It can provide powerful evidence on a range of mental health issues in addition to traditional questions concerning sanity at the time of the offense, competency to stand trial, and mitigation. It can offer a basis for challenging the validity of prior offenses and convictions, for disproving specific intent for underlying felonies as well as the murder itself, and for defending against premeditation and malice. Diminished capacity, extreme emotional disturbance, duress, domination by others, and non-accomplice status are all factors that can be addressed by mental health professionals. A defendant's mental status has obvious implications for defense challenges to events surrounding the arrest and its aftermath such as consent to search, *Miranda* waiver, voluntariness of confessions, and reliability of confessions. A thorough and reliable mental health evaluation is also relevant to any waivers, *i.e.*, of counsel, specific defenses, right to be present at all stages of trial, mitigat-

ing circumstances or a jury trial, as well as to any determination of competency at the various stages of litigation from the preliminary hearing to an execution. The point is clear: *defense counsel should not be precluded from pursuing viable avenues of defense by an incomplete, incompetent or unreliable mental health evaluation*. It is also the purpose of this article to provide counsel with practical steps to follow to secure a competent evaluation at any stage of a case.

## II. The Constitutional Framework

In *Ake v. Oklahoma*, 470 U.S. 68 (1985), the United States Supreme Court held that "the Constitution requires that an indigent defendant have access to the psychiatric examination and assistance necessary to prepare an effective defense based on his mental condition," when the defendant's mental health is at issue. *Id.* at 70. The Court, after discussing the potential help that might be provided by a psychiatrist, stated:

We therefore hold that when a defendant demonstrates to the trial judge that his sanity at the time of the offense is to be a significant factor at trial, the state must, at a minimum, *assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation and presentation of the defense.* This is not to say, of course, that the indigent defendant has a constitutional right to choose a psychiatrist of his personal liking or to receive funds to hire his own. Our concern is that the indigent defendant have access to a *competent psychiatrist* for the purpose we have discussed, and as in the case of the provision of counsel we leave to the states the decision on how to implement this right. *Id.* to 83 (emphasis added).

This holding recognized the entitlement of an indigent defendant, not only to a "competent" psychiatrist (*i.e.*, one who is duly qualified to practice psychiatry), but also to a psychiatrist who performs competently - who conducts a professionally competent examination of the defendant and who on this basis provides professionally competent assistance.

The rationale underlying the holding of *Ake* compels such a conclusion, for it is based upon the due process requirement that fact-finding must be reliable in criminal proceedings. *Id.* at 77-83. Due process requires the state to make available mental health experts for indigent defendants, because "the potential accuracy of the jury's determination is...dramatically enhanced" by providing indigent defendants with competent psychiatric assistance. *Id.* at 81-83. In this context, the Court clearly contemplated that the right of access to a competent psychiatrist who will conduct an appropriate examination would include access to a psychiatrist who would conduct a professionally competent examination. To conclude otherwise would make the right of "access to a competent psychiatrist" an empty exercise in formalism.[1]

Some courts have explicitly or implicitly recognized this aspect of *Ake* holding that the due process clause entitles an indigent defendant not just to a mental health evaluation, but also to a professionally valid evaluation. *See, e.g.*, *Mason v. State*, 489 So.2d 734 (Fla. 1986). Because the psychiatrists who evaluated Mr. Mason pretrial did not know about his "extensive history of mental retardation, drug abuse and psychotic behavior," or his history "indicative of organic brain damage," and because the court recognized that the evaluations of Mr. Mason's mental status were flawed if the physicians had "neglect[ed] a history" such as this, the court remanded Mr. Mason's case for an evidentiary hearing. *Id.* at 735-37; *see also Sireci v. State*, 536 So.2d 231 (Fla. 1988);[2] *but see Waye v. Murray*, 884 F.2d 765 (4th Cir), *cert. denied* 492 U.S. 936, 110 S.Ct. 29, 106 L.Ed.2d 634 (1989).

Similarly, in *Blake v. Kemp*, 758 F.2d 523 (11th Cir. 1985), the court recognized that the defendant's right to effective assistance of counsel was impaired by the State's withholding of evidence "highly relevant, or psychiatrically significant, on the question of [defendant's] sanity" from the psychiatrist who was ordered to evaluate the defendant's sanity. 758 F.2d at 532. Even though that evidence was disclosed to the psychiatrist on the witness stand at trial, "[o]bviously, he was reluctant to give an opinion when confronted with this information for the first time on the witness stand.... This was hardly an adequate substitute for a psychiatric opinion developed in such a manner and at such a time as to allow counsel a reasonable opportunity to use the psychiatrist's analysis in the preparation and conduct of the defense." *Id.* at 532, n. 10, 533.[3]

Additionally, there have been numerous cases where counsel has been found to have rendered ineffective assistance of counsel for failing to adequately develop and present evidence regarding a client's mental state, even in cases in which counsel retained expert assistance. *See, e.g.*, *Baxter v. Thomas*, 45 F.3d 1501, 1514-15 (11th Cir. 1995) (Counsel was ineffective for failing to investigate petitioner's long history of mental illness and resulting psychiatric commitments. Information was readily available had counsel only obtained records. Counsel's omission was prejudicial because "[p]sychiatric mitigating evidence 'has the potential to totally change the evidentiary picture.'"); *Hill v. Lockhart*, 28 F.3d 832, 835 (8th Cir. 1994) (Counsel was ineffective at penalty phase for failing to present in coherent fashion evidence regarding capital defendant's mental state at the time of the offense, history of psychiatric hospitalizations and failure to take anti-psychotic medications); *Deutscher v. Angelone*, 16 F.3d 981 (9th Cir. 1994) (Counsel was found ineffective in successor habeas petition for failing to develop and present mitigating evidence regarding petitioner's history of mental illness. Counsel failed to discover petitioner's history of mental illness, diagnoses of schizophrenia and organic brain damage and his commitments to mental institutions. There was also evidence, which was available and not presented, that petitioner had been severely abused as a child); *Lloyd v. Whitley*, 977 F.2d 149 (5th Cir. 1992), *cert. denied*, 113 S.Ct. 2345 (1993) (Counsel was ineffective for failing to obtain adequate independent mental health evaluation which would have discovered "mental defects" and organic brain damage).

The purpose of this article, however, is not to discuss in detail the legal bases of a challenge to an inadequate evaluation but rather to attempt to outline *what is an adequate evaluation*.

## III. The Elements of a Complete, Competent and Reliable Mental Health Evaluation

As the *Ake* Court held, the due process clause protects indigent defendants against incompetent evaluations by appointed psychiatrists. Accordingly, the due process clause requires that appointed mental health professionals render that level of care, skill, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances.[4] In the mental health area, as in other medical specialties, the standard of care is the national standard of care recognized among similar specialists, rather than a local, community-based standard of care.[5]

### A. The Proper Standard of Care Involves a 5 Step Process Before Diagnosis

In the context of diagnosis, exercise of the proper level of care, skill and treatment requires adherence to the procedures that are deemed necessary to render an accurate diagnosis. On the basis of generally agreed upon principles, the standard of care for both general mental health and forensic mental health examinations reflects the need for a careful assessment of medical and organic factors contributing to or causing psychiatric or psychological dysfunction. H. Kaplan & B. Sadock, *Comprehensive Textbook of Psychiatry*, 543 (4th ed. 1985). The recognized method of assessment, therefore, must include, at a minimum, the following five steps:

**1. *An accurate medical and social history must be obtained.***

Because "[i]t is often only from the details in the history that organic disease may be accurately differentiated from functional disorders or from atypical lifelong patterns of behavior," R. Strub & F. Black, *Organic Brain Syndromes* 42 (1981), an accurate and complete medical and social history has been called the "single most valuable element to help the clinician reach an accurate diagnosis." Kaplan & Sadock, *supra* at 837.

**2. *Historical data must be obtained not only from the patient, but from sources independent of the patient.***

It is well recognized that the patient is often an unreliable and incomplete data source for his own medical and social history. "The past personal history is somewhat distorted by the patient's memory of events and by knowledge that the patient obtained from family members." Kaplan & Sadock, *supra* at 488. Accordingly, "retrospective falsification, in which the patient changes the reporting of past events or is selective in what is able to be remembered, is a constant hazard of which the psychiatrist must be aware." *Id.* Because of this phenomenon,

> [I]t is impossible to base a reliable constructive or predictive opinion solely on an interview with the subject. The thorough forensic clinician seeks out additional information on the alleged offense and data on the subject's previous antisocial behavior, together with general "historical" information on the defendant, relevant medical and psychiatric history, and pertinent information in the clinical and criminological literature. To verify what the defendant tells him about these subjects and to obtain information unknown to the defendant, the clinician must consult, and rely upon, sources other than the defendant. Kaplan & Sadock *supra* at 550.

*See also* American Psychiatric Association, "Report of the Task Force on the Role of Psychiatry in the Sentencing Process," *Issues in Forensic Psychiatry* 202 (1984); Pollack, *Psychiatric Consultation for the Court*, 1 Bull. Am. Acad. Psych. & L. 267, 274 (1974); H. Davidson *Forensic Psychiatry* 38-39 (2d ed. 1965).

**3. *A thorough physical examination (including neurological examination) must be conducted.***

*See, e.g.*, Kaplan & Sadock *supra* at 544 837-38 & 964. Although psychiatrists may choose to have other physicians conduct the physical examination,[6] psychiatrists:

> [s]till should be expected to obtain detailed medical history and to use fully their visual, auditory and olfactory senses. Loss of skill in palpation, percussion, and auscultation may be justified, but loss of skill in observation cannot be. If the detection of nonverbal psychological cues is a cardinal part of the psychiatrists' function, the detection of indications of somatic illness, subtle as well as striking, should also be part of their function. Kaplan & Sadock *supra* at 544.

In further describing the psychiatrist's duty to observe the patient s/he is evaluating Kaplan and Sadock note in particular that "[tlhe patient's face and head should be scanned for evidence of disease.... [W]eakness of one side of the face, as manifested in speaking, smiling, and grimacing, may be the result of focal dysfunction of the contralateral cerebral hemisphere." *Id.* at 545-46.

**4. *Appropriate diagnostic studies must be undertaken in light of the history and physical examination.***

The psychiatric profession recognizes that psychological tests, CT scans, electroencephalograms, and other diagnostic procedures may be critical to determining the presence or absence of organic damage. In cases where a thorough history and neurological examination still leave doubt as to whether psychiatric dysfunction is organic in origin, psychological testing is clearly necessary. *See* Kaplan & Sadock *supra* at 547-48; Pollack *supra* at 273. Moreover, among the available diagnostic instruments for detecting organic disorders, neuropsychological test batteries have proven to be critical as they are the most valid and reliable diagnostic instruments available. See Filskkov & Goldstein, *Diagnostic Validity of the Halstead-Reitan Neuropsychological Battery*, 42 J. Of Con-

sulting & Clinical Psych. 382 (1974); Schreiber, Goldman, Kleinman, Goldfader, & Snow, *The Relationship Between Independent Neuropsychological and Neurological Detection and Localization of Cerebral Impairment*, 162 J. of Nervous and Mental Disease 360 (1976).[7]

5. ***The standard mental status examination cannot be relied upon in isolation as a diagnostic tool in assessing the presence or absence of organic impairment.***

As Kaplan and Sadock have explained, "[C]ognitive loss is generally and correctly conceded to be the hallmark of organic disease," and such loss can be characterized as "(1) impairment of orientations; (2) impairment of memory; (3) impairment of all intellectual functions, such as comprehension, calculation, knowledge, and learning; and (4) impairment of judgment." *Id.* at 835. While the standard mental status examination (MSE) is generally used to detect and measure cognitive loss, the standard MSE - in isolation from other valuative procedures - has proved to be very unreliable in detecting cognitive loss associated with organic impairment. Kaplan and Sadock have explained why:

> When cognitive impairment is of such magnitude that it can be identified with certainty by a brief MSE, the competent psychiatrist should not have required the MSE for its detection. When cognitive loss is so mild or circumscribed that an exhaustive MSE is required for its recognition then it is likely that it could have been detected more effectively and efficiently by the psychiatrist's paying attention to other aspects of the psychiatric interview.
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> In order to detect cognitive loss of small degree early in its course, the psychiatrist must learn to attend more to the style of the patient's communication than to its substance. In interviews, these patients often demonstrate a lack of exactness and clarity in their descriptions, some degree of circumstantiality, a tendency to perseverate, word- finding problems or occasional paraphasia, a paucity of exact detail about recent circumstances and events (and often a lack of concern about these limitations), or sometimes an excessive concern with petty detail, manifested by keeping lists or committing everything to paper. The standard MSE may reveal few if any abnormalities in these instances, although abnormalities will usually be uncovered with the lengthy MSE protocols.
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> The standard MSE is not, therefore, a very sensitive device for detecting incipient organic problems, and the psychiatrist must listen carefully for different cues. *Id.* at 835.

Accordingly, "[c]ognitive impairment, as revealed through the MSE, should never be considered in isolation, but always should be weighed in the context of the patient's overall clinical presentation past history, present illness, lengthy psychiatric interview, and detailed observations of behavior. It is only in such a complex context that a reasonable decision can be made as to whether the cognitive impairment revealed by MSE should be ascribed to a organic disorder or not." *Id.* at 836.

In *sum*, the standard of care within the psychiatric profession which must be exercised in order to diagnose is concisely stated in Arieti's *American Handbook of Psychiatry (1986)*:

> Before describing the psychiatric examination itself, we wish to emphasize the importance of placing it within a comprehensive examination of the whole patient. This should include careful history of the patient's physical health together with a physical examination and all indicated laboratory tests. The inter-relationships of psychiatric disorders and physical ones are often subtle and easily overlooked. Each type of disorder may mimic or conceal one of the other type.... A large number of brain tumors and other diseases of the brain may present as "obvious" psychiatric syndromes and their proper treatment may be overlooked in the absence of careful assessment of the patient leading him to the diagnosis of physical illness. Indeed, patients with psychiatric disorders often deny the presence of major physical illnesses that other persons would have complained about and sought treatment for much earlier. *Id.* at 1161.

## IV. Common Deficiencies in Forensic Evaluations

It can be readily seen that many, if not most, of the mental health evaluations conducted in criminal cases do not satisfy the applicable standard of care. This is not surprising because, as in many other areas, the indigent defendant receives short shrift in the criminal justice system. Most state institutions do not have the funds or staff to follow the above five steps. Furthermore, since many defendants are sent to these institutions for a very limited purpose—in most cases only to determine if the defendant is competent to stand trial—the staff may not believe it is necessary to do a complete evaluation.[8] Additionally, in many cases defense counsel are not sufficiently conversant with the elements of a complete, reliable mental health evaluation to educate the court regarding that to which the client is legally entitled. In other instances, some mental health professionals, used to working on forensic cases without adequate resources, fail to follow the above five steps. However, in this section of the article, I will focus in on the elements of an evaluation which are generally most deficient and result in the most unreliable results. My experiences since I first published this article in 1990 have only confirmed the basic weaknesses in many forensic evaluations detailed below.

### A. Client's History

Many forensic evaluations are unreliable because the history upon which they are based is erroneous, inadequate or incomplete. All too often, the medical and social history relied upon by mental health professionals is cursory at best and comes

exclusively from the client or possibly from the client and discussions with one or two family members.

This can result in a fundamentally skewed view of the relevant history because often the client, and even their family members, are very poor historians and may fail to relate significant events which are critical to a proper determination of an individual's mental state at the time of the offense.

For example individuals who are physically, emotionally and/or sexually abused often minimize the severity and extent of the abuse. Their view of what is "normal" and thus what should be related to a clinician is frequently impaired. Similarly, individuals with mental retardation or other organic brain impairments generally are unable to recall significant events regarding their medical history which maybe critical to a reliable diagnosis. It is also well established that many mental illnesses, *e.g.*, bipolar mood disorder and schizophrenia, run in families and thus it is important to know the family as well as the client's medical and psychiatric history.

It is for this reason that it is essential that a mental health professional obtain as much information as possible regarding a client's social and medical history to reliably determine what genetic, organic, environmental, and other factors may have played a role in the client's mental state at the time of the offense. Thus all available records for both the client and significant members of his family should be obtained. These records include, but are not limited to:

- Client's and sibling's birth records
- Client's medical records and family medical records
- Any social services records relevant to client or his family
- Client's and siblings' school and educational records
- All jail and/or department of corrections records, including medical records
- All records relevant to any prior psychiatric treatment or psychological evaluation for client or family members including grand parents, siblings, etc., including the evaluating professional's raw data (do *not* be content with obtaining the discharge summary or final report)
- Death records for any immediate family members
- Any military records, including medical records
- All police or law enforcement records regarding the arrest, offense, and any prior offenses
- All records relevant to any codefendants
- Family court records for parents and client
- Attorney files, transcripts, and court files for any prior offenses by the client or his family members

Reviewing these records will often lead to additional records documents and materials which should be obtained.[9] You must ensure that this time consuming process is meticulously followed because it is impossible, before an investigation is complete, to determine what will be the fruitful sources of information thus creating the risk of an additional skewed evaluation.

However, you cannot prepare the history solely from talking with your client and obtaining records. Other family members, friends and persons with knowledge about your client must be interviewed. These people, especially family members should not be talked to in a group, but individually. It is important to bear in mind, for example, that any family member or caretaker you interview may have abused your client. This information will rarely come out in a family gathering, and will even more rarely come out the first time you talk with the individual. In addition to family members, your client's friends, prior counsel, teachers, social workers, probation and parole officers, acquaintances, neighbors, employers, spouses (current or former), and any witnesses preceding, during and after the offense should be interviewed. Any or all of these persons may have critical information relevant to your client's mental state.

An excellent discussion of the needed investigation can be found in Lee Norton's article "Mitigation Investigations," *The Champion*, Vol. 16, No. 4 (May 1992) at 43.

**B. Inadequate Testing for Neurological Dysfunction**

While not all of our clients have organic brain damage, many do. Due to poverty, abuse and neglect which characterizes so many of our client's lives, a substantial percentage of our clients have mothers who abused alcohol and drugs during their pregnancies and who received poor or no prenatal care. Inadequate medical attention to head injuries and other illnesses is also common, as is exposure to various neurotoxins (*e.g.*, lead based paint and pesticides). Long histories of substance abuse, including the use of organic solvents, is also not unusual. These, and other factors, predispose our clients to varying degrees of neurological impairment. Organic brain damage can and does affect behavior. It can impair judgment and rob an individual of the ability to make decisions in crises rationally and responsibly. It can destroy or diminish a person's ability to learn, to carry out a plan of action, to understand long term consequences of actions, to appreciate cause and effect, and to mediate impulse-driven behavior. However, despite its obvious relevance in mental health evaluations in criminal cases, neurological impairment is often not diagnosed.[10]

Another very common deficiency in state forensic evaluations is the inattention to the possibility of organic damage, other neurological dysfunction, or a physiological basis for psychiatric symptoms. Based on my experience, many of our clients are at risk for organic brain damage. They have a history of serious head injuries from chronic childhood physical abuse, car accidents, and falls. Their developmental years are plagued with chronic illness and fevers, frequently untreated, and malnutrition. Poor or nonexistent prenatal care and/or birth trauma are routinely found in their histories. Many clients had mothers who drank large amounts of alcohol or used drugs during their pregnancies, now well recognized as a cause of permanent and sometimes devastating mental disabilities in the developing fetus. Most of our clients are chemically dependent, and their early and prolonged use of drugs and alcohol, including organic solvents, can cause permanent brain damage.

However, as a result of inadequate histories, or for other reasons, inadequate attention is frequently given to the possibility of neurological impairment. For example, very few of my clients have ever been examined by a neurologist, despite indications in their histories that warrant neurological consultation. Occasionally, the extent of the neurological evaluation may be an EEG, which was likely conducted without any specific leads or without having the client sleep during the test thus making it an inadequate study. It is also a rare case in which any meaningful neuropsychological testing has been conducted, even though neuropsychological testing is one of the best ways to determine the presence of more subtle brain damage prevalent in our clients. The extent of the testing, if any testing at all is done, may be a few neuropsychological screening tests such as the Bender-Gestalt or the trail-making test. This, however, is often inadequate and will yield unreliable results. A complete neuropsychological battery is often the only way to rule out the possibility of neurological damage. Unfortunately, I have been involved in numerous cases where it was only discovered after the trial that the defendant had a serious organic deficit. For example, in one case, we only discovered during the federal habeas corpus proceedings that our client had a brain tumor exerting pressure on critical brain structures, which was present at the time of the offense. While this is a dramatic example, in countless other cases we have discovered that our clients have serious neurological impairments that went undiagnosed in earlier evaluations.

This can have tragic consequences. It can deny your client a concrete way to reduce his blame-worthiness. It is a fact of death penalty life that juries, and judges, are often less impressed with psychosocial explanations for violent behavior than they are with organic explanations. While this is changing somewhat due to our better understanding of the long term effects of various types of trauma, *see, e.g.,* Judith Herman, *Trauma and Recovery*, it is still true. Organic deficits, however, frequently have their origin in events and situations over which the defendant had no control, such as Fetal Alcohol Syndrome, temporal lobe epilepsy, measles, encephalitis, or prolonged exposure to neurotoxins such as those found in lead-based paint. These factors can be presented in an empathy-provoking manner, as part of a constellation of factors that affected your client's behavior. While we may appreciate psychosocial diagnoses such as post-traumatic stress disorder, in some cases it is not compelling enough unless it is accompanied by a physical explanation. For example, if you can show that part of your client's brain is literally missing, most jurors and judges can understand that such an impairment might affect an individual's behavior. The same presentation can be made with less dramatic or "softer" neurological impairment, *e.g.,* diffuse brain damage. The important thing is to insure that the evaluation your client received at trial, or receives in connection with post conviction litigation, fully takes into account the possibility of neurological impairment.

This cannot be done without a reliable history and appropriate testing and examination. A competent neurologist, psychiatrist, or neuropsychologist will recommend a complete neurological examination when indicated by physical symptoms such as one sided paralysis or weakness, facial asymmetry, seizures, headaches, dizziness, blurred vision, or imbalance. Laboratory tests, including blood and endocrine work-ups, may also be necessary to determine the presence of diseases that affect behavior. Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), and CT scans can also be useful in this regard. However, it is important to note that a negative (or normal) result on a CT scan, EEG, or MRI does not rule out the possibility of neurological impairment. While a positive finding establishes organicity, a negative finding does not rule brain damage out.[11] Organicity may still be discerned through more sensitive neuropsychological testing and/or a neurological evaluation.

## V. Choosing Experts

There are a number of different types of experts you may need in any particular case. However, you will not know exactly what type of experts you will need until the social-medical history is completed. As I have stressed throughout this article, this must **always** be the first step. I cannot stress this point enough as it is virtually always the basic flaw in forensic mental health evaluations. You must resist the temptation to hire a psychologist or psychiatrist immediately upon being appointed or retained.[12] Without first conducting the necessary life history investigation, your expert may well overlook significant factors and come to premature or erroneous conclusions.

Furthermore, it is critical that you obtain the assistance of a social worker, or someone with similar skills, to assist in compiling and understanding the social and medical history. Social workers are specially trained not only in gathering the type of information you need - both from documents and individuals - but also in organizing and interpreting the data in coherent themes. *See* Arlene Andrews, *Social Work Expert Testimony Regarding Mitigation in Capital Sentencing Proceedings*, 1991 Social Work 36. While you or someone in your office can collect most documents and interview the witnesses, you may not be attuned to significant facts in the records, or be less able to obtain information from the client, the client's family and friends, and other persons with relevant knowledge about your client than someone with special expertise in this area. Thus, you should always attempt to obtain funds for the assistance of an individual with a social work background in the investigation, compilation and assimilation of the social and medical history.

If the court resists funds for this type of assistance, educate the judge, via affidavit or testimony, as to the critical nature of this aspect of the mental health evaluation.[13] For example, a psychiatrist or psychologist with whom you have a collegial working relationship may be willing to provide you with an affidavit laying out specific factors in the "known" social his-

tory warranting further exploration by a person with specialized training and discussing the need for full and reliable background information. Furthermore, many of the sources discussed in this article will also be of use in establishing the need for the assistance. It is also important to be adamant about the need for specialized social history assistance in cases where the client's ethnic or cultural background impairs your ability to obtain accurate and complete information.

Depending on the results of the social history, it is then time to obtain your own experts. In doing so, you should search for professionals with expertise in the themes that have developed in the social history, *e.g.*, abuse (physical, emotional and sexual trauma); alcoholism and/or substance abuse; familial or genetic predisposition to certain mental illnesses; head injuries or other indicators of organicity, mental retardation or all of the above. It is important to keep in mind that one mental health professional can very rarely help you with all of these things. *See* Clark, Veltkamp & Monahan, *The Fiend Unmasked: The Mental Health Dimensions of the Defense*, 8 ABA Criminal Justice 22 (Summer 1993).

Thus it is almost always necessary to put together a multidisciplinary team of professionals, including a social worker, to determine the client's mental state reliably. For example, if the social history indicates a history of chronic child maltreatment and abuse, it may be best to begin with a full psychological battery including neuropsychological testing. This testing may confirm or deny the presence of posttraumatic stress disorder, organic impairment or other diagnoses resulting from the abuse. Similarly, in many cases involving child abuse, the individual will often have a long history of substance abuse. Thus, it may be necessary to retain a pharmacologist to explain the nature of the substances abused, their effects on an individual's judgment, impulse control, cognitive functioning etc., and to explain the long-term effects of these drugs on a person's brain. Furthermore, depending on the results of the neuropsychological examination, a neurological consultation will often be in order.

Other types of experts may also be necessary. We have enlisted the assistance of audiologists, mental retardation experts, special education teachers, toxicologists and a variety of other types of experts, in addition to social workers, psychologists, neurologists, neuropsychologists, pharmacologists, and psychiatrists.

The important thing, however, is to assemble the necessary mental health professionals *on the basis of the history as you uncover it*. Furthermore, it is frequently necessary to have one professional, generally a forensic psychiatrist, who can "bring it all together." In other words, many of your experts may be testifying as to only one piece of the mental health picture, for example, your client's history of substance abuse. It is useful to have one person who, in consultation with all the other members of the team, is prepared to discuss all the history, testing, and diagnosis and give the fact-finder and sentencer a comprehensive picture of the individual's mental state at the time of the offense, and, if relevant, at trial.

## VI. Meaningfully Presenting Expert Testimony

Regardless of which phase of the trial expert testimony is presented, and even regardless of what type of criminal case it is, persuasive expert testimony must have one element: *it must enable the jury to see the world from your client's perspective, i.e., to appreciate his subjective experience*. Most people have no idea, for example, what it is like to suffer from schizophrenia or other major mental illnesses, or what it means to be psychotic or to have auditory, visual or tactile hallucinations. It is often not enough for your expert to tell the jury or judge that your client is schizophrenic and was out of touch with reality at the time of the offense. Rather, she must attempt to explain, in common sense, persuasive, concrete terms, what schizophrenia means, and what the world looks like to a person with this mental illness. Similarly, it is not enough to have the expert testify that your client is plagued by auditory command hallucinations. Without an adequate explanation a juror may react as follows: "Big deal, I don't care, if someone told me to kill somebody I wouldn't do it."

You and your expert(s) must look for ways to convey what it is truly like to be mentally ill, mentally retarded or brain damaged, and how confusing and frightening the world is to your client as a result of his impairments. In other words, you have to give the fact-finder a view of the crime from the defendant's perspective. If you don't, you run the risk of making your client seem "otherly," frightening and thus expendable. What you are striving for is to enable the fact-finder to look through your client's eyes and to walk, at least for a few minutes, in his shoes. If you can accomplish this through your expert testimony, you can facilitate understanding rather than fear.

It takes time and energy, but the key is to avoid jargon and words that ordinary people don't understand. It may be useful to have someone not connected with the case, preferably not a lawyer, sit in on a meeting with your expert witness and see if they understand their explanation of your client's mental state as well as its relevance to the facts of your case.

## VII. Attacking Anti-Social Personality Disorder

Many of our clients are diagnosed by mental health professionals, employed by either the state or the defense, as having an antisocial personality disorder. This diagnosis is not only very harmful but, unfortunately for many of our clients, it is often arrived at erroneously. In my opinion, antisocial personality disorder is the lazy mental health professional's diagnosis. The criteria for the disorder are essentially a description of people's behavior. It may describe **what** the client has done, but never **why**. For example, one of the characteristics is that the individual engaged in sexual activity at a young age, or began using substances at an early age.

Besides the fact that many of these characteristics are economically and racially biased, the diagnosis is often erroneously arrived at because of an inadequate history and lack of other adequate testing and evaluations. DSM-IV specifically

states that "the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy."[14] In other words, the clinician is obligated "to consider the social and economic context in which the behaviors occur." *Id.* at 647. This is another area where a thorough and reliable social history can have a significant impact.

For example, to qualify for the diagnosis of Anti-Social Personality Disorder, the client must have met the criteria, prior to age fifteen, for a DSM-IV diagnosis of Conduct Disorder. Conduct Disorder has a number of criteria including a history of running away from home, truancy, etc. Thus, it is critical, to an accurate diagnosis, to know **why** your client ran away from home. If he ran away because he was being physically, sexually or emotionally abused, then the diagnostic criteria would not be satisfied. Similarly, if the child was truant because his caretakers would not allow him to go school, or if he broke into people's houses because his father was a thief and forced him to do so to further the family enterprise, the diagnosis of Conduct Disorder, and correspondingly Anti-Social Personality Disorder, would be inappropriate. Thus once the dysfunctional nature of most of our client's environments is exposed, the diagnosis can be defeated.

Similarly, if there is an organic or other cause such as mental retardation for some of the behaviors, then the diagnosis should, in many cases, not be given. In this regard, it is useful to look at and study the decision trees published in the *American Psychiatric Association's Diagnostic and Statistical Manual-III.* These "trees" indicate a number of other diagnoses that preempt the diagnosis of anti-social personality disorder. However, because all many psychologists do is talk to the client, and look at his or her criminal record and other behaviors, the diagnosis is often arrived at despite other factors which would either prevent the diagnosis or move it sufficiently far down on an axis as to make it irrelevant to the other more significant diagnoses in explaining the individual's behavior.

Finally, it is important to note that the diagnosis can not be given unless your client is at least eighteen years old, and if there is clear evidence that a diagnosis of Conduct Disorder was warranted before your client was fifteen years old. In other words, if the alleged "antisocial" behaviors began after your client was fifteen, the Anti-Social Personality Disorder would not be an appropriate diagnosis. Thus, if some neurological impairment or other contributing condition occurring after age fifteen explains your clients actions, the diagnosis is not correct. In the same vein, DSM-IV states that if the antisocial behavior occurs during the course of schizophrenia or manic episodes, the diagnosis is not appropriate. *Id.* at 650.

The point of this discussion is that you should never accept at face value any professional's, including your own, determination that your client has antisocial personality disorder. It is always critical, for diagnostic purposes, to know **why** the seemingly anti-social behavior occurred. While in some cases the diagnosis may be unavoidable, in many it is not. If the steps outlined previously in this article are followed, you dramatically increase your chances of avoiding a diagnosis that establishes aggravating factors, and obtaining one instead that offers a compelling basis for mental health related claims.

## VIII. Considering Prior Diagnoses

In many cases, you will be confronted with a client who has been previously evaluated, in some cases on many occasions. If this is true, it is also likely that different professionals have arrived at different diagnostic conclusions. In examining the prior evaluations, it is important to know when the prior conclusions were reached, and, more specifically, what version of the Diagnostic and Statistical Manual of Mental Disorders was in effect at the time any prior diagnosis was rendered. *See* K. Wayland, "The DSM: Review of the History of Psychiatric Diagnosis in the U.S.," *Capital Report* #40 (Nov/Dec 1994). For example, it was not until the late 1970's and early 1980's that depression emerged as a diagnosis to be seriously considered in children and adolescents. Thus, prior to that time, a child with a history of suicide attempts and other depressive symptoms would almost certainly not have been diagnosed as suffering from depression. Similarly, Post-traumatic Stress Disorder (PTSD) was not officially recognized as a diagnosis until the publication of DSM-III in 1980. Thus, while there may be clear support for PTSD in descriptions of your client's behavior in a pre-1980 evaluation, the diagnosis of PTSD would likely not have been given.

This indicates—again—the critical need for a detailed history and review of all information regarding your client's life. For it may be that the mental health records contain descriptions of your client's behavior which warrant a different (and more favorable) diagnosis today than was available using previous diagnostic criteria.

## IX. Don't be Fooled by the Client

Many times when I consult with lawyers, I hear them say, when we are discussing the possibility that their client is mentally ill or mentally retarded, that "Well, I've talked to him and he seems pretty sharp to me." Or they say "Well, he seems normal to me." Sometimes they describe their client as manipulative, evasive, hostile, or street smart. It is crucial to remember that as lawyers we are not trained to recognize signs and symptoms of mental disabilities. It is equally important to keep in mind that many mentally retarded, mentally ill or brain damaged individuals are quite adept at masking their disabilities. For example, one skill that mentally retarded people typically master is some degree of hiding their disability. One client of mine sat in his cell for hours at time pretending he could read because he thought, if people thought he could read, they wouldn't believe he was mentally retarded. Other clients with severe mental illnesses are often good at masking their illness for short periods of time. This is especially true when they are in a structured setting, such as prison or jail, which may minimize many of the symptoms of their impairments.

Unfortunately the quality of many attorney-client conversations does not allow probing into the client's mind to determine delusional or aberrational thought processes. However, this does not mean that they are not there. Many ill people, for example, know that other people don't think like they do, and may need to get to know you before they share their thoughts. Similarly, many people with brain damage may not appear dysfunctional when engaged in casual conversation. The important thing is that neither you nor any mental health professional should prejudge a client's mental state based upon casual contact. It is only through the assistance of competent mental health professionals who recognize the importance of a documented social history, and who are trained in appropriate testing, that you can reliably and adequately determine your client's mental state.

## X. Essential References

Because of the pivotal role of mental health issues in criminal and capital litigation, counsel must gain a working knowledge of behavioral sciences. Whether an attorney has only one criminal or capital case or several, it is essential to become familiar with the diagnosis and treatment of psychiatric disorders. Two publications need to be on the shelves of attorneys in criminal litigation and studied: *Comprehensive Textbook of Psychiatry*, *Fifth Edition*, edited by Harold L. Kaplan, M D., and Benjamin J. Sadock, M.D. (Williams & Wilkins, 1989) and *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), published by the American Psychiatric Association in 1994. These references offer a guide through the labyrinth of mental health information and allow counsel to participate fully in developing appropriate mental health claims.

## XI. Conclusion

Defense counsel in criminal, especially capital, litigation can and should insure that their clients receive complete, competent and reliable mental health evaluations. In order for a mental health evaluation to meet the nationally recognized standard of care in the psychiatric profession it must involve a multistep process that requires far more than a clinical interview. A thorough and documented social history, physical examination and appropriate testing are necessary components of any psychiatric diagnosis. Mental health professionals must consider whether there is an organic cause for behavior before reaching any psychiatric diagnosis. Counsel has a responsibility to ensure that mental health evaluations reflect this multistep process.

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### Footnotes

[1]See also *Youngberg v. Romeo*, 457 U.S. 307 (1982) (recognizing that psychiatrist's performance must be measured against a standard of care when due process demands adequate performance.)

[2]Other cases involving similar claims associated the effect of the actions by the state court, the prosecution and psychiatric witness with the issue of effectiveness of counsel. Courts have recognized a particularly critical interrelation between expert psychiatric assistance and minimally effective assistance of counsel." *United States v. Edwards*, 488 F.2d 1154, 1163 (5th Cir. 1974).

[3]Although the *Blake* court analyzed the impairment of the psychiatrist's ability to conduct a professionally adequate evaluation in terms of its impact on the right to effective assistance of counsel, it recognized that its analysis was "fully supported" by *Ake*. In support of this conclusion, the court gave emphasis to *Ake's* requirement that "'the state must at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and in presentation of the defense.'" 758 F.2d at 530-31 (quoting *Ake*, 470 U.S. at 83). Thus, *Blake* recognized that if an appointed psychiatrist's ability to "conduct an appropriate examination" is impaired, due process is violated.

[4]*See generally*, Note, *A Question of Competence: The Indigent Criminal Defendant's Right to Adequate and Competent Psychiatric Assistance After Ake v. Oklahoma*, 14 Vt.L.Rev. 121 (1989).

[5]A national standard of care is important to insure that your client receives a complete, competent mental health evaluation. If a local standard of care applied, for example, your client could conceivably be deprived of available diagnostic studies, *e.g.*, a MRI scan on the ground that such a study is not readily available in the local community. The same may be true of neuropsychological testing if there are no trained neuropsychologists. However, your client's right to a trial conducted in conformity with the Sixth Amendment and the Due Process Clause demands a national standard as opposed to a local standard of care.

[6]Thus, if your primary mental health professional is a psycholo-

gist, it is critical that you obtain the services of a physician to complete a physical examination. If your client is indigent and the court has only approved funds for a psychologist, it is important to bring to the court's attention (and to litigate if necessary) the need for a complete physical examination.

[7]Neuropsychological test batteries were developed as a method for assessing cognitive deficits and involve an assessment of specific cognitive functions, such as memory, attention, and fluency of thinking. The two most widely used neuropsychological batteries are the Halstead-Reitan and the Luria Nebraska. A clinician assessing patients neuropsychologically will often use tests from both batteries as well as other neuropsychological instruments to tailor the assessment to the types of problems that the specific patient is having and to try to identify whether a specific area of deficit is present. When a grouping of neuropsychological tests such as those described above is administered to an individual, the clinician obtains some sense of the person's overall patterns of abilities and deficits.

[8]The determination of whether a defendant is competent—whether he has a rational and factual understanding of the charges and is able to assist counsel—is a limited inquiry which a mental health professional may, under some circumstances, be able to make without following all of the steps outlined in this article. Even in the competency context, however, the failure to obtain a complete and reliable history may skew the results. Unfortunately, in many cases, a mental health professional who only evaluated the defendant for competency purposes, and often conducted a limited examination, proceeds, at the request of either the prosecution or even sometimes the defense, to testify regarding a wide array of forensic issues such as criminal responsibility and mitigation. While a detailed discussion of the various types of mental health evaluations is beyond the scope of this article, **any** time a mental health professional fails to follow the steps outlined in this article, there is a corresponding risk that the conclusions reached will be erroneous.

[9]There are many excellent, more detailed life history records' checklists which can be obtained from various post-conviction defender organizations and public defender agencies including the Kentucky Post-Conviction Defender Organization.

[10]The reasons organicity so often goes undiagnosed are varied. One reason has to do with the complexity of so many of our clients' histories. For example, when confronted with a substantial history of abuse and poly-substance abuse, a mental health professional may too quickly conclude that the interaction of the trauma and the intoxicants caused the behavior, failing to adequately pursue any existing neurological impairment. Another reason has to do with the circumstances of the evaluation; many people with organic brain damage respond very well to a structured environment such as prison. Thus, when confined and removed from the complexities and temptations of life on the outside, the symptoms of their impairment are significantly less pronounced and may be overlooked. In some cases, the damage is missed because the particular mental health professional retained by counsel has inadequate training in the diagnosis of brain damage, *e.g.*, a psychologist without any experience in neuropsychological testing.

[11]Furthermore, if the CT scan or MRI film has not been reviewed by an expert you have confidence in or was conducted at the request of the state or state psychiatric hospital, I would recommend that you have a neurologist or neuro-radiologist retained by the defense review the actual film. I have been involved in a number of cases in which the initial hospital report indicated for example that the MRI was "normal" when it was not. Erroneous CT scan and MRI readings occur for a variety of reasons, a discussion of which is beyond the scope of this article, but counsel should obtain the film and have it reviewed by your own expert.

[12]Many times counsel do so, reasoning that it is important to have the defendant seen as soon by a mental health professional as possible after the offense. There may be some limited circumstances where this is true, *i.e.*, if you are appointed or retained within a few hours of the offense and upon consulting with the client, you determine he is floridly psychotic. Such situations are, however, few and far between, and the temptation to conclude that your case falls in this category must be resisted.

[13]A detailed discussion of how to secure funds for investigative and expert services is beyond the scope of this article. As a general matter, I would advise you to review Ed Monahan's articles: *Funds for Resources: Persuading and Preserving*, The Advocate, Vol. 16 No. 6 at 82 (January 1995); and *Confidential Request for Funds for Experts and Resources*, The Advocate, Vol. 17, No. 1 (February 1995) at 31. As an initial matter, you should always vigorously assert your client's right to an *ex parte* hearing. Most jurisdictions provide for such a hearing, and it is important to assert your client's right to confidentiality in connection with funds requests. Furthermore, in developing the argument for funds it is important to be as specific as possible and to build the case for funds "from the ground up." For example, a detailed showing of factors in your client's life suggesting neurological impairment is much more likely, than a general assertion, to result in the approval of funding. This is especially true if you can convince a neurologist to submit an affidavit, based on the facts in the history which you have developed, detailing the need for a neurological evaluation. It is also helpful to submit a similar affidavit from a forensic psychiatrist or psychologist, and possibly even a social worker, expressing the need for a neurological consultation. A similar process should be followed in attempting to obtain funds for other types of expert assistance. The affidavits from other professionals in useful in convincing the court that you are not on a fishing expedition.

[14]This was also true of DSM-IIIR.■

# Chapter 6: Principles of Developing and Presenting Mental Health Evidence in Criminal Cases

**by John H. Blume and Pamela Blume Leonard**

***Authors' Note***

*In this article, we will attempt to provide a general framework for developing and presenting mental health evidence in criminal cases. It is intended to complement "The Elements of a Competent and Reliable Mental Health Examination,*[1] *which described a process for acquiring an accurate assessment of a client's mental condition and set mental health issues within the constitutional framework. We suggest you read that article carefully. It provides suggestions for obtaining a favorable mental health evaluation in the first instance. Obviously, without a favorable evaluation, there will be little mental health evidence to present. The suggestions in both articles are widely applicable to criminal defense and, in our view, are specifically relevant to death penalty cases where the development and presentation of mental health evidence are frequently the difference between life and death.*

**Introduction**

Mentally disordered clients can be challenging, their crimes bizarre, their lives tragic and their illnesses difficult to convey. To address mental health issues competently and effectively, defense counsel must understand the wide range of mental health issues relevant to criminal cases, recognize and identify the multitude of symptoms that may be exhibited by our clients, and be familiar with how mental health experts arrive at diagnoses and determine how the client's mental illness influenced his behavior at the time of the offense. Without this knowledge, it is impossible to advocate effectively for a mentally ill client or to overcome jurors' cynicism about mental health issues. We believe juror skepticism often reflects inadequate development and ineffective presentation rather than a biased refusal to appreciate the tragic consequences of mental illness.

For our purposes, the term "mental health issues" encompasses the diagnosis and treatment of mental illnesses and mental retardation. The information in this article will be useful in all of those areas but it predominantly offers guidance in litigating cases involving mental illness. (Substance abuse and addiction are recognized as a forms of mental illness but they are complex subjects that are beyond the scope of this article. However, since a great deal of substance abuse has its origins in clients' efforts to self medicate and quell the disturbing symptoms of mental illness, it behooves counsel to recognize and understand the mental illnesses that underlie addition.)

Obviously, all of the steps discussed in this article must be adjusted to the particular client and the facts of the case. However, even though every case is unique, we believe there are four principles that must be applied to the development and presentation of mental health evidence in all cases, especially those involving the death penalty. Conveniently, they all start with the letter C.

**"4 Cs": Basic Principles of Developing and Presenting Mental Health Issues**

There are no shortcuts to developing and presenting mental health evidence effectively in a criminal case. You must build a theory of defense based upon evidence that is **credible, comprehensive, consistent and comprehensible**. These principles must not be compromised at any stage of litigation. We encourage you to constantly evaluate your evidence and your advocacy in light of these "4 Cs".

1. **Is your evidence CREDIBLE?** Have you supported your theory with a thorough life history investigation, life history documents, lay witnesses and expert witnesses?
2. **Is your evidence COMPREHENSIVE?** Have you applied your evidence of mental health issues at every stage of litigation, including your relationship and meetings with your client, every motion, court appearance and meeting with the government?
3. **Is your evidence CONSISTENT?** Have you formulated and communicated a unified theory of the case that takes into account all the facts and circumstances about the client and the offense and tells the same story at every stage of litigation?
4. **Is your evidence COMPREHENSIBLE?** Have you presented your evidence in ordinary language in a common sense manner?

**Developing and Presenting Credible Evidence**

**Learn About Mental Health Issues**. Once you have a working knowledge of several fundamental precepts of mental health issues and mentally ill clients, you will be able to develop and present credible evidence to the jury. You can convince jurors to walk a mile in the defendant's shoes if you have learned everything you can about your client's mental illness and its role in a tragic crime. Armed with the insight and empathy that knowledge brings, you can convincingly convey mental illnesses as involuntary impairments that affect the simplest aspects ofordinary life. There is no shortcut to being a persuasive advocate for a mentally ill criminal defendant.

To adequately represent a mentally ill client, every member of the defense team must become a student of mental health issues. Initially, this includes acquiring a general understanding as well as specific knowledge of the defendant's past and present mental illness(es) before determining how to litigate the case and mastering a new vocabulary that will allow you to present complicated medical and psychological issues in a comprehensible manner to the judge and to each individual on the jury. Excellent starting places are the web sites for National Institute of Mental Health and National Alliance for the Mentally Ill[2], where you will find plain language descriptions of mental illnesses as well as links to journals, studies and other helpful web sites. *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV)[3], published by The American Psychiatric Association, and *Comprehensive Textbook of Psychiatry*[4] by Kaplan and Saddock are essential references for understanding mental health issues. Most cases will require additional particularized research. Web sites for every major mental disorder will give you a basic introduction to the nature and impact of your clients' impairments.

**Identify Mental Health Issues**

Accurate identification and meticulous documentation of your client's mental health issues are necessary steps to building **credible** evidence.

**Look for Indications of Mental Illness**. Determining whether your client suffers from a mental disorder and, if so, the severity of the illness, is a complex process. A frequent and unfortunate assumption is that a difficult client is rude, suspicious, unhelpful or manipulative by choice. A client with a history of disagreeable, irrational or foolish behavior may be mentally ill or mentally retarded rather than simply bad company. Your client's behavior is a vital clue to his mental status. When objectively assessed, such behavior may, in fact, be found to be symptomatic of a mental disorder or deficits.[5]

Keep in mind that symptoms of mental illnesses wax and wane so that even severely psychotic patients can intermittently appear normal. Conversely, overt signs that a defendant is psychotic - people who are out of touch with reality - can be overlooked even by a trained professional performing a cursory mental status examination. How your client appears when you first meet him may have no bearing on his behavior at the time of an alleged offense. While the rules and regulations of jail are an aggravation to you, the institutional structure and regularity may actually be therapeutic for a mentally ill defendant, especially if his mental illness is exacerbated by alcohol or if he is regularly receiving appropriate medication for his mental illness.

All these variables mean that the defense team must meet with the client over time and under different conditions to get an accurate picture of his behavior and capabilities. It is most likely that your client and his family will reveal symptoms of mental illness to you only after you have built a trusting relationship them. Keep in mind that the client and his family may not have been previously exposed to mental health experts or the process of a mental health evaluation. Reassure them that the mental health experts are there to assist the defense. In addition to family members, any person who has had an ongoing relationship with the individual, can be a source of invaluable information about the characteristics and progression of your client's behavior and his state of mind at the time of the offense.

**Look for Evidence of Mental Health Issues**. A thorough inquiry into all the circumstances of your client's life is always the necessary first step in identifying mental health issues. The product of this inquiry, a social history, is an organized, written presentation that puts into context every event, person, institution and environment — often going back several generations — that has had an impact on the defendant. The social history presents a family's genetic history and vulnerabilities to mental illness as well as a description of family patterns of behavior. It is usually prepared by a specially trained investigator who is experienced in gathering documents and conducting interviews that form the basis of the psycho-social history.

**Gather All Documents Related to Your Client and His Mental Condition**. In all criminal cases, any document potentially bearing social history information about the client may be significant. That is why you need to get them all. It's like panning for gold — you gather all available material, then meticulously sift through it for the valuable parts. Important clues about your client may be found in records regarding birth and death, school, marriage, social services, military service, employment, and medical treatment, among others. This is especially true when the client or his family is known or suspected to suffer from mental illness. In our experience, it is common to find evidence of mental illness dating back several generations. The investigative net necessarily widens when interviews or documents reveal that earlier generations or members of the larger family have exhibited signs of mental disorder. Continue to expand the investigation exhaustively so long as you find family members who have documented mental health issues. Such records shed invaluable light on your client's mental health history and demonstrate that the mental condition was a significant factor in your client's life long before the offense that brought him into the criminal justice system.

**Talk to Everyone Who Has Known the Client Over Time**. Interviews are the other major tool, in addition to documents, used to compile an accurate social history. Keep in mind that most people consider mental handicaps shameful and may be reluctant to reveal any signs of mental trouble. Like the client, they may think they are being helpful by minimizing, normalizing or rationalizing signs of mental illness

in the defendant and his family. In some instances, they may not be candid because they want to cover up their own misdeeds, *e.g.*, acts of physical or sexual abuse. These factors help us to understand and explain why many severely mentally handicapped defendants remain completely unidentified as such in the criminal justice system. Recognize that the tendency of a client's family and friends to minimize, normalize or deny mental illness is a barrier to achieving a reliable social history. The necessity of overcoming this hurdle is the main reason you must carefully select a social history investigator who has the ability to probe these matters with sensitivity and respectful perseverance. It also makes it critical to interview people such as neighbors, ministers and teachers who are outside the client's intimate circle of family and friends, so you get a picture of the client's life that is both broad and richly detailed.

**Take Another Look at Labels Attached to Your Client**. "He's not crazy, he's just mean!" How often have you heard that assessment? Too often you've probably heard it from defense lawyers. A kinder but equally ineffective lawyer may conclude, "I talked to him, and he seems pretty bright to me" or "He's a drug addict, but I don't think he has any major mental illnesses." Learn to be skeptical of pejorative terms such as "sociopath," "cold," "manipulative" or "street smart" that normalize abnormal behavior. In our experience, our clients are good at hiding their mental illness. In fact, they often have years of experience "passing" as normal. Further, because of the stigma attached to mental illness, many mentally ill people find it less dangerous to be considered "bad" rather than "mad." Combinations of mental illnesses are common: mental health professionals refer to a "dual diagnosis" or "multiple diagnosis" to indicate a person who simultaneously suffers from more than one mental disorder.

Poor people with limited access to mental health treatment often use alcohol or drugs as a means of self-medication to treat disturbing symptoms of mental disease. However, it is important to remember that intoxication often occurs because of, and in conjunction with, other mental illnesses. We have represented such people. This type of defendant is likely to be inaccurately labeled as a drug addict with a disagreeable and mistrustful personality, rather than a paranoid schizophrenic who has tried to control intolerable auditory hallucinations with drugs and alcohol. Never assume that substance abuse rules out additional mental illness or mental retardation. They often co-exist.

Recently, as government programs have increasingly failed to provide needed residential care and treatment, we see the criminalization of the mentally ill. De-institutionalization and severe restrictions on community based programs have resulted in is a growing number of mentally ill criminal defendants, many of whom are charged with violent crimes. Even though properly treated mentally ill persons are no more violent than the general population, untreated or improperly medicated illnesses can contribute to tragic and avoidable offenses.[6] Consequently, the mental illnesses of many criminal defendants are often overlooked, making it imperative that you consider whether mental health issues are present in every defendant you represent. In many cases, they will be. Many mental illnesses have a gradual onset, making it even more important to acquire an accurate social history. Sometimes early warning signs can be identified as far back as elementary school. New research into paranoid schizophrenia, long thought to first appear in early adulthood, has identified subtle symptoms that were, in fact, present in children and adolescents.[7] Tragically, a number of these kids were labeled "behavior disordered" and considered *to be* a problem rather than *to have* a problem of mental illness. Sexualized or aggressive behavior in your client's childhood history should always raise your suspicions. Clients who have suffered sexual abuse may have been described as "inappropriately knowledgeable about sex" or as "sexually forward." Children who were physically abused may have been called bullies themselves. Don't accept pejorative labels without looking deeper.

**Secure Expert Assistance**. Upon completion of a thorough social history, secure the services of a neuropsychologist to administer neuropsychological testing. This will help you understand how your client's brain is actually working (or failing to work). It will also help you determine whether the client has suffered injury to his brain and, if so, to assess the extent and effect of the damage.

Often it is difficult, if not impossible, for mental health experts to determine the cause of a mental handicap, even when there is damage to the brain. In the same way, it is difficult for an expert to pinpoint the cause of brain injury. However, it is widely accepted that damage to the brain can be the result of prenatal trauma, disease, exposure to neurotoxins, or head injury,[8] among other factors. Always search diligently for causal factors of brain damage. Remember that in the absence of severe head injury or an illness known to damage the central nervous system, an accumulation of small insults to the brain can result in serious neurological impairment and account for organic brain damage.[9] Medical diseases, such as diabetes or pancreatitis, can also have psychiatric consequences.

**Consider Additional Expert Assistance**. Next, consider whether you need to ask for expert assistance from a psychiatrist. The answer will very often be yes. Both neuropsychologists and psychiatrists are qualified to diagnose and treat mental disorders. However, the two professions do not otherwise overlap since only medical doctors, such as psychiatrists, are qualified to assess medical factors and prescribe medication. Conversely, only psychologists are qualified to administer psychological tests. If you suspect mental retardation, further psychological testing will be needed to ascertain the client's deficits in intellectual and social domains.

At this point, you may also able to determine if additional mental health experts, such as a neurologist (a medical doctor who can help to pinpoint the causes and the effects of brain damage), a psycho-pharmacologist (a psychologist, pharmacologist or medical doctor who specializes in the effects of chemical substances, and combinations of chemical substances, on human behavior), a developmental psychologist (a psychologist who specializes in the various stages of development humans go through from infancy to adulthood), or a clinical social worker (a licensed mental health professional who understands human development and social relationships), are needed to assist you in achieving a thorough and reliable mental health evaluation of your client. You will also be in a better position to demonstrate why you need funds to complete the evaluation.

## Developing and Presenting a Comprehensive Defense

If the mental health evaluation confirms that your client is brain damaged or mentally retarded, the severity and characteristics of the condition will influence your strategy regarding how and where to present mental health evidence. However, in ALL mental health cases, it is critical that you utilize each and every motion, court appearance and meeting with the government to emphasize your client's condition.

Mental illness can affect all aspects of a person's feelings and behavior to the extent that almost all actions and decisions made by a mentally ill client are called into question. This means that every stage of a criminal case is loaded with mental state considerations. For instance, was the waiver of your client's rights knowing and intelligent? Was the confession voluntary and reliable? Was the defendant coerced to make a statement? Did the defendant have the specific intent to commit the offense? Was there an irresistible impulse? Are prior convictions — especially guilty pleas — valid or are there grounds to challenge admissibility? We could go on with examples, but you get the picture: Whenever any issue is affected by what might have been going on in your client's mind, mental health evidence is potentially relevant. Unless you present your client's mental illness as a major cause for the offense, it may appear to be nothing more than an excuse dragged out by the defendant to avoid punishment for the crime. Even worse, a poor presentation could result in your client's mental illness being perceived as a fabricated justification for a heinous offense.

### Determine When and How to Raise Mental Health Issues

Make your theory **comprehensive** by applying it to each stage of the criminal proceedings. In order to provide an adequate defense and a cohesive presentation of mental health issues, every step in the proceedings against your client must be analyzed in light of the mental health issues in your case. Whether you enter a special plea of incompetency, put forward a mental retardation defense or plead Not Guilty by Reason of Insanity (NGRI) on behalf of the client will depend upon the severity of the mental condition and the time of onset. However, in all cases, your analysis of how mental health factors influenced your client should be wide ranging. Even if you believe as a rule of thumb that mental health issues are strategically unwise, your client will only benefit from your in-depth investigation and consideration of specific facts relating to his mental health.

**Waiver of Rights and Consent**. A voluntary waiver of rights must be made by a person who gives it knowingly and intelligently. Can a person who has auditory hallucinations be expected to comprehend *Miranda* warnings, much less understand the consequences of waiving a right? Is a person whose brain is damaged in the frontal lobe region and who is unable to monitor his impulses able to intelligently consent to having his room searched? Ask your experts to review the warnings given to the defendant and comment upon how his mental condition could impact his understanding of the warnings. Also determine how the symptoms of his mental illness would affect his judgment in an interrogation setting. In this context mental retardation is of particular significance, given the propensity of mentally retarded persons to agree with authority figures.[10]

Be sure to review any police notes and look for signs of mental or physical distress in the client before, during and after the waiver. If the interrogation or confession was taped, your experts should review it. Investigate whether the authorities knew about your client's mental condition - and whether they exploited it during their interaction with him-through the community grapevine, by personal interaction with him on the street, or from prior arrests and. Also determine whether your client was under the influence of drugs or alcohol — or mentally debilitated due to withdrawal from drugs or alcohol — at the time he waived his rights. Find out if medication was prescribed for your client and if he was taking it.

**Competency**. Competency, which is related to the client's fitness to stand trial, is usually determined prior to the trial on the merits. If you believe the client is unable to comprehend the nature of the proceedings against him or unable to assist you in his defense, competency is the first big issue to consider. Remember, competency has to do with the mental state of the defendant at the time of trial. It is an inchoate matter, in that a defendant who has been found incompetent may later become competent and stand trial. The reverse is also true: a client who has been found competent may later become incompetent, perhaps even during the trial. Many skilled attorneys fail to appreciate the difference between competency to stand trial (here and now) and criminal responsibility for the alleged offense (then and there).

Competency involves more than a superficial knowledge of the role of the courtroom actors. It requires that a defendant be able to understand and keep pace with courtroom proceedings, process and retain relevant information from witnesses, and be motivated to act in his own defense.

This article is too brief to provide a comprehensive discussion of competency but in our experience, attorneys avoid competency proceedings too often, even though the prospect of a competency trial can be a catalyst for a favorable outcome. The best example of this is the federal prosecution of Theodore Kaczynski, where vigorous, intelligent litigation of the defendant's competency to stand trial provided a framework where government mental health professionals agreed that Mr. Kaczynski was severely mentally ill. The competency litigation ultimately led to a plea. However, acknowledgment of mental illness in a high profile defendant by state doctors would never have happened if the defense had not set the stage with credible, comprehensive evidence of the defendant's long standing mental illness.

The constitutional standard of incompetence to stand trial is formidable and, as a rule, is very strictly applied by mental health professionals in state forensic hospitals. In some instances, it may be advisable to open a dialogue with the state doctors. You may want to provide evidence of prior mental disorders you have discovered in the social history investigation, especially if hospitalization or psychological testing was required. This is a difficult decision and should always be made after a full consideration of potential consequences, both positive and negative. If you do decide to communicate with state mental health experts, leave your aggressive courtroom tactics at the office and present your evidence in a collegial, supportive manner.

Failure to aggressively litigate questions of the defendant's competency results in far too many mentally ill and mentally retarded defendants facing trial when they are clearly unable to assist their attorneys. This is especially true of paranoid schizophrenics who may well understand the nature and sequence of a trial but, as a result of their illness, believe that their defense lawyers are determined to harm them and therefore withhold or distort evidence. This is an example of how an individual may appear competent on the surface when manifestations of his illness are, in fact, gravely undermining his defense.

In a situation where your client is unable to assist meaningfully in his defense, it is sometimes helpful to have your mental health experts observe your efforts to interact with your client so they have direct knowledge of the defendant's limitations in being able to assist in his defense as required by *Dusky v. United States*, 362 U.S. 402 (1960) and *Drope v. Missouri*, 420 U.S. 162 (1975).

Because mentally retarded persons are characteristically passive and suggestible, they often agree with authority figures and responding affirmatively when asked questions. It is easy to misinterpret passive compliance for cooperation and thereby overlook the fact that a mentally retarded defendant may have no understanding of the proceedings against him or that it is his role to assist his lawyers. It is especially critical to acquire the assistance of experts in identifying characteristics of mental deficits when you have — or think you may have — a mentally retarded client or a client with a compromised intellect.

**Criminal Responsibility.** While there are variables among jurisdictions, mental disorders that rise to the level of a defense are narrowly defined so that there are far too many instances when a profoundly mentally ill defendant may not meet the requisite criteria. However, most jurisdictions have some form of a diminished capacity verdict as an alternative to NGRI as well as lesser included offenses.

Since mental health evidence supporting a plea of NGRI or diminished capacity go to the state of mind of the defendant at the time of the crime, it is often advisable to give jurors the widest range of possible verdicts that reflect mental health issues. Also give them multiple opportunities to apply your client's mental health issues to their deliberations. This is especially true in a death penalty case because jurors are considering punishment from the outset of the trial process.[11] These types of more favorable verdicts often turn on the defendant's mental state (*e.g.*, absence of malice or no specific intent) so it does not necessarily follow that mental health issues that do not rise to the level of a defense should be reserved for sentencing considerations.

**Not Guilty by Reason of Insanity**. Insanity means either the defendant was too mentally disabled to form the requisite intent to commit a crime or the illness is manifested by a delusion so frightening that, if it were true, would justify the crime. A verdict of Not Guilty by Reason of Insanity exonerates the defendant from responsibility for the crime and results in mandatory confinement to a mental hospital. Because the definition of insanity is so narrow and the defendant has the burden of proof, attorneys often fail to plead NGRI, saying the success rate is virtually *nil*. Yet, how many of these same attorneys would decline to put up a credible alibi defense in a difficult factual case? In our experience, it is far more likely that mentally ill defendants forgo mental health defenses because their own attorneys, unfamiliar with the field and inexperienced in litigating these complex issues, inaccurately assess the severity and impact of the client's mental condition and fail to understand the link between the mental disability and the offense. This is not to say that NGRI should always be pursued. Certainly, there are many cases in which it may not be the most effective way to present mental illness. However, the possibility of litigating NGRI should not be disregarded out of hand simply due to the currently reigning theory that juries won't buy an insanity defense.

**Guilty But Mentally Ill**. While evidence of a defendant's mental illness may not result in a verdict of NGRI, in some jurisdictions the jury may compromise at a verdict of Guilty But Mentally Ill (GBMI). In a death penalty case, a verdict of GBMI would certainly indicate openness to mental health themes in sentencing. Doubtless, the defense is in a stronger position in the punishment phase of a capital trial if the jury has heard evidence that the defendant acted under the influence of mental illness rather than malice. Take care, though. Entering a plea of Guilty But Mentally Ill in a death penalty case should be approached with caution because it may render errors harmless, including issues of waiver and consent.

## Developing and Presenting Consistent Mental Health Evidence

### Mental Health Issues Must Be Integrated into All Phases and Pleadings in the Case

We have seen countless cases where the defense proclaims innocence in the media, in the courtroom and before the jury and then switches to a mental health theory of mitigation during the sentencing phase. Such inconsistency undermines your credibility and diminishes the weight jurors will give to your mental health evidence.

Mental health evidence that comes as a surprise to jurors will be interpreted as a last ditch effort by the defendant to avoid the consequences of the crime. Therefore, every characterization you make of the case, whether in court, in negotiations with the state, in conversations with jail personnel, in public or to the media, should be consistent and shed light on the mental health aspects of your case. Above all, no facet of the presentation should allow a juror to think the defense considers mental health factors to be a justification for the offense.

**Front Loading**. To avoid sharp distinctions among the phases of litigation, present mental health evidence as early as possible. This method is sometimes called front loading. It allows you to influence the tone of the proceedings and acquaint the community, the court and the state with your theory of the case. Front loading is the cornerstone of a consistent presentation of your case.

When mentally ill defendants are indigent, acquiring necessary resources to provide an adequate defense requires energy and ingenuity. Take every opportunity to educate the court regarding the mental health issues in your case through well-crafted ex parte motions and arguments for funds for expert assistance. If the judge denies the funds, request evidentiary hearings on each expert and call witnesses to support your requests. Use all your skill and creativity to avoid the mis-characterization of your client as an evil individual rather than a severely mentally handicapped human being who deserves compassion.

An excellent example of front loading occurred in Susan Smith's trial when her history of sexual abuse, suicidality and depression was presented in the guilt/innocence phase to rebut the state's allegation of motive — that she had killed her children to improve her chances of marrying a wealthy bachelor. This approach clearly influenced the jury to unanimously reject the death penalty for Susan Smith.

Likewise, front loading evidence regarding mental retardation or brain damage also is usually helpful. This was illustrated by the comments of a man who had served on a capital jury in which a verdict of Guilty but Mentally Retarded was rejected in the guilt/innocence phase but presentation again in sentencing proved critical. In explaining why the jury reached a life verdict, the juror said, "We weren't sure he was mentally retarded, but we weren't sure he wasn't either." As for his own vote for life, he said, "I've heard all my life that mentally retarded people are God's angels and I was scared to take a chance I might be killing one."

**Voir Dire**. It is crucial that you explore attitudes toward mental disabilities during voir dire. Use the voir dire process to educate prospective jurors about the particular mental disabilities suffered by your client. Then, when impaneled jurors hear evidence from expert and lay witnesses, they already will have been exposed to the concepts and evidence you present and are far more likely to understand the significance of that evidence.

In a capital case, prospective jurors who are not willing to give meaningful consideration to your mental health mitigation evidence, even after the client has been convicted of a death- eligible murder, are not qualified to sit on the jury.[12] Attempt to prevent the court or the state from rehabilitating prospective jurors who will automatically reject mental health evidence during deliberation in either phase.

**Opening Statement**. An opening statement is your chance to display the 4 Cs. Never overstate the longevity, severity or effects of your client's mental condition or exaggerate the findings of mental health experts. Clearly and systematically lay out your theory of how the mental disability affected all aspects of the case — events leading up to the crime itself (including motive and intent to commit the crime), the investigation, arrest, interrogation of your client and even how your client appears in the courtroom. In cases of innocence, point out how mental health factors contributed to the accusations against your client. Remember that jurors in death penalty cases almost always think about punishment as they consider guilt/innocence issues so it's necessary to consistently provide a framework for jurors to consider the offense and punishment in the context of your client's mental condition.

**Capital Sentencing Issues: Rebutting Aggravation**. Whatever statutory aggravating circumstances the state puts forward, the state's goal is to keep the jurors' attention on the defendant's criminal behavior and to portray him as the vile, depraved, inhuman monster who committed that heinous crime. Mental health evidence is a way for you to assert your client's humanity through his frailties. When possible, recast motive and intent in each aggravating circumstance. In a recent capital trial, the defense acknowledged intent to commit armed robbery of an elderly man, an act described by the state as predatory. Even so, in the sentencing phase, the defense effectively demonstrated through testimony from mental health experts that the victim's unexpected aggressive response to the defendant's demand for money resulted in panic in the defendant. Family witnesses testified about repeated beatings of the client and his siblings by their father that were so severe they had felt their own lives were threatened. In this instance, the expert and lay witnesses, in combination with the defendant accepting responsibility for armed robbery, provided a credible explanation other than malice for a tragic death. As a result, the jury rejected the death penalty as fitting punishment.

**Capital Sentencing Issues: Prior Convictions**. When left unrebutted or unexplained, a defendant's prior offenses serve as evidence that he is incorrigible and dangerous. Look for evidence that the same mental health factors that influenced the current charges were also at work in earlier offenses, and for correlations between periods of treatment and reduced criminal activity. Review the social history with a fine tooth comb for signs that the mental condition was present at the time of the earlier offenses. Then, have your mental health experts review records of the prior offenses for signs that mental disorders also influenced these offenses. In a case of mental retardation, look for evidence that your client has been repeatedly duped into committing crimes by smarter accomplices who manage to get away and let him take the blame.

Rebuttal of prior offenses must be consistent with your theory of the present case and treated with the same care as the current charges. It is absolutely necessary to have a comprehensive social history in order to identify recurring influences on your client's behavior. When you use mental health evidence to rebut prior offenses, the presentation must be credible, comprehensible and consistent in every way with your theory of defense in the current case. Otherwise, you not only fail to present an alternative perspective regarding prior convictions, you undermine the credibility of the current case as well.

**Capital Sentencing Issues: Mitigation**. Research on the factors that influence capital jurors in the sentencing phase repeatedly has found that mental health issues are extremely significant. When jurors are convinced that a defendant was acting under an extreme mental condition or emotional disturbance or has significant mental limitations, they are more inclined to grant mercy.[13]

During the sentencing phase, the stringent technical definition of NGRI is a thing of the past. Take advantage of the somewhat relaxed rules of evidence in sentencing, and put the jurors in the shoes of the defendant. Don't let your experts give dry, psychobabble testimony or rely on vague, overused phrases like "dysfunctional." Use the expert witnesses to compassionately portray to the jurors the turmoil inside your client's head.

Most people have no idea what it is like to experience auditory hallucinations and mistakenly believe they can be turned on or off like a radio. This was dramatically disproved in a workshop we recently attended where the participants, all lawyers, were given headphones with tapes simulating auditory hallucinations. While listening to the tapes, selected participants were asked to answer ordinary questions and perform simple tasks like drawing a map from home to a nearby restaurant. Invariably, these routine activities proved difficult under the influence of intrusive auditory commands. Consider using demonstrative evidence to illustrate your client's mental disorder, or refer to familiar characters in books, movies and television. Make the mental illness real to the jury so they can comprehend its devastating and disastrous effect on your client.

When mitigation evidence is developed and presented within a unified theory of the case, jurors not only are prepared to accept it, they actually will view the case differently. The 4 Cs are especially important in maintaining continuity between the phases of a capital trial. It is impossible to maintain credibility if you deny all allegations in the first phase, and then look to mental health issues to explain the crime and sway the jury toward a life sentence during the punishment phase. Anticipate potential contradictions — they must be resolved and incorporated into the unified theory of your case.

**Closing Argument**. In closing argument, weave all the strands of evidence together to form a compelling, comprehensible narrative that is a reasonable alternative to the prosecutor's proclamation that the client is evil to the core. You can only accomplish this if the mental health issues have been presented throughout the proceedings with time-consuming thoroughness, scrupulous integrity and righteous advocacy that place the tragic facts of the offense in the context of the severe and involuntary mental disorder of the defendant.

## Developing and Presenting Comprehensible Evidence

When your witnesses testify, all of the 4Cs must be interlocked. Jurors must understand your evidence before they can accept your theory. They also must believe it. If they question the credibility of your evidence, they will likely stop listening and start resisting your theory. Without doubt, for your evidence to be understood **(comprehensible)** by jurors, it must have a reliable foundation **(credible)**, it must not come as a surprise **(comprehensive)** and it must not be used as an excuse only after all else has failed **(consistent)**.

## Presenting Comprehensible Mental Health Evidence

**Emphasize Lay Witnesses**. Jurors tend to be skeptical of expert witnesses. As a general rule, they do not believe defense expert witnesses unless pre-existing information supports the expert's opinion.[14] Therefore, you must support expert findings through lay witnesses whose testimony traces the client's mental disability over time. In this way, the diagnosis of mental disorder is corroborated by reports of symptoms that existed before the offense and before the expert witnesses ever evaluated the client and reached a conclusion that he is mentally handicapped. Your strongest rebuttal to the state's claim that your client fabricated a mental handicap as an excuse for committing the offense is credible testimony by lay witnesses, especially if their testimony is backed up by contemporaneous documents. Jurors tend to identify with lay witnesses, whose testimony will resonate with the life experiences of the jurors. Remember, lay witnesses, expert witnesses and social history documents must be interlocked if you are to achieve a comprehensible presentation of mental health issues.

**Explain Your Client's Mental Illness with a Teaching Witness**. As a prelude to testimony by the expert witness(es) who evaluated your client, it is sometimes helpful to have a teaching witness describe to the jury the symptoms and behavior associated with a particular mental condition. This witness does not evaluate or testify about your client but does educate the jury and the court about your client's mental disorder by defining it, describing the symptoms and course of the illness, and explaining the pervasive force the disorder has on an individual's life.

**Use Expert Witnesses to Show How Mental Illness Affected Your Client**. The mixture of experts who evaluate and testify for the defense depends entirely upon the specifics of your case. You will need a neuro-psychologist to perform and testify about neuro-psychological testing and conclusions. You may need testimony regarding a psychiatric evaluation, particularly if your client has a history of hospitalization and medication for mental illness or, as is all too often the case, the client previously has been incorrectly diagnosed and improperly medicated. Obviously, if more than one expert testifies, all should be fully informed of each other's findings.

Mental health evaluations by psychiatrists and psychologists, especially in a forensic setting, tend to be tailored to answer narrow referral questions about the client's mental condition, such as whether the defendant is competent, insane or mentally retarded. As a result, expert testimony will be dry and technical unless you take steps to ensure the experts speak **to** the jurors in a conversational tone, rather than **at** them with academic arrogance. Make sure your expert witnesses are well versed in the details of your client's life and family history as well as his mental illness. That way, both expert and lay witness testimony will be consistent, comprehensible, credible and comprehensive.

**Consider Additional Expert Witnesses**. To paint a picture of your client's life with a broader brush, consider presenting testimony by a social worker with a master's degree (a person commonly called an M.S.W.) or doctorate who is qualified to assess the accumulated risk factors that contributed to his frailties.[15] After conducting a psycho-social assessment, a social worker can talk about the hazards an individual client faced at home and in the wider community. This perspective is particularly useful to a jury when a defendant's childhood was spent in a deprived environment where neither his family nor his environs had the resources to meet his basic needs such as food, shelter and stable, nurturing relationships over time. Such an analysis will anticipate and diminish an attack on your mental health evidence as nothing more than an "abuse excuse." A social worker will discuss how numerous psycho-social risk factors contributed to the client's conduct, exacerbated the ravages of mental problems and prevented meaningful intervention during his childhood when he was in dire need of treatment for his mental disabilities.

In death penalty cases, where the defendant's future dangerousness is always a consideration of the jury, whether statutory or not, an expert in prison adaptability can be very helpful in explaining that the structure of incarceration can control mentally handicapped inmates and, in fact, often leads to improvement of mental illness. This expert can also point out that inmates face the overwhelming mechanisms of behavior control available to corrections officers and can assure the jurors that in prison, taking prescribed medication is not voluntary and non-compliance with any prison regulation is not an option.

**Be Sure Expert Witness Testimony Is Comprehensible**. Jurors tend to be skeptical of expert witnesses in general and particularly skeptical of defense expert witnesses. Keep in mind that mental health experts are accustomed to talking to each other in the technical terms of their field. They have to be reminded that a diagnosis is professional shorthand for a cluster of symptoms that may be incomprehensible jargon to the average juror. To make sure jurors do not reject the

testimony of your experts simply because they didn't understand it, help your mental health experts state their findings in plain, comprehensible language and common sense terms used by the average person.

**Prepare Witnesses to Testify**. Prepare the direct examination questions of every witness — lay or expert — with great care. Mental health cases can easily disintegrate into a series of disconnected, contradictory witnesses who testify in a disjointed manner in language that makes no sense to the jury. Every witness presenting mental health evidence must be thoroughly prepared by the defense team for direct examination and cross examination. Make sure your witnesses know your theory of the case and how their testimony supports it.

### Demonstrate Compassion for Your Mentally Disabled Client

Making an effective presentation of mental health issues involves understanding and anticipating the effects of trial on your client. A person with a mental disorder does not perceive events or process ideas normally. The inability to process ideas and to communicate in a normal fashion is the very nature of mental disorder. When a mentally impaired person is enmeshed in the criminal justice system, his misperception of events around him and his communication disorders will only be exacerbated. This is especially true of the many mentally ill capital defendants who have paranoid tendencies and believe that you are part of a system that exists to cause them harm. However difficult it may be, remember that within the straightjacket of mental illness, this is logical.

You should expect that the defendant's symptoms and limitations will become increasingly apparent as trial approaches. This tendency, in combination with your own rising anxiety, can be explosive unless you prepare yourself and the client. In other words, if you think the client's accusations that you are doing nothing to protect his rights were irritating during pre-trial conferences at the jail, just wait until he hurls them at you in front of the jury and TV cameras.

By taking precautionary steps, you can limit the risk of your client acting out. For example, make sure that the client is receiving proper medication and that it is administered as directed. It is not unusual for the law enforcement officers who transfer your client from jail to court to forget to bring his medications, which are usually stored in a dispensary. If necessary, request the court to order that medication be provided and administered during the days when you are in court.

Continuously monitor your client's state of mind and take steps to reduce the stress he must endure. For example, in the case of a mentally retarded defendant who would characteristically become increasingly confused and frustrated during any proceeding, a motion to take a small portion of every hour to confer with the defendant and explain the proceedings to him is very helpful. Similarly, a mentally ill client may be able to withstand a six to eight hour day in court but beyond that, becomes unmanageable. A motion to end the proceedings every day at a certain hour might provide the relief and structure you client requires to control his impulsive behavior.

Returning to jail pandemonium at the end of the day is difficult for any client, but it can be especially agitating for a mentally handicapped one. It may be that assignment to an individual cell, where the client can retreat and calm himself, would be preferable. If he needs solitude, ask the jail custodians to make this arrangement in light of your client's mental state. Consult the client in all these decisions and respect his reasonable requests even though you may not be able to attain ideal trial circumstances. Keep track of his schedule and make sure he is allowed adequate time to sleep, eat, bathe and rest. Jails, especially those in large metropolitan areas, sometimes transport defendants hours before court is scheduled and make them wait hours after court before returning to the jail.

In short, do everything you can to reduce the stress your client experiences during trial. Every protective step you take helps avoid an outburst in open court. Such events are inevitably covered by the press and will be interpreted as signs of dangerousness rather than symptoms of mental illness. They almost always lead to increased courtroom security and overtly reinforce the picture of your client as unmanageable and threatening.

Anticipating and responding to the needs of a mentally impaired defendant is more than a behavior modification technique. It is a means of demonstrating to the client and everyone who has custody or control over him that you take his mental disorder seriously and intend to treat him with dignity and humanity. If you don't do it, how can you possibly expect that a jury will? Remember, you serve as a role model for the court, courtroom personnel, prosecution and jury, and, through your interaction with the client, teach others that your client deserves mercy.

### Conclusion

Even though the fields of law and mental health share some mutual values and goals, the criminal justice system is not user-friendly for mentally impaired criminal defendants. Archaic definitions, burden-shifting, and cultural bias against mentally ill persons are only a few of the formidable challenges an attorney faces when defending a client with a mental disability. For mental health issues to be considered with fairness and mercy, evidence must be developed and presented in a consistent, comprehensive, credible and comprehensible manner. To shortchange any of these principles is to squander your client's compelling mental health issues.

Worst of all, you are more likely to arouse anger and vengeance against the defendant rather than to foster the compassion and mercy you seek on his behalf.

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2. The web site for the National Alliance for the Mentally Ill is www.nami.org. The web site for National Institute of Mental Health is www.nimh.nih.gov.
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8. If your client suffered head injury, or if you suspect head injury, consult the web site for Head Injury Hotline at www.headinjury.com.
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13. *See* Stephen P. Garvey, *Aggravation and Mitigation in Capital Cases: What Do Jurors Think*? 98 Colum. L. Rev.1538 (1998).
14. *See* Scott Sundby, *The Jury as Critic: An Empirical Look at How Capital Juries perceive Expert and Lay Testimony*, 83 Va. L. Rev. 1109 (1997).
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# Chapter 7: Avoiding or Challenging a Diagnosis of Antisocial Personality Disorder

**by John H. Blume and David P. Voisin**

It's an all-too-familiar scenario in capital litigation. The prosecution moves for a psychiatric evaluation to assess a defendant's capacity to stand trial and criminal responsibility. The state evaluators review incident reports of the offense as well as the defendant's adult and juvenile criminal record—if any—interview the defendant and perhaps a family member or two, and possibly administer an IQ test and a personality assessment, probably the MMPI, and a few "projective" tests. Their diagnosis: antisocial personality disorder ["APD"]. This can be the kiss of death, because to many people, and most judges, this means that the defendant is little more than a remorseless sociopath.[1] Or as the "ubiquitous Dr. Grigson"[2] would state, the defendant has "a severe antisocial personality disorder and is extremely dangerous and will commit future acts of violence."[3] The state's expert will also explain that those with APD are deceptive, manipulative, and violent and show no remorse for their actions. The prosecution will remind the jury of this expert medical evidence in closing argument, telling the jury that the defendant is simply too dangerous and evil to spare and that the defendant's attempts to present mitigating evidence are nothing more than the contrived attempt of a manipulator to con them. Or as one prosecutor argued:

> You heard crazy like a fox and I think that's what a sociopathic personality is. . . . Sociopathic personality is what fits here, some guy that if he wants — he gets what he wants or he creates problems for people, a guy that is either going to get what he wants in the future in prison or he's going to create problems for people, and those jailers are living human beings with careers and lives on the line.[4]

Too often, it is the defense mental health expert who concludes that the defendant has APD. As a result, counsel may decide to forgo presenting any expert testimony on the client's behalf in order to avoid having the jury learn from a defense expert that the defendant may be a sociopath.[5] Without expert assistance to help them understand his actions, however, jurors will likely sentence the defendant to death.[6] At that point, it will be difficult to obtain relief on appeal or in post-conviction proceedings based on issues centering on the defendant's mental state. For instance, if trial counsel sought expert assistance and then made a decision not to conduct additional investigation or present much evidence, a reviewing court will almost always find that counsel made a reasonable, strategic decision. For example, in *Satcher*, trial counsel retained a psychiatrist and psychologist, both of whom diagnosed the defendant having APD. As a result, counsel opted not to investigate further and instead relied on testimony from family members. The reviewing court found that counsel's decisions were reasonable under the circumstances.[7]

The APD diagnosis is not only harmful, but it is frequently wrong. Sometimes the error rests on a misunderstanding of the disorder. At times, it is erroneously diagnosed because of an over-reliance on personality tests, a failure to consider the defendant's culture and background, or an inaccurate or incomplete factual basis. Too often, mental health professionals conclude that a defendant has APD for no other reason than he has been accused of a heinous crime and may have previously committed bad acts, and the experts make no effort to understand the context in which the actions took place. In short, it is often "the lazy mental health professional's diagnosis."[8]

Many experienced capital litigators, especially in Texas, are no stranger to this sort of drive-by evaluation. For example, in *Chamberlain v. State*,[9] the defendant was convicted of sexually assaulting and murdering a neighbor. Evidence of his guilt was not uncovered until six years after the crime. At the penalty phase, the defense argued that he had a non-violent past. The state, however, introduced evidence of an attack against a fellow soldier, an attack on a woman at a shopping mall, and the burglary of a pornography shop. The state then called a psychiatrist to testify that "the facts of the offense reveal a sexually sadistic, antisocial personality disorder."[10] There is very little in the court's opinion that suggests that the defendant actually met the criteria for APD.

Likewise, in *White v. Johnson*,[11] the prosecution's psychiatrist testified that the defendant had APD. This conclusion was based on the circumstances surrounding the offense, the defendant's alleged lack of remorse shortly after his arrest, and testimony that he had beaten a former spouse.[12] Although the facts of the offenses for which he was convicted were gruesome, the state's expert could point to little else that supported the criteria for APD. Both *White* and *Chamberlain* illustrate two common deficiencies with drive-by type diagnoses of APD: there is nothing about the defendant's conduct prior to age fifteen, and little or no evidence of repeated and pervasive antisocial conduct.

By understanding the criteria for identifying personality disorders in general and APD in particular, and by conducting a thorough and reliable social history, defense attorneys can often avoid and always be prepared to legitimately challenge an APD diagnosis. We will first identify the criteria for APD. We will also focus on critical features of APD that are often overlooked but which are necessary predicates to an accu-

rate diagnosis. We will then suggest ways to attack a state expert's conclusion that the defendant client has APD and recommend several courses of action that will help ensure that defense experts do not make the same mistakes that the state experts made.

## WHAT IS ANTI-SOCIAL PERSONALITY DISORDER?

### Diagnostic Criteria for Antisocial Personality Disorder

According to the Diagnostic and Statistical Manual, Fourth Edition ["DSM-IV"], "[t]he essential feature of Antisocial Personality is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood."[13] DSM-IV provides a number of criteria that must be met before an evaluator should conclude that a patient has APD:[14]

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
   (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
   (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
   (3) impulsivity or failure to plan ahead
   (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
   (5) reckless disregard for safety of self or others
   (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
   (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of Conduct Disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

At first blush, these criteria seem fairly broad and damning to many capital defendants. However, they contain very important limitations and exclusions that are often ignored or overlooked. First, APD requires that a defendant be at least eighteen years of age. Second, there must be evidence of a Conduct Disorder before age fifteen. Failure to meet these criteria eliminates APD as a diagnosis. Similarly, a mental health professional should first consider the possibility of organic impairments or other serious mental illnesses or disorders before finding a defendant to have APD. Finally, one of the most important limitations of APD that is frequently not considered is that an accurate diagnosis requires evidence of traits that "are pervasive (that is, present in a wide range of situations), distressing or impairing, of early onset, and enduring."[15] That is to say, there must be numerous examples of antisocial acts in a wide variety of contexts over a period of time before APD may qualify as an appropriate diagnosis. We shall discuss these exclusions and limitations in more detail.

### Age-Related Exclusions and Limitations on an APD Diagnosis

A. The Defendant Must be at Least Eighteen Years of Age.

The diagnosis should not be made if the defendant is under age eighteen. Generally speaking, "the definition of a personality disorder requires an early onset and long-term stability."[16] Prior to age eighteen, personalities are often not well-developed, and problematic traits observed during adolescence may disappear during early adulthood.[17] At most, juvenile defendants can be said to have a Conduct Disorder.[18] And even then, there are a number of limitations on that diagnosis for juveniles, including evidence of a pattern of misconduct and not merely isolated bad acts, a need to understand the context in which the actions took place, and a consideration as to whether the actions stemmed from a more serious underlying mental illness or disorder.

B. Evidence of Conduct Disorder Before Age Fifteen

Experts frequently gloss over this criterion for APD, often concluding that a defendant has APD with little or no information concerning the defendant's life prior to age fifteen. Under the DSM-IV criteria, a defendant absolutely cannot be classified as having APD unless he has a history of symptoms of Conduct Disorder before that age. Conduct Disorder "involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated."[19] DSM-IV requires the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:[20]

Aggression to people and animals:

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (*e.g.*, a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (*e.g.*, mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of Property:

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft:

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (*i.e.*, "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (*e.g.*, shoplifting, but without breaking and entering; forgery)

Serious violations of rules:

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years.

DSM-IV adds that the disturbance in behavior must cause "clinically significant impairment in social, academic, or occupational functioning. Finally, DSM-IV notes that if these criteria are not evidence until an individual is over eighteen years of age, the criteria for APD cannot be met.[21]

Defense counsel must pay particularly close attention to these criteria. Many children commit isolated occurrences of antisocial behavior without repeatedly violating the law or social norms, especially in reaction to a serious disruption in their family or school life.[22] The fact that a defendant was in a fight, bullied someone on a couple occasions, or cut school a few times should not count against him, except perhaps as a diagnosis of Oppositional Defiant Disorder or Disruptive Behavior Disorder.[23] If an occasional antisocial act prior to age fifteen is the only basis for determining that the defendant had a Conduct Disorder, then the expert was wrong to diagnose APD, yet this happens all the time.

It is also essential to be familiar with the context in which any bad acts or rules violations took place. The DSM-IV acknowledges that APD is more often found in those of low socioeconomic status and in urban settings, and thus there are concerns that the diagnosis has been applied "in settings in which seemingly antisocial behavior may be part of a protective survival strategy."[24] As a result, it cautions experts to consider "the social and economic context in which the behaviors occur."[25]

For example, children may run away from home if they are being physically or sexually abused. A young adolescent may steal or sells drugs to obtain money to meet basic needs. Similarly, a client who grows up in a violent area may join a gang and participate in gang-related unlawful activities because it is his way of coping with the harsh circumstances of his surroundings. The mentally retarded or those with severe learning disabilities sometimes skip school to avoid the pervasive sense of always being a failure.[26] Though these are unlawful or undesirable activities, they reflect not so much an enduring and inflexible personality trait of the client but his method of coping with difficult circumstances. They should not factor into a diagnosis of Conduct Disorder.

Counsel must also consider whether the antisocial act was the product of a more severe mental illness or disorder. For example, psychotic disorders, especially with paranoid symptoms or hallucinations, may explain aggression, destruction of property, or running away.[27] "In general, extremely violent behavior, especially if unpredictable and unjustified, should raise the suspicion of an underlying psychotic disorder or of specific brain pathologies, such as seizure disorders, tumors, subacute encephalitis, tuberous sclerosis, and dissociative illnesses."[28] Similarly, children with attention deficit/hyperactivity disorder may at times be disruptive. Finally, children and adolescents may react aggressively and exhibit hypervigilance in response even to trivial events because they have posttraumatic stress disorder as a result of physical and sexual abuse.[29] The defendant's antisocial acts committed prior to turning fifteen that are attributable to another mental disease or disorder should not lead to a diagnosis of Conduct Disorder.

Many clients have committed bad acts prior to age fifteen; of these, however, a large number did not engage in significant or repeated antisocial conduct. Regardless, then, of what they may have done after turning fifteen, these defendants do not fit the criteria for APD. And even for those who may at first glance meet the Conduct Disorder criteria, thorough and reliable investigation of the defendant's early life will uncover mental illnesses, disorders, or severe trauma that frequently explain the misconduct. If defense counsel can explain childhood and early adolescent misconduct and avoid a finding of a Conduct Disorder, the defendant should not be diagnosed with APD.

**Other Limitations on an APD Diagnosis**

Besides the age-related exclusions, the other specific criteria for APD contains a number of other significant limitations.

**A. There Must be a Pattern of Antisocial Acts**

Too often, clinicians, judges, and lawyers view the APD criteria as nothing more than a checklist of antisocial acts. If a client has committed several prior bad acts, then he is anti-

social. It is simply wrong, however, to equate several antisocial acts with APD. Category A of the APD criteria lists a number of types of antisocial acts, including unlawful behaviors, lying, impulsivity, irritability or aggressiveness, reckless disregard for the safety of self or others, irresponsibility, and lack of remorse. What is often overlooked is that the criteria explicitly require evidence of "*repeatedly* performing acts that are grounds for arrest," or "*repeated* lying," or "*repeated* physical fights or assaults." Thus, even if the state's experts or the defense's own experts uncover evidence that the defendant committed prior criminal acts or lied to someone or got into a fight, without reliable evidence that he repeatedly engaged in the antisocial acts, he would not meet the criteria for APD. This is obviously a critical area to be aware of because most people, and not just capital defendants, have engaged in antisocial acts in their lifetimes, but no one would jump to the conclusion that they have APD.

**B. The Context and Motivation for the Antisocial Acts.**

A repeated pattern of a variety of antisocial acts may be necessary for an APD diagnosis, but it is hardly sufficient. It answers only what the client did but does not explain why. As discussed in the context of Conduct Disorder, experts and defense counsel must consider the circumstances under which the bad acts took place. APD is supposed to characterize those who are deceitful or manipulative and who act for personal gain or pleasure without regard for the feelings of others.[30] Those with APD are said to "lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal . . . and may be excessively opinionated, self-assured, or cocky."[31]

These concerns should lead a clinician and defense counsel to investigate the defendant's past in greater detail to learn what was driving his conduct at the time. Did the defendant commit thefts or burglaries for the thrill of it or to obtain money to run away from an abusive home? Or was he pressured by older siblings or a parent to participate in a robbery? Did the defendant get into fights out of a sense of loyalty or obligation to a gang that everyone felt pressured to join? Or is there any evidence that he initiated fights for no reason. Even though the defendant may have performed bad acts, he may not have done so for purely personal reasons or for reasons that do not make sense under the circumstances in which they took place. Understanding why certain acts took place may uncover more sympathetic mitigating evidence and also rule out APD.

Another way to approach this is to recall that under the APD criteria, antisocial acts must be pervasive, that is, present in a wide range of situations. If the defendant acts out only when he is with other gang members but does not otherwise get into fights or break the law when with other people or with his family, the motivation behind the defendant's actions may have little to do with his personality traits but is a response to his environment. Thus, "[a]ntisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder."[32]

**C. Differential Diagnoses**

Many defendants suffering from schizophrenia, other serious mental illnesses, or substance dependence have engaged in unlawful or antisocial acts. Likewise, several of the criteria for other personality disorders, such as borderline personality disorder, schizotypal personality disorder, narcissistic personality disorder, are similar to the criteria for APD. If an expert and defense counsel do little more than count the number of antisocial acts that the defendant committed, they may not realize that the defendant is suffering from something much more serious and more mitigating in the eyes of the jury. In addition, as a general rule, experts may generally not diagnose APD if there is evidence of other disorders affecting conduct.

APD should not be diagnosed if antisocial acts result from organic causes, occur exclusively during an episode of an Axis I or clinical disorder, or are not typical of the individual's long-term functioning.[33] In fact, one of the criteria for APD is that the occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.[34] This also highlights the need to investigate whether the defendant may have brain damage and ensure that he has undergone a reliable battery of neuropsychological tests. An evaluator should also consider when the defendant's antisocial actions began. If antisocial acts did not begin until the defendant was exposed to severe trauma or extreme stress, it is possible that he is suffering from posttraumatic stress disorder and thus the undesirable acts would not reflect his inherent personality traits.

Distinguishing APD from other personality disorders is difficult, especially since many personality disorders have similar criteria. For instance, those with a narcissistic personality disorder also tend to be tough-minded, superficial, glib, and exploitative. They, however, do not tend to be impulsive. Those with borderline personality disorder are often manipulative. They, however, aim to gain nurturance, whereas those with APD tend to be manipulative for profit or power and are more emotionally stable. Individuals with Paranoid Personality Disorder or paranoid schizophrenia, by contrast, are sometimes motivated by revenge.[35] Some of these more subtle differences between APD and other personality disorders demonstrates the need for a careful investigation not only into what the defendant may have done but also why he did it.

An APD diagnosis is also problematic if the defendant has a substance-related disorder. DSM-IV cautions against basing a diagnosis of any personality order solely "on behaviors that are the consequence of substance intoxication or

withdrawal or that are associated with activities in the service of sustaining a dependency."[36] In fact, APD should not be diagnosed at all for an adult with a substance-related disorder unless signs of APD were already apparent in childhood and continued into adulthood.[37] Many clients suffer from chronic and long-standing alcohol and other drug related disorders. They may have to steal or sell drugs to satisfy their own needs. They may not get into fights unless they are drunk. Alcohol, especially in conjunction with some types of brain damage, may impair a defendant's ability to think through the consequences of his actions and cause him to be more impulsive. If all or most of the defendant's antisocial conduct is linked somehow to dependence on alcohol or other drugs, several of the APD criteria may not be applicable.

## AVOIDING A DEFENSE DIAGNOSIS OF APD

An APD diagnosis by a defense expert almost always results from a lack of diligent and thorough investigation into the client's social history. Even good lawyers occasionally take steps that lead to APD. Although expert assistance is almost always needed in a capital case, it is often not wise to send in a psychiatrist at the outset of the investigation. At that time, the defense psychiatrist will know only what the state evaluators usually know: the defendant committed a horrible crime and perhaps has a prior criminal history. Knowing only a list of antisocial acts in the defendant's past, even well-meaning experts may begin to think of APD in the absence of additional information, including details that explain or mitigate some of the prior bad acts. Once an expert begins to entertain the possibility that the defendant has APD, the expert may later be resistant to changing his or her initial impression.

Counsel should also avoid having the defendant undergo personality tests, such as the MMPI, or projective tests. These tests are not designed for client's with the history of most capital defendants. Many defendants will score high on antisocial traits and appear to be manipulative and deceitful when they are in fact being candid. In particular, defendants who are tested under stressful conditions, *e.g.*, shortly after being incarcerated, tend to endorse a large number of extreme symptoms. Thus, they erroneously come across as malingering and manipulative.[38] In addition, defendants from different cultural backgrounds may have elevated scores on various scales. Similarly, defendants with low intelligence, reading problems, or other impairments may not understand all of the questions or may respond inconsistently to different items, which again may make them appear to be malingering and therefore deceitful.[39] There is a real danger that experts will use the tests as a window into the mind of the defendant and conclude that he has the personality traits of a sociopath. In turn, the jury will likely be swayed by seemingly "objective" evidence of the defendant's antisocial personality.

If counsel should not send in experts immediately or administer various personality tests, what should be done? The simple answer is that counsel should follow the five step process recognized as providing the requisite standard of care to assure that the client receives a competent and reliable evaluation.[40] The first step is to obtain an accurate medical and social history. Second, counsel must obtain other historical data not only from the client but from independent sources. Thus, defense counsel will require funds for a mitigation investigator to collect school, employment, military, medical, psychological, and all other records pertaining to the client and his family. An investigator will interview the client, close family members, friends, acquaintances, teachers, employers, and anyone else who was close to the client and his family.[41] Third, the defendant should undergo a physical examination, including a neurological evaluation. Fourth, depending on the client's history and results of the physical examination, counsel should decide which additional diagnostic studies are required. Often, this will involve neuropsychological testing, especially if the client has a history of head injuries, trauma, learning disabilities, or other problems or diseases affecting the brain. In addition, the defendant may require an MRI, CT scan, EEG, or other neuroimaging procedures. Finally, counsel should be aware that the standard mental status exam cannot be relied upon in isolation for assessing the presence of organic impairment. The standard mental status examination may not detect more subtle signs of organic impairment. To accurately assess the presence of these types of problems, the examiner must consider all of the data collected. Once defense counsel has assembled this information, counsel can show the expert whether there is any evidence of a Conduct Disorder before age 15. Counsel will be able to apprise the psychiatrist whether the defendant was subjected to overwhelming trauma or can point to hospital records documenting brain injury or exposure to neurotoxins. The expert will also have access to well-documented information concerning the client's alcohol and drug history. Counsel may be able to establish that the defendant has experienced hallucinations or delusions. Counsel will be able to document the environmental factors that shaped the defendant's life choices. For example, the expert may learn that the defendant used alcohol to blunt the trauma of being sexually abused, and that he began skipping school at a young age to drink. In sum, counsel will uncover facts such as organicity or psychosis that will exclude APD or that will put the defendant's actions in a more sympathetic light.

In prior psychiatric or psychological evaluations, some defendants may have already been diagnosed as having APD or a Conduct Disorder. That, however, should never be taken as the last word on the defendant's mental condition. Those prior evaluations usually suffer the same infirmities as court-ordered evaluations in capital cases: insufficient facts, inadequate investigation, or inattention to the specific criteria. A defendant may even have been labeled as having a Conduct Disorder, as opposed to a mental illness, when he was a

juvenile to save the state the expense of having to offer mental health care.[42] Moreover, juvenile and other facilities may also have been the setting for trauma that cause serious mental disorders.

The take home message is that there are no short cuts. Nothing less than a comprehensive social history can provide the data needed to make a reliable and more favorable diagnosis and avoid a diagnosis of APD. It is also the only way to have a meaningful chance to rebut an APD diagnosis by the state's experts. The credibility of the state's expert will be undermined only if the defense can present reliable and independently corroborated evidence either excluding APD or ruling out several of the criteria supporting the state expert's conclusions. Without evidence that specifically rules out various criteria or knocks out APD altogether, the jury will be left with the picture that the defendant is, by nature, violent, manipulative, and remorseless.

**ATTACKING THE STATE'S FINDING OF APD**:

Clearly, APD is the state's preferred diagnosis. It enables the prosecution to present expert evidence that the defendant has had a "pervasive pattern of disregard for, and violation of, the rights of others that beg[an] in childhood or early adolescence and continue[d] into adulthood."[43] In other words, the defendant was, is, and will continue to be mean, violent, and remorseless. Can defense counsel do anything to prevent or dilute this type of testimony?

In some states, state experts may be limited to evaluating a defendant's capacity to stand trial and criminal responsibility.[44] Defense counsel should oppose prosecution motions to have the defendant evaluated if the prosecution cannot show a basis to question the defendant's competency or unless counsel believes that there may be a question of competency. Counsel should also move to prohibit the introduction of state expert testimony that exceeds the scope of the initial commitment order.

State evaluations that exceed the limited scope of the trial court's order for competency and criminal responsibility evaluations may also raise Sixth Amendment concerns. The defense is entitled to notice about the specific purpose of an evaluation so that counsel can advise the defendant accordingly. Counsel cannot perform this function if the prosecution misuses the court-ordered evaluation to gain additional information beyond the express scope of the evaluation to use at the penalty phase, for example evidence of future dangerousness or evidence that the defendant meets several of the criteria for APD.[45] Therefore, if the defendant has been sent to the state hospital for the limited purpose of determining his capacity to stand trial, defense counsel should challenge on Sixth Amendment grounds the state's attempt to present information garnered during that evaluation at the penalty phase.

In most jurisdictions, courts will allow state expert testimony at least in rebuttal to defense mental health experts. Counsel must then research possible suppression motions and prepare for rigorous cross-examination. Counsel must obtain the client's complete state hospital file, including documents that had been provided by the prosecution. Often a release from the client will suffice. If not, the defense must move for the production of all such material. In most jurisdictions, experts must disclose the underlying facts or data upon which their conclusions rest.[46] Moreover, the prosecution is also constitutionally obligated to disclose anything in the records that is favorable to the defendant or that would provide the basis for undermining any of the criteria for the APD diagnosis.

In many cases, the records will reflect that the state's experts have little or no basis for concluding that the defendant has APD. For instance, state hospital records may contain no information at all about the defendant's life prior to age fifteen, or they may show that the defendant's antisocial acts did not begin until after age fifteen. Thus, there would be nothing on which to base a finding of Conduct Disorder, and hence the defendant cannot have APD. Likewise, the records will show that the state experts did not have evidence of ***repeated*** acts of misconduct. They may have known about one or two arrests for relatively minor crimes or fights, but nothing more.

When it is fairly clear that the criteria for APD do not fit, which will be true in the majority of cases, defense counsel should move to exclude the state's expert testimony under *Daubert v. Merrell Dow Pharmaceuticals*[47] or analogous state law precedent. Counsel can show that the state expert's opinion has no factual support and runs counter to accepted standards and practices in the mental health field.[48] Even if counsel cannot shield the defendant from a court-ordered evaluation and cannot suppress state expert testimony on APD, counsel can at least cross-examine the state's expert about the lack of factual support. Finally, counsel may be able to cross-examine the state's experts about additional information, such as organic brain damage or schizophrenia, that may rule out APD or at least undercut various criteria.

## CONCLUSION

At the penalty phase, jurors are already likely to be leaning to sentence the defendant, a person whom they have just convicted of a heinous crime, to death.[49] State expert testimony that the defendant has APD will confirm what the jurors have come to believe about the defendant. To improve the client's chance of receiving a life sentence, defense counsel must either preclude evidence concerning APD or present a compelling case in mitigation that not only helps jurors understand the defendant's history but that also assures them that the defendant is not a future danger, is not remorseless, and is worth saving.

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**ENDNOTES**

1. *See, e.g., Graham v. Collins*, 506 U.S. 461, 500 (1993) (Thomas, J., concurring) (equating antisocial personality disorder with being a "sociopath").
2. *Satterwhite v. Texas*, 486 U.S. 249, 268 (1988) (Blackmun, J., concurring in part and concurring in the judgment).
3. *Id.* at 253.
4. Record on Appeal, *State of South Carolina v. Franklin* at 3182-83.
5. *See, e.g., Satcher v. Pruett*, 126 F.3d 561, 572 (4th Cir. 1997).
6. Stephen P. Garvey, *Aggravation and Mitigation in Capital Cases: What Do Jurors Think?*, 98 Colum. L. Rev. 1538, 1559-60 (1998) (jurors more likely to vote for death if they think that the defendant is a future danger and shows no remorse).
7. Satcher, 126 F.3d at 572-73.
8. John Blume, *Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination*, THE ADVOCATE 4, 10 (AUGUST 1995).
9. 998 S.W.2d 230 (Tex. Crim. App. 1993).
10. *Id*. at 233.
11. 153 F.3d 197 (5th Cir. 1998).
12. *Id*. at 205-06.
13. American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 645 (4th ed. 1994) [hereinafter DSM-IV] at 645.
14. *Id.* at 649-50.
15. John G. Gunderson and Katharine A. Phillips, *Personality Disorders*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1425, 1432 (Harold I. Kaplan & Benjamin J. Sadock eds., 6th ed. 1995).
16. *Id.* at 1425.
17. *Id.* at 1433.
18. DSM-IV at 648.
19. *Id.* at 85, 646.
20. *Id.* at 90-91.
21. *Id.* at 91.
22. Benedetto Vitiello and Peter S. Jensen, *Disruptive Behavior Disorders*, in 2 COMPREHENSIVE TEXTBOOK ON PSYCHIATRY 2311 (Harold I. Kaplan & Benjamin J. Sadock eds., 6th ed. 1995); Caroly S. Pataki, *Child or Adolescent Antisocial Behavior*, in 2 COMPREHENSIVE TEXTBOOK ON PSCHIATRY 2477, 2478 (Harold I. Kaplan & Benjamin J. Sadock eds., 6th ed. 1995).
23. DSM-IV at 91-94.
24. *Id*. at 647.
25. *Id.* at 647; *see also id.* at 631 ("Judgments about personality functioning must take into account the individual's ethnic, cultural, and social background."
26. *Id.* at 86.
27. Vitiello and Jensen, *supra* note 22, at 2315.
28. *Id*.; *see also* Pataki, *supra* note 22, at 2481.
29. Pataki, *supra* note 22, at 2481.
30. DSM-IV at 645-46.
31. *Id.* at 647. DSM-IV and other sources are rich with negative descriptions of the characteristics of those with APD. They are "frequently deceitful and manipulative in order to gain personal profit or pleasure (*e.g.*, to obtain money, sex, or power)." *Id.* at 646; *see also Id*. at 647 (those with APD lack empathy and have an inflated self-appraisal and superficial charm). Those with APD are often found to "egocentrically value others for what they can provide, and they believe that, to survive, they need to extort whatever they can." Gunderson and Phillips, *supra* note 15, at 1431.
32. DSM-IV at 649.
33. *Id.* at 632.
34. *Id*.
35. *Id*.
36. *Id.*
37. When both the substance use and antisocial behavior began in childhood, both a substance-related disorder and APD may be diagnosed, even if some antisocial acts were related to the substance-related disorder, *e.g.*, selling drugs or thefts to obtain money to buy drugs. DSM-IV at 648-49.
38. Kenneth S. Pope, James N. Butcher, and Joyce Seelen, THE MMPI, MMPI-2 & MMPI-A IN COURT: A PRACTICAL GUIDE FOR EXPERT WITNESSES AND ATTORNEYS 104 (1993).
39. *Id.* at 103.
40. *See* Blume, *supra* note 8, at 5-7.
41. *See, e.g.*, Russell Stetler, *Mental Disabilities and Mitigation*, THE CHAMPION 49 (April 1999); Russell Stetler, *Mitigation Evidence in Death Penalty Cases*, THE CHAMPION 35 (January/February 1999); Lee Norton, *Capital Cases: Mitigation Investigations*, THE CHAMPION 43 (May 1992).
42. Carl Ginsburg and Helen Demeranville, *Sticks and Stones: The Jailing of Mentally Ill Kids*, THE NATION 17, 18 (December 20, 1999).
43. *Id.* at 645.
44. *See, e.g.*, S.C. Code ' 44-23-410.
45. *Powell v. Texas*, 492 U.S. 680 (1989) (*per curiam*); *Satterwhite v. Texas*, 486 U.S. 249 (1988); *Estelle v. Smith*, 451 U.S. 454, 465 (1981) (trial judge ordered a "psychiatric evaluation for the limited, neutral purpose of determining his competency to stand trial, but the results of that inquiry were used by the State for a much broader objective that was plainly adverse to [the defendant].").
46. *See, e.g.*, Fed. R. Evid. 705.
47. 509 U.S. 579 (1993); *see also Kumho Tire Co. v. Carmichael*, 119 S. Ct. 1167 (1999).
48. *See generally* Hilary Sheard, *What to do about Daubert?*, THE CHAMPION ___ (forthcoming) (addressing *Daubert* and suggesting methods of using it to attack a variety of state expert evidence, including findings of APD and future dangerousness).
49. *See, e.g.*, Theodore Eisenberg and Martin T. Wells, *Deadly Confusion: Juror Instructions in Capital Cases*, 79 Cornell L. Rev. 1, 12, 14 (1993) (there is a "presumption of death" . . . . A defendant on trial for his life at the punishment phase has one foot in the grave. The defendant needs affirmative action by jurors to pluck him from the crypt, action that is likely to annoy other jurors, at least initially."; Theodore Eisenberg, Stephen P. Garvey, and Martin T. Wells, *Jury Responsibility in Capital Sentencing: An Empirical Study*, 44 Buff. L. Rev ■

# Chapter 8: The Use of "Generators" in Brainstorming
## An Interactive-Environmental Approach to Case Conceptualization©

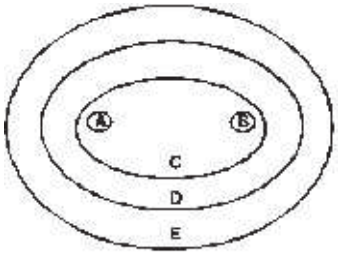
**by Eric Drogin, J.D., Ph.D.**

This is an exercise designed to generate as many ideas as possible in the initial *brainstorming* approach to case conceptualization. An analogical model with interchangeable *components*, interactive *currents*, and concentric or otherwise related *fields* may add significantly to the creative output of the multidisciplinary team.

There is something counterintuitive to imposing too much *structure* on the free-for-all brainstorming process, and this is not our intent. Rather than viewing the basic graphic tools in this exercise as *templates* or *categories* for group discussion, we will discuss a system of *generators* designed to spark the improvisatory energies of each member of the multidisciplinary team.

Some *generators* will be proposed which can serve as standard models for the conceptualization of any criminal case. Others may be more specialized. A systemic method will be provided for the construction of customized generators that can be designed around the requirements of each individual case.

### I. The Basic Generator




A: primary component
B: secondary component
C: primary field
D: secondary field
E: tertiary field

The primary component (A) is that entity which is viewed in this generator as the most important or initial focus of brainstorming.

The secondary component (B) is that entity which is viewed as an addition focus of brainstorming, complementary to (or in opposition to) the primary component.

The primary field (C) is the environmental context of the relationship between the primary and secondary components.

The secondary field (D) is the immediate area or context in which the primary field is located.

The tertiary field (E) is the broader area or context in which the secondary field is located.

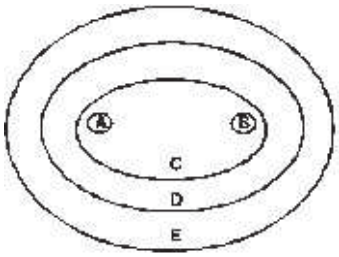
As the first of a series of pragmatic observations on the development and use of generators, it should be noted that the labels applied to various fields and components are not essential to employment of the model, which is designed to be as straightforward and utilitarian as possible. Ongoing use of generators will probably lead to such shorthand labels as *the A character*, *the B character*, etc., without detriment to the purpose of the exercise.

### II. The Initial Generator

Let's construct a sample generator for the following basic case example:

> We are representing a defendant who is a member of a neighborhood gang and who is accused of murdering another gang member. The gang in question is one of several operating in a ten-square-block area.

The components and fields might look something like this:




A: the defendant
B: the alleged victim
C: their gang
D: all gangs in the neighborhood
E: the neighborhood itself

Once an initial generator is constructed, its use can begin. This consists of three basic activities:

1) Brainstorming every question we might want to ask about each individual component and/ or field, and

2) Brainstorming every question we might want to ask about the interactions or *currents* between each individual component and/or field.

3) Recasting the questions in (1) and (2) above in terms of the past and future as well as the present.

The first activity would yield a wealth of inquiry concerning the status or functioning of the defendant, the alleged victim, the constellation of gangs in the neighborhood, and the neighborhood itself, all in isolation.

The second activity would involve generating all questions we might have about the relationships between each of the components and each of the fields. on a one-to-one basis, the following relationships can be examined:

A/B B/C C/D D/E
A/C B/D C/E
A/D B/E
A/E

In other words, what was the relationship between the defendant and the alleged victim, their gang, the other gangs in the neighborhood, and the neighborhood itself? What was the relationship between the victim and their gang, the gangs in the neighborhood, and the neighborhood itself? What was the relationship between their gang and the other gangs in the neighborhood, and the neighborhood itself? Finally, what was the relationship between the community of neighborhood gangs as a whole and the neighborhood in which they were located?

The third activity would involve going over all of the questions posed about the individual components and fields, and all of the questions about their various interrelationships, and asking: How would the answers to these questions differ if we looked at these fields and components in the past? What if we were to look at them in the future?

After the changes in answers are discussed, the team can ask itself: What are some of the different questions we would ask about all of the components and fields, if we were thinking in terms of the past or the future?

## III. Altering the Initial Generator

Once the three activities outlined above have been performed, the generator can be altered by changing any or all of the components or fields in a systematic fashion, and then recapitulating the three activities in light of different component or field descriptions and interrelated currents.

To use our initial example, we might want to replace our secondary component, the victim, with each known member of the gang. We might want to replace our primary component, the defendant, with other gang members. The primary field of the gang might shift to that of the classroom. The tertiary field of the neighborhood might expand to that of the city.

Of course, the interpolation of some new components or fields may dictate alteration of other components or fields; for example, if we wish to examine the relationship of the defendant and his mother, we would probably want to change the primary, secondary, and tertiary fields to the family home, the brook, and the neighborhood, or to the family, the extended family, and the ethnic community.

This last example also serves to illustrate the point that fields need not be viewed strictly as physical, environmental entities. Indeed, they could function as little more than ideas; for example, they could stand for local ordinances, state laws, and constitutional laws, or friends, acquaintances, and fellow citizens. Similarly, components need not stand for individuals, but could be symbolic of alternate diagnoses, potential suspect genders, or different verdicts.

## IV. Constructing New Generators

Once a certain number of alterations have been made to the initial generator, the team may decide to start from scratch with brand new generators that represent a paradigm shift from their predecessors.

To continue with our earlier example, the initial primary component of the defendant might be plucked out of the universe of options in which the crime allegedly took place, and might instead be placed with classes or categories of potential jurors or other courtroom figures within the various levels of our court system, or within the context of each of a series of related charges, or as diagnosed with each of an array of potential diagnoses.

Different potential treating professionals, invest-igators, or witnesses might be examined as primary or secondary components. How would each of the available judges be expected to view the defendant? What would be the likely environmental effects of different venues?

## V. Rewiring, Expanding and Chaining Generators

The initial A/B/C/D/E construction and one-to- one currents of the simple generator are readily adaptable to more elaborate brainstorming opportunities.

*Rewiring* would involve looking at more complex interactions than just A/H, D/E, etc. Team members could develop issues related to A/B/C, B/C/D/E, and other interactions.

Generators could be *expanded* with addition of multiple components (for example, A, B, C, D, and E) and multiple fields (for example, F through J). Certain components could be combined within some fields while other components could be combined within additional fields;

For example, A through C could be combined in field D while E through I could be combined in field J, all existing within Field K.

These combinations are made easier by the fact that there is no theoretical significance attached to the use of any particular letter or sequence of letters in the construction of generators, and by the use of graphic representation as opposed to complex formulae for expression of individual descriptions and currents.

*Chaining* of generators could occur in much the same way that other systems combine *genograms* into *ecomaps*. Currents could run from various components of one generator between any number of components or fields from a bank of additional generators, as well as between components of related genograms, ecomaps, and *timelines*.■

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**PRINCIPLES OF BRAINSTORMING**

1) 3 OR MORE PEOPLE
2) CREATIVE STATE OF MIND
3) RELATE FACTS
4) GENERATE EVERY IDEA POSSIBLE
5) LIST OUT ALL IDEAS
6) DO NOT EVALUATE
7) DO NOT PRIORITIZE
8) DO NOT DISPARAGE IDEAS
9) DO NOT DISCARD IDEAS
10) FIND A WAY TO WIN

# Chapter 9: Decision-Rules for Integrating the Expert into the Case: An 8-Step Process

**by James J. Clark, Ph.D., MSW, LCSW &**
**Ed Monahan, Public Advocate**

**Updated March 2011**

**Step 1:**
**Assess Mental Health or Other Expertise Needs of the Case**

**Step 2:**
**Finding and Evaluating Experts**

**Step 3:**
**Retaining the Expert**

**Step 4:**
**Preparing the Expert for Evaluating**

**Step 5:**
**The Direct Examination of the Expert: Telling the Story Well**

**Step 6:**
**Preparing the Expert for Cross-Examination and Improving Cross-Examination**

**Step 7:**
**Revise Direct Examination**

**Step 8:**
**Develop Demonstrative Evidence**

One of the strangest findings in the scientific literature of decision-making and judgment research is that decision-makers typically choose "quick-and-easy" approaches to making important decisions, instead of using approaches which are thoughtful, deliberative, and demonstrably most productive. This short-cut approach, known as "satisficing," (a combination of satisfying and sacrificing) values speed and closure over taking the time to achieve optimal results. H.A. Simon, *Administrative Behavior: A Study of Decision-Making Processes in Administrative Organizations*, Free Press (1976).

People sacrifice in order to deal with the overwhelming number of decisions and the complexity of possible alternatives. Without doubt, attorneys preparing to try difficult cases choose to satisfice because of such cognitive overload.

One effective alternative to satisficing and then hoping-for-the-best, is to use decision rules which can guide the decision-maker through the labyrinth of multifaceted alternatives. The purpose of this article is to present a step-wise process, a set of decision rules that attorneys can employ to manage expert witnesses in criminal and civil cases. Although this article refers to the "mental health" expert, it is applicable to experts from other domains as well.

Despite the importance of managing expert witnesses, attorneys often give little attention to the process of developing the expert-attorney relationship. They neglect this relationship at their client's peril. An inappropriate or poorly prepared expert witness can damage a case beyond repair. Service to the client supported by the attorney's development of a productive relationship with the appropriate expert will necessarily be of a higher quality.

Although time consuming, attention and enactment of this eight-step process is an investment which regularly pays substantial dividends for the client and the attorney.

## Step 1: Assess Mental Health or Other Expertise Needs of the Case

Good decision-making begins with accurate assessments of the needs of the case. Will the case be enhanced with the assistance of a consulting or testifying expert? Will an expert's involvement be to the benefit of the client? If yes, then an attorney is legally and ethically bound to obtain the help of an expert.

In order to make this assessment, it is essential for the attorney and other members on the defense team to brainstorm the case and arrive at potential theories of the case. The defense team acts as a decision-group that can "qualify, shape, and tune" the massive amounts of information into a manageable set of alternatives or directions for action. P.C. Nutt, *Making Tough Decisions*, Josey-Bass at 216. Developing a workable theory through careful analysis of the issues in the case will reveal whether an expert's help will benefit the client.

There are obvious examples of cases needing experts. A defense of insanity with an expert testifying to the opinion of insanity is more likely to help fact-finders understand the client's behavior and persuade fact-finders of his ability to know whether something is wrong or conform his conduct to the law. In a series of decisions the Supreme Court has "sent a clear signal to the courts that the provision of mental health expertise... is crucial to adjudication without which a criminal trial involving mental aberration would not be fair and just." P. Casey and I. Keiletz, *An Evaluation of Mental Health Expert Assistance Provided to Indigent Criminal Defendants: Organization, Administration, and Fiscal Management*. New York Law School Law Review Vol. 34, No. 1 (1989) at 34.

There are less obvious examples. A defense of extreme emotional disturbance can be successfully launched without an expert's testimony in support of it. However, it is more likely that the client will benefit from an expert's opinion on the extent of the emotional disturbance, its development and its influence on this particular client's behavior. The *subjective experience* of the client is a paramount perspective for the fact-finders to understand in considering whether there is a reasonable justification for this particular defendant's behavior. Mental health professionals are experts at eliciting and identifying a client's subjective experiences. Shawn Shea, *Psychiatric Interviewing: The Art of Understanding* (1988) at 50.

There are obscure examples. An expert can persuasively communicate why facts which appear to have an evil origin in fact have a comprehensible explanation. For instance, a client is charged with shooting her husband six times during a domestic argument. Lay witnesses testify that your client probably planned the crime to gain insurance money, and the prosecutor cites such "overkill" as evidence of your client's violent character. However, your expert explains the application of battered woman syndrome, and specifically, the client's core belief that her husband was "larger than life or death" and would be able to pursue and kill her even after he received several gunshot wounds. Lenore Walker, *Terrifying Love: Why Battered Women kill and How Society Responds* (1989).

**Role: consulting or testifying.** In assessing the need for an expert, the team must ask the question: What role do we need the expert to play?

A consulting jury expert can help select the best juror on the defense to the crime or for mitigation of the penalty. A consulting mental health expert can help decide on the mental health dimensions in the case and which mental health experts to employ to evaluate and testify.

A testifying expert can affirmatively set out matters which are elements of the defense can rebut prosecution evidence; provide context and explanation of behavior.

**Selection.** After understanding the needs of the case, it is necessary to select the type of expert(s) who will most advance a viable theory of defense or theory of mitigation. If the case merits mental health assistance, the selection of the mental health expert is an essential decision because different experts offer different advantages and disadvantages. For instance, it is ineffective to employ a psychiatrist when the fact-finders need to hear the results of psychometric testing; in this case a clinical psychologist or neuropsychologist is indicated.

**Consulting Expert.** When the case has mental health dimensions it is enormously helpful to use a consulting mental health expert to help think about the case needs in a thorough, unrestricted, critical way. Clark, Veltkamp, Monahan, *The Fiend Unmasked: The Mental Health Dimensions of the Defense*, Criminal Justice, Vol. 8, No. 2 (1993) at 22.

Desirable characteristics for a mental health consultant include:

1. Expertise in the area of family theory and a biopsychosocial systems orientation. George L. Engel, *The Clinical Application of the Biopsychosocial Approach*, 137(5) Am.J. Psychiatry 535-43 (1980).

2. Expertise in detecting childhood trauma and a clinical understanding of how it affects persons later in life.

3. In-depth background in human development research and theory, along with a practical knowledge of psychopathology *and* the ability to "translate" this specialized knowledge for laypersons.

4. Understands human behavior as purposeful and sees even violent behavior as often an attempt to meet crises and to solve problems.

5. An interdisciplinary orientation and an understanding of the expertise of mental health professionals from disciplines other than his/her own.

6. Enjoys working with attorneys, investigators, and paralegals, and understands and appreciates legal ethics as well as the criminal justice system's valuing of the adversarial process.

7. *Perhaps most critical*: Sees the client as a human being who is ultimately comprehensible and deserving of the best mental health assistance and advocacy possible." *Id.* at 61.

It is important to note that the consulting expert functions as an agent of the attorneys and should never be expected to later assume the role of the testifying expert in the same case. *ABA Mental Health Standards* at 12.
The team must also be wary of choosing any expert only because he or she is the most "credentialed," *e.g.*, choosing a psychiatrist because of the medical degree's status. The defense must carefully deliberate which mental health discipline might make the best "fit" for this case." In short, the various mental health professions should be perceived as equally qualified as experts with respect to *general* training in legally relevant assessment; but attention should be given the specific spheres of specialized knowledge the expert may offer." G.B Melton, J. Petrila, and C. Slobogin, *Psychological Evaluation for the Courts*, Guilford (1987) at 18.

**Social workers.** These experts are skilled at conducting psychosocial assessments through highly effective interviews and the development of professional-client relationships. Generally, social workers are willing to spend more time with a person than other mental health professionals. Social workers pride themselves on their thoroughness in investigating and effectively communicating the client's story. "The social worker as expert witness informs the sentencer about the defendant's social history and social functioning and the social context of the crime. He or she interprets this information, using social research and theory, to explain the defendant's behavior." Arlene Bowers Andrews, *Social Work Expert Testimony Regarding Mitigation in Capital Sentencing Proceedings*, Social Work Vol. 36, No. 5 (Sept. 1991) at 441.

Social workers identify, document and testify to social behavior themes including:

- Absence of consistent social supports;
- Lack of supervision;
- Maternal deprivation;
- Paternal absence or deprivation;
- Untreated learning, mental, physical needs;
- Malnutrition;
- Inadequate moral development;
- Early exposure to violence;
- Childhood physical, emotional, sexual abuse and chronic neglect;
- Intimate partner violence;
- Head injuries;
- Poverty, homelessness, transience;
- Dysfunctional family patterns;
- Familial mental illness;
- Attachment and relational disturbances;
- Fetal alcohol or other addition issues;
- Rehabilitative prognosis. *Id.* at 442.

Social workers are especially skilled at employing ethical methods of developing relationships and obtaining information from persons who normally would vigorously defend from disclosing their life stories, especially information that the client perceives as humiliating for self or family members. Social work training also emphasizes the use of "systems theory" which stipulates that individuals can be understood only in the context of their environment, *i.e.*, the significant micro and macro systems which impinge on them. Francis J. Turner, *Social Work Treatment: Interlocking Theoretical Approaches* (Third Edition, 1986).

A comprehensive psychosocial assessment is an essential first step in any mental health evaluation. "Many forensic evaluations are unreliable because the history upon which they are based is erroneous, inadequate, or incomplete. All too often, the medical and social history relied upon by mental health professionals is cursory at best and comes exclusively from the client or possibly from the client and discussions with one or two family members. This can result in a fundamentally skewed view of the relevant history because often the client, and even their family members, are very poor historians and may fail to relate significant events which are critical to a proper determination of an individual's mental state at the time of the offense." John Blume, *Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Evaluation*, The Advocate, Vol. 17, No. 4 (Aug. 1995) at 7.

Social workers routinely employ genograms, timelines, and social behavior themes are to organize and communicate the voluminous relevant information in lucid and cognitively manageable ways. See M. McGoldrick and R. Gerson, *Genograms in Family Assessment* (1985).

While social workers, especially licensed clinical social workers with doctoral degrees, are gaining acceptance as forensic experts, there is still resistance in some jurisdictions to considering them as "real" experts. Janet Warren, *The Clinical Social Worker as Forensic Expert.* Institute of Law, Psychiatry, and Public Policy Monograph (1993) at 11.

**Psychologists**. These experts base their opinions on both subjective (*e.g.*, the clinical interview) and objective (current and past psychological tests) information. Standard tests classify intellectual and cognitive functioning (*e.g.*, Wechsler Adult Intelligence Scale-Revised [WAIS-R]); assess patterns and conditions of severe psychopathology and adjustment to same (*e.g.*, Minnesota Multiphasic Personality Inventory [MMPI]);

identify serious personality disorders (*e.g.*, Millon Clinical Multiaxial Inventory [MCMI]); and basic personality patterns in individuals (*e.g.*, Cattell Sixteen Personality Factors [16 PF]). A skilled forensic psychologist will can communicate how a client's intellectual functioning, longstanding personality traits, and life experiences contribute to the client's patterns of behavior. Joseph Matarazzo, *Psychological Assessment Versus Psychological Testing: Validation from Binet to the School Clinic and Courtroom*. American Psychologist Vol. 45, No. 9 at 1000.

The clinical psychologist's specialization in psychometrics, the quantification and classification of psychological and intellectual functioning, can introduce a healthy rigor into the mental health theory of the case.

However, effective testimony demands that the psychologist is prepared to "translate" these data into language and mental models accessible to lay factfinders. "Jurors look for a *Gestalt*, a scenario that integrates and explains the data... makes the data meaningful [and] one that fits with the other facts of the case." R.G. Meyer, *The Clinician's Handbook*, Third Edition, Allyn and Bacon (1993) at 463.

**Psychiatrists**. "Behavior is at the core of clinical psychiatry. Behavior can be studied physiologically, psychologically, or socially. Ideally, it should be studied in every way possible, so that the efforts of professionals to understand human behavior may capture something of the complexity and richness of the phenomena they observe. If anything differentiates the training of the psychiatrist from other mental health professionals, it is the ability to live in several of these domains simultaneously." Kaplan, MD & Sadock, MD, *Comprehensive Textbook of Psychiatry/IV* (1985), Foreword.

These experts have the advantage of being medical doctors, a profession that generally commands widespread respect from lay people. Many lay persons view psychiatrists as operating on a very high level with much competence. However, psychiatrists often talk in terms that are difficult for the layperson to understand. Sometimes they are too focused on the diagnosis of psychopathology as found in *The Diagnostic and Statistical Manual*, DSM-IV-TR (2000). The primary data of their opinion, the client interview, can be viewed as highly subjective and miss the larger picture of impact of other systems on the client's life.

However, of all mental health professionals, they continue to hold the greatest prestige in the criminal justice system--at least among the judiciary. In *Ake v. Oklahoma*, 470 U.S. 68, 80-81 (1985) the United States Supreme Court observed that psychiatrists "gather facts, through professional examination, interviews, and elsewhere, that they will share with the judge or jury; they analyze the information gathered and from it draw plausible conclusions about the defendant's mental condition, and about the effects of any disorder on behavior; and they offer opinions about how the defendant's mental condition might have affected his behavior at the time in question. They know the probative questions to ask of the opposing party's psychiatrists and how to interpret their answers. Unlike lay witnesses, who can merely describe symptoms they believe might be relevant to the defendant's mental state, psychiatrists can identify the "elusive and often deceptive" symptoms of insanity, *Solesbee v. Balkcom*, 339 U.S. 9, 12, 70 S.Ct. 457, 458, 94 L.Ed. 604 (1950), and tell the jury why their observations are relevant. Further, where permitted by evidentiary rules, psychiatrists can translate a medical diagnosis into language that will assist the trier of fact, and therefore offer evidence in a form that has meaning for the task at hand. Through this process of investigation, interpretation, and testimony, psychiatrists ideally assist lay jurors, who generally have no training in psychiatric matters, to make a sensible and educated determination about the mental condition of the defendant at the time of the offense."

**Neurologists.** These experts are specifically skilled at detecting physical disease and damage to the central nervous system, especially the brain. The identification of physical injury does not automatically address how the damage influences behavior, and the forensic neurologist can communicate the link between brain and behavior. "Regardless of the school of psychology to which one subscribes, there must be consensus on one point: diseases of the brain are accompanied by disordered behavior." J.R. Merikangas, *Brain-Behavior Relationships*, Lexington Books (1981) Introduction.

Neurologists use an increasingly impressive armamentarium of brain-imaging techniques (*e.g.*, magnetic resonance imaging [MRI]) along with the traditional physical neurological examination and medical testing (*e.g.*, blood analysis, EEG, and cerebrospinal fluid analysis). The connection between generalized CNS pathology, disconnection syndromes, and violence have been long established, and should always be explored when developing the mental health theory of the case.

**Neuropsychologist.** These experts are psychologists with special training in using psychometric testing to infer the nature of brain injury and its effects on a person's conduct. In lay-person's terms they act as the bridge between psychology and neurology. Typical tests include the Halstead Reitan Neurology Battery and the Luria-Nebraska Neuropsychological Battery. B. Kolb and I.Q. Whishaw, *Fundamentals of Human Neuropsychology*, Freeman (1990). Forensic neuropsychologists have proven especially adept in explaining normal brain development and functioning to the jury, and then demonstrating the impact of abnormal development and dysfunction on the client. It is important to note that what some clinician's

label as "personality disorder," may in fact be seen by the neuropsychologist as the development of consistent, if maladaptive, coping techniques which attempt to compensate for brain dysfunction. The capacities of "intellect, memory, speech and linguistic functions, perception, attention and concentration, and problem-solving, decision-making, and planning" are clearly impacted. D. Tranel, *Neuropsychological Assessment*, Psychiatric Clinics of America 15 (2) 1992 at 283.

**Step 2:**
**Finding and Evaluating Experts**

Once the mental health theory of the case is developed, the search begins for an expert to evaluate the client and to testify. Before looking for an expert, it is necessary for the attorney to carefully prepare. The attorney has to have enough understanding of the expert's area of competence to dialogue meaningfully with the expert and to know whether *this* expert is best for *this* client in *this* case.

Evaluating whether a particular expert is the "right fit" for the needs of your client and your case is a critical process. The most effective approach is to meet with prospective experts to determine whether they meet your client and case needs. At a minimum, some dialogue must take place on the phone and in writing. Preparing an agenda for your communication with the expert is helpful toward focusing on what the attorney and the expert need to accomplish; it will use the limited time with the expert efficiently, and it will communicate the attorney's competence and professionalism to the expert.

An agenda for a first meeting with an expert might include:

1. **The Defense Team's Needs.** What information is needed to determine if this expert is the correct fit for your client, your case;
2. **Expert's Needs.** What the expert needs to know to determine if the expert wants to commit to work on this case;
3. **Money.** Financial arrangements: rate, total amount, in-court and out-of-court rates, timing of payments;
4. **Next Steps.** If an agreement is reached, what are the next steps in the process.

Critical information the attorney will need want to know by the conclusion of this initial meeting with the expert includes:

1. The expert's education and experience - obtain a resume;
2. The methodology the expert will employ, how the expert views the methodology used in light of national practice and standards;
3. The core values of the mental health discipline of the expert;
4. How a person and his personality comes to be formed; and why the expert believes some people commit criminal acts;
5. How the expert views culpability and responsibility;
6. The expert's understanding of mitigation;
7. Whether the expert is willing to see the client more than once;
8. Whether the expert is willing to see and interview more than just the defendant in making their evaluation, *e.g.*, the family of the defendant, prosecution witnesses;
9. Whether the expert is willing to review materials provided them;
10. What testing (if appropriate) will the expert conduct;
11. How the expert will come to form the opinions;
12. Fees;
13. Whether the expert is willing to spend time to prepare for direct testimony and for cross-examination;
14. Willingness to help the team prepare cross-examination of the prosecution's mental health expert;
19. Ethical issues, including confidentiality and whether there are any conflicts with the expert, defense team, client, the case, the office or firm;
20. Whether criminal defendants are amenable to treatment, rehabilitation;
21. Report writing: *i.e.*, should there be a report; can a draft report be obtained; what will the report focus on;
22. Timelines: when can the expert do the evaluation and report writing; when can the team give the expert the necessary information;
23. Does the expert have anything to worry about on cross-examination, *e.g.*, academic difficulties, license problems, board certification, personal matters;
24. What work the expert has done on other civil, criminal cases; how often has the expert testified; has he or she ever worked or testified for the prosecution; is he or she currently working on any cases that will present any conflict;
25. After generally indicating your case, ask what the expert thinks the case presents, and obtain the expert's reaction.

It is important to remember that experts will be simultaneously assessing both the case and the attorney as a person with whom to work. Experts have substantial needs and they will assess the capacity of the defense team to meet those needs. Experts want to look professional; be protected; and to be a part of an endeavor that has meaning. Experts do not want to be manipulated, blind sided, or misused.

It is likely that the expert will have questions for the attorney. These might include:

1. **Money.** Payment timing & guarantees;
2. **Control.** Who is in charge of decisions in the case; who is running the defense team; who will be the liaison;
3. **Trust.** Is this attorney and defense trustworthy or manipulative;
4. **Communication.** Will the attorney fully & accurately communicate the relevant "good and bad" information;
5. **Goals.** Will the attorney try to obtain an unfairly lenient resolution of the case?
6. **Focus.** Is there a clear theory of the case and a focus for the expert's involvement?

The defense team has not only to locate and evaluate experts but also develop the expert's interest in the criminal process in this case and motivate the expert to work on the case.

Knowing when this expert is not ethically permitted to take the case in question is extremely important. The mental health expert has an ethical responsibility to decline a case when: the forensic arena is too anxiety-provoking for proper performance; the clinician has no training, knowledge, or experience in the area in question; the defendant is a patient, former patient, or connected in some other way that presents a conflict of interest; when there is any other conflict of interest present. B.A. Weiner and R.M. Weinstein, *Legal Issues in Mental Health Care* Plenum Press (1993) at 359. Additionally, the expert should decline cases for which he or she has insufficient time to perform adequate evaluations, research, and preparation for testimony.

Finally, the defense team should inquire with other attorneys and colleagues about this expert's. Past performance is generally a good predictor of future performance.

**Step 3: Retaining the Expert**

Good, competent, caring experts are busy; they can pick and choose how to spend their time. To interest a quality expert in assisting, it is usually necessary to sell the merits of the case and the meaningfulness of working for this client to the expert. This involves having some understanding of what motivates experts and, in particular, what causes this expert to become involved in any endeavor, especially a forensic case.

During the expert's decision-making process, he or she will assess the client, the crime and the attorney. The defense team needs to market the case, the client, and the team and to demonstrate the case's importance, as well as its interesting and challenging aspects. For example, some experts prefer a case with difficult assessment issues; certain experts want to help present the humanity of the client; others want to insure fair and just results.

The defense team needs to praise the expert and demonstrate the timely, reliable support the team will provide. Create an atmosphere of safety and support. In retaining the expert, communicate that the team is presenting the expert with a set of developed material and will spend the time necessary to make sure the expert is prepared in a way to maximize a successful, persuasive testifying experience. The expert needs to know that this will be a safe voyage through the constant white water of the criminal justice process because the attorney and the team will be competently captaining the ship with full communication to the expert. Above all, communicate commitment to your client, and the real need that the client has for the involvement of this expert. Communicate precisely what is expected from the expert, including the role of consulting or testifying and the exact areas of focus and obtain the expert's explicit commitment to you, the case and the client.

The process of employing the expert can culminate in a formal letter of understanding, agreement or contract which sets out:

1. What the attorney will do;
2. What the expert will do;
3. The issues to be addressed by the expert;
4. The timetable for the attorney's work and the expert's work;
5. Payment; and,
6. Legal and ethical working principles.

A sample agreement could look like this:

**CONFIDENTIAL: Attorney/Client Privilege & Work Product**
**AGREEMENT FOR EXPERT ASSISTANCE**

1. On behalf of John Smith, Ed Solomon, John Smith's attorney, agrees to retain Jill Jones, MSW, as an expert in the case of *Smith v. State*, Indictment No. 2011-1-MR, a capital murder case with the aggravating factor of first degree rape.

2. Jill Jones will do the following:

   a. interview, assess and evaluate John Smith on two separate days for at least 2 hours each day;
   b. interview John Smith's mother, father, brother at their home;
   c. review all records and materials supplied to her;
   d. provide a preliminary oral report by _____;
   e. provide a draft of a written report by _____;
   f. provide a final written report by _____;
   g. meet with Ed Solomon and review the report & prepare for testifying;
   h. testify as needed prior to trial, at trial or at sentencing;

3. Jill Jones will investigate, evaluate and report on the following:

   a. who John Smith is;
   b. what traumas and assaults he suffered and their impact on him;
   c. what kind of family did he come from and how did it influence who John is;
   d. how John perceived reality;
   e. what explains his periods of no memory;
   f. an analysis of the treatment John received, what treatment would have been appropriate for him in the past, and whether he is amenable to treatment today;
   g. what role anger plays with John;
   h. why he raped and killed; what was the purpose of the behavior.

4. The payment to Jill Jones will be at the following rate/amounts _____; and payment will be made at the following time: _____.

5. Jill Jones understands that since this expert assistance is being performed at the request of the attorney for Mr. Smith, it is confidential within the legal and ethical attorney-client and work product privileges, which can only be waived by the client. I will not divulge to the court, the prosecutor, or any other person confidential information without the approval of the attorney for Mr. Smith.

6. Jill Jones will maintain the confidentiality of the communications and materials I receive.

7. Jill Jones agrees that all communication and materials received by me and my entire work product are the property of Mr. Smith.

DATE: _____ _____
JILL JONES

DATE: _____ _____
ED SOLOMON

A sample letter could look like this:

**CONFIDENTIAL: Attorney/Client Privilege and Work Product**

DATE

RE: John Smith

Dear Expert Psychologist,

I am representing John Smith. I would like you to do a psychological evaluation of John Smith.

John Smith is charged with murdering and raping a twelve-year-old girl. He is in the county jail.

He appears to me to be severely mentally ill. He has a significant mental illness history.

The case is now in the pretrial process before this county's circuit court. We need a preliminary report and any recommendations for further evaluations by you or other experts by _____, and a final written report by _____.

I have spoken with the client and he is agreeable to your evaluation of him. He understands you will be evaluating him on _____ at _____ p.m. I will be present at that time. While I have generally explained the testing to him, I think it appropriate that you give him more details about your methodology.

The issues we would like you to address are:

1. Is Jack Cary mentally retarded, mentally ill?
2. Does he meet the criteria of KRS 532.013 (no death penalty if mentally retarded)?
3. If he is mentally ill/mentally retarded, how would Jack's mental retardation, mental illness affect
   a. competency to stand trial;
   b. confessing crime to police.

4. What was his mental state at the time of the killing and attempted killing
   a. intentional;
   b. extreme emotional disturbance; what was the trigger?
   c. duress, domination

5. What are Jack's interpretations, perception of and processing information from the victim, inmates?
6. How does mental retardation affect Jack's ability to communicate?
7. What is the relationship between behavior of Jack under stress, anger, provocation?
8. The relationship between mental illness (psychosis) and mental retardation.
9. What are causes of Jack's mental problems?
10. Does polio, poverty, neglect, abuse, race contribute to mental retardation?
11. What are the treatment possibilities for Jack?
12. Consequences of imprisonment (structure) on Jack before and after 1984.
13. What are the reasons for fluctuations of Jack's I.Q. scores?
14. Is Jack sorry?
15. Why did Jack kill the victim and attempt to kill the inmate? How did this come to happen?
16. Is this killing a crime about sex or something else?
17. What is the relationship between mental illness or retardation and impulsivity?
18. What other areas should we be focusing on?

Your fee of $_____ and expenses will be paid for in the following manner: Travel time will be compensated as follows:

Enclosed are the records and mental health reports that we have on Mr. Smith and other materials relevant to this case. We appreciate your help. As this consultation is being performed at the request of Mr. Smith's defense attorney, it is confidential within the legal and ethical attorney-client and work product privileges, which only the client can waive upon advice of his counsel. What additional information do we need to provide you with?

### Step 4:
### Preparing the Expert for Evaluating

Too often attorneys assume that experts know how to prepare themselves to evaluate the client, *i.e.*, that is part of their expertise. Yet mental health professionals are just as likely to "satisfice" as other professionals in order to lighten their workload. See S.B. Berlin and J.C. Marsh, *Informing Practice Decisions*, Macmillan Co. (1993).

It is important for an expert to have as much information and context as possible about the client and the case before the expert assesses the client. An expert must, therefore, understand the defense attorney's desires and needs, the theory of the case, the facts, and the focus for the evaluation and the necessity for confidentiality. A busy and costly expert must be provided the case information and background material in a form that can be easily digested, and a form that will in fact be used by the expert in the evaluation process.

For instance, if the expert is a psychologist the team might present the expert with the social history of the client in both narrative and chart form, prior school records, relevant prison records, relevant mental health, medical and military records, prior mental health test results, work records, the relevant good and bad facts of the case. This should be organized, identified and indexed for easy use and retention. A sample table of contents for a capital case could look like this:

| TAB # | ITEM |
|---|---|
| 1. | A fact timeline. |
| 2. | Birth records, family history, client's baby book. |
| 3. | Genogram. |
| 4. | 1974-84 Ohio School Records & 1952-53 Georgia School Records. |
| 5. | 1984 hospital records. |
| 6. | 1984 Mental Health Center records. |
| 7. | 1989-90 work records. |
| 8. | 1990 Middletown Hospital records. |
| 9. | 1990 psychiatric evaluation |
| 10. | 1991 State Hospital records |
| 11. | 1992 prison records |
| 12. | Military records |
| 13. | Police records in this case |

The expert must be fully informed of all the good and the bad data that the prosecution is likely to know about so that the expert's opinions are completely accurate and not subject to being undermined on cross-examination. Mental health experts will spread the word about an attorney and defense team who have abused him or her, potentially burning bridges to the entire community of mental health professionals in a given region. Provide the expert all relevant information in a way that recognizes the prosecution's entitlement to reciprocal discovery.

Inform the expert what the defense is, what the mitigating factors are, what direction the team is moving. Educate penalty experts well on the expansive nature of mitigation in capital cases. Inform the expert who else he/she must interview. Make sure those interviews take place. An opinion must be based on all relevant evidence. Preempt cross-examination to undermine the expert's opinion by demonstrating that he or she had incomplete information or that the expert's opinion is only based on the self-serving interview with the defendant. Make sure the expert knows that he/she will have to do things that may *not* be required by their professional discipline in order to increase the chances of persuading the triers of fact and reducing damaging cross, *e.g.*, talking to defendant more than once, talking to more than just the defendant, being fully informed of all facts and prior history of defendant, basing their opinion on as much objective information as possible; supporting their opinion with concrete facts and examples, presenting their conclusions in more persuasive ways.

### Step 5: The Direct Examination of the Expert: Telling the Story Well

Communicating the reality of the client through the direct examination of the expert pretrial, at trial or in the penalty phase of a case is pivotal to persuasion. A persuasive direct examination is structured in a manner that increases its digestibility, comprehension, and retention by the triers of fact. Recent empirical research has found that factfinders' attitudes and behaviors can be shaped by their understanding and interpretation of events. Presenting events in a story or narrative form enhances the ability of jurors to understand events in the way formulated by the storyteller. (N. Pennington and R. Hastie, *Evidence Evaluation in Complex Decision Making*, 51 (2) J. Personality and Soc Psychology (1986); *Inside the Juror*, 1993, chapter 8). The legal profession has begun to adopt this paradigm in its teaching of complex ethical principles to students (N. Morris, *The Brothel Boy and Other Parables of the Law*, Oxford University Press, 1992) and to communicate through argumentation and witnesses' presentations compelling, dramatic, and persuasive stories about their clients. See, *e.g.*, the symposium on storytelling in the legal system in 87 Michigan L. Rev. 2073 (1989).

Commonly accepted working principles for effective communication of the client's story through the direct examination of an expert witness include the following:

1. **Maximize the Persuasion: Telling the Client's Story; Revealing the Client's Humanity**
   A. Primacy and recency: start and end with the most important, the most persuasive, or what the factfinders are most interested in.
   B. Create our Persuasive Images, Themes.
   C. Emphasize the heart of the matter.
   D. Confront and explain the bad to preempt it, or convert it to be consistent with the theory of the case.
   E. Consider the audience: use language they will understand, answer the questions they likely have, dialogue with them, do not talk down to them.
   F. Witness is the star; communicate the identity and the credentials of your expert.
   G. Re-direct.

2. **Attorney's Leading of the Learning and the Listening**
   A. Do not lead except...
   B. Looping
   C. Stretch Out
   D. Narrative Tone, Tell the Story of the Client
   E. Chapter Headings: organization for emphasis & persuasion

3. **Preparation by Attorney and Expert**
   A. Thinking
   B. Writing
   C. Revising
   D. Consulting
   E. Practicing

4. **Organization Based on Plan to Propel the Theory of the Case, Tell the Client's Story, Reveal the Humanity of the Client**
   A. Art of persuasion
   B. Power of communicating centered on understanding who the audience is in this case

Do a thorough direct examination, one that recognizes the bad facts and the limitations of the expertise but also one that emphasizes the good facts and conclusions. Anticipate cross-examination and preempt the prosecution from revealing bad aspects. Dealing with the obvious hurtful facts on direct can provide damage control. Do not let the expert overstate information, opinions or conclusions.

Put the expert's information and conclusions in a *context* which will increase persuasion. For instance, when a psychiatrist testifies, a persuasive context might be:

1. **BASIS.** The scientific basis for a psychiatrist's expertise,
2. **QUALIFICATIONS.** The qualifications of the psychiatrist,
3. **WHAT WAS DONE IN THIS CASE.** What the expert considered and did in the evaluation process,
4. **FACTORS OF CONCLUSION.** The basis of the conclusion,
5. **THE BAD** and how the bad facts are understood in the case in a way that lessens their damage.

It is important for the expert to explain the basis for the conclusion, and to explain the nature of the methodology used to arrive at conclusions. For instance, if the defense psychiatrist has diagnosed a personality disorder, it is important for the expert to explain the context for this decision to give full meaning to lay jurors:

1. What a personality is,
2. How it develops,
3. How a person operates in the world, etc.

If a psychologist is presenting a test result, present the context that makes the results more meaningful:
1. What the test is,
2. How it was developed,
3. How it was administered,
4. The rationale of the test,
5. Its results,
6. How subjective/objective it is,
7. Its degree of confidence,
8. How widely it is used, etc.

One of the most useful things an expert can do during direct is to explain the meaning of the constellation of facts lay witnesses cannot explain, *i.e.*, to offer their expert *opinion*. An expert can explain how facts, which on the surface appear to be only bad, are *consistent with the defense or the mitigation* theory.

For instance, if intentionality is an issue in a case where mental retardation is the defense, an expert can talk about why the defendant's throwing his bloodstained pants away or why his refusal to talk to his interrogators after the crime do not show intentionality or premeditation as much as it is an expected manifestation of the confusion, fear and subjective experience of this mentally retarded defendant.

If drugs are the basis for an intoxication defense, an expert can explain the client's heavy use of them by talking about why many people turn to drugs, why the defendant turned to them, why his use escalated, why he had difficulty in controlling his increasing use of them, what influence the drugs had in his actions, whether persons can recover from serious drug problems, how drug problems are analogous to alcohol problems that may be more understandable to middle class jurors. An expert can explain that the defendant did not continue to take drugs to get high, but rather, to avoid the vicious pain of withdrawal.

Experts can explain the reality of what was going on with the client in common terms of control, stress, and anger. What are these emotions, where do they originate, how do they develop, how do they explain this client and his acts? If a client's demeanor or affect seems aggravating, an expert can mitigate that superficial negative view of him by talking about why he appears as he does.

Use the expert's direct testimony to emphasize the guts of your case. One way to do this through direct is to:

1. Set up the basis for the conclusions (experience, qualifications, testing, interviewing);
2. Have the conclusions stated,
3. Then emphasize aspects of the conclusion (*e.g.*, stress, anger, control, understanding of himself, affect);
4. Restate the expert's findings.

Work to have the expert's opinions surrounded by persuasive witnesses. Have a context for the expert's testimony which is supported and corroborated with facts and conclusions of lay witnesses. For instance, in an extreme emotional disturbance case, present lay witnesses to relate the stressors on the client and how these influenced him, so the expert opinion that the client was extremely emotionally disturbed rings true.

Above all, do not lose lay decision-makers in a tangle of impressive but intimidating jargon. If the expert is testifying about the client, work to present the conclusions in a way that jurors do not fear the defendant if they believe the conclusions. Place the information in a full context, and present it in terms that jurors can connect themselves to assist in this effort.

Anticipate any evidentiary difficulties with the expert's testimony, reciprocal discovery, admissibility of underlying facts, and expression of opinion on ultimate facts. Prepare the defense expert on the potential evidentiary difficulties with his testimony and the manner to proceed if prosecution objections are successful. Obtain transcripts of the expert's previous testimony and be prepared to deal with any prior opinions.

Preparation is highly predictive of the persuasive quality of an expert's direct examination. It has been observed that all direct examinations "take 1% inspiration and 99% preparation." C.L. Hunt, *Calling Your Attention to the Direct Examination: How to Avoid the What Happened Next Question*, 42 Mercer L. Rev. 619 (1991).

**Step 6: Preparing Defense Expert for Cross-Examination and Improving Cross-Examination**

"Good cross-examination is the successful and unseen closing of all available escape routes. Like war, it has a strategy and like all battle, it has a theory. In war however, the first casualty of battle is often the theory." D.L. Lewis, *Cross-examination*, 42 Mercer L. Rev. 627 (1991).

Therefore, anticipate what theories on which the state could cross the expert. Find out what cross the prosecutor has previously used on similar experts. Familiarize yourself with the three volume work by Ziskin and Faust, *Coping with Psychiatric and Psychological Testimony*, Law and Psychology Press, (5th Ed. 1995), and the two volume work by Faust, Ziskin & Hiers, *Brain Damage Claims: Coping with Neuropsychological Evidence* (1991).

The most effective experts become better over time on cross-examination and the client's story is told all the more effectively. The expert turns what appears to be a damaging or inconsistent fact into yet another reason which supports the expert's analysis. This is usually done through reframing the adverse question. M.T. Nietzel and R.C. Dillehay, *Psychological Consultation in the Courtroom* (1986) at 113.

Often, this process of anticipating particular cross will lead the attorney to alter the direct. Ask the expert what areas present vulnerabilities and how he or she will respond to possible areas of cross. Discuss and revise those responses with the expert. It is essential for the expert to understand the sophisticated strategies of a skilled cross-examiner. Pozner and Dodd, *Cross-Examination: Science and Techniques* (1993).

**Step 7: Revise Direct Examination**

Based upon a mock cross-examination of the expert or a dialogue with the expert on what he or she would say, you will want to reflect what you learn from the expert's practice answers by revising the direct examination.

The role-playing experience, a technique with which the mental health expert is quite familiar, helps the attorney and the expert discover what approaches will probably be most effective.

**Step 8: Develop Demonstrative Evidence**

The "principle nemesis of any trial lawyer is not so much his adversary as boredom on the part of the factfinder. Ennui dulls or kills receptivity to information and argument." G.P. Joseph, *Modern Visual Evidence* (1995) section 1.01.

Use demonstrative evidence to increase the understanding and retention of the expert's information, especially on the most important three points. For example, blow up or have an overhead of the MMPI results to emphasize the concreteness, the objectivity of a basis of your expert's conclusions. Present the client's genogram life time-line or social history themes on overheads to emphasize critical family relationships, and the timing and order of critical life events.

"Courts look favorably upon the use of demonstrative evidence, because it helps the jury to understand the issues raised at trial." *People v. Burrows*, 592 N.E. 2nd 997, 1022 (Ill. 1992).

## CONCLUSION: INTEGRATING THE EXPERT INTO THE CASE

The defense team would not be using an expert unless the expert substantially contributed to the theory of the case. Therefore, the attorney must be disciplined in fully integrating the "expert's benefit" throughout the case. Some examples:

A. **Motions.** Pretrial motions allow attorneys to shape issues around the expert's testimony at trial. If a prosecutor has previously cross-examined the expert about a matter that the defense believes improper, a motion in limine to prohibit that cross is appropriate. If the judge has previously prohibited testimony of an expert in an area the defense needs to address, a motion in limine to permit the testimony is appropriate.

B. **Voir Dire.** It is essential to determine such things as if the prospective jurors are interested in hearing from experts; believe experts are qualified to render opinions; and are open to being persuaded by the opinion of an expert. The defense wants jurors who are eager to hear from and rely on the opinion of experts.

C. **Opening.** The opening argument is our opportunity to continue to persuade by preconditioning the selected jurors to the importance of the expert's opinions on the issues critical to the jurors' decision-making. "What does being raped as a 9 year old do to a kid? You will hear what the effects childhood physical and sexual abuse had on John from an expert who has looked at hundreds of physically and sexually abused persons."

D. **Cross-Examination** of state witnesses. The defense expert's opinions will not prevail alone. They must be supported by our providing a basis for them through eliciting supporting information on cross-examination from prosecution witnesses or undermining contrary information or opinions from prosecution experts via our cross-examination.

E. **Direct Examination.** Persuasion is incremental and contextual. The direct examination of the expert must be crafted to maximize the favorable conclusions. The defense must corroborate the expert's conclusions through the direct testimony of our witnesses.

F. **Closing.** With some intensity, focus jurors on how credible and persuasive the expert's analysis is to understanding this case, the client, the client's behavior.

**Conclusion.** The above decision-rules are presented as a guide to the defense team to optimize the employment of the defense mental health expert witness. However, it is clear that any attorney in civil or criminal cases (including prosecution teams) can implement this process effectively. This process not only serves the advocate and enhances the participation of the expert, but it serves the public good as well. Effective presentation of experts help factfinders thoughtfully analyze a complex case and render a just decision.

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# Chapter 10: The Fiend Unmasked
## Developing the Mental Health Dimensions of the Defense

**by James J. Clark; Lane J. Veltkamp; Ed Monahan**

A defense attorney litigating a criminal case on behalf of a troubled client can benefit from using a mental health consultant to help develop and manage the mental health dimensions of the case. With the consultant's assistance, the defense team can meet a range of critical goals:

- Develop a mental health theory of the case that communicates the client's subjective experience of the offense, which is relevant to criminal culpability issues.
- Find expert witnesses to develop the mental health evidence and present it effectively.
- Brainstorm to develop a streamlined argument and avoid hurting the case by overinterpreting the mental health issues.

Most important, the defense team must create empathy for the client and reduce misunderstanding of the client's behavior through the careful use of mental health evidence. By presenting the client's actions as an attempt to resolve a specific problem, it becomes possible to gain an understanding of the human being behind the act, no matter how monstrous the act may be.

When a client's mental health plays a significant role in determining whether he or she is guilty, or what degree of punishment is appropriate, a defense attorney cannot provide competent representation without the assistance of a mental health consultant. This article provides a realistic view of what mental health experts can and cannot offer and how to make the best use of their services to defend your client.

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**Your relationship with the expert**

It is often imperative that an attorney include mental health testimony as a part of the defense, but mental health experts present attorneys with a dilemma. On the one hand, attorneys need such experts to offer evidence regarding a client's behavior, incompetence, insanity, or mitigating factors. On the other hand, these experts can sometimes seem unpredictable, stubborn, superficial, and oblivious to the pressing needs of the case.

**Deciding on a specialist.** Before choosing a mental health specialist, it is important to develop an accurate mental health history of the client. On the basis of that history, the attorney can formulate a range of possible mental health theories to explain the client's behavior and then decide what specialist might be appropriate for the case.

**Evaluating the expert's report.** Consider the following example:

> *Feeling that your client has some very serious mental problems, but unable to formulate exactly what they are or to identify what relevance they have to the case, you hire Dr. Stanley Jones, a psychiatrist, to testify regarding your client's apparent mental illness. Dr. Jones conducts a psychiatric interview of the client, which includes a mental status exam and a medical and psychiatric history. He reports his conclusions: The client's lifelong antisocial behavior justifies a DSM-III-R diagnosis of Antisocial Personality Disorder (that is, a diagnosis based on the American Psychiatric Association's* Diagnostic and Statistical Manual of Mental Disorders *(American Psychiatric Press, 3d ed. Rev. 1987)). You complain that Dr. Jones's findings give you no better understanding of your client than you had before and that Jones, your own expert, is revealing information that will be viewed only as harmful by the fact finders.*

Many attorneys who find themselves in a similar situation feel they have no basis for further dialogue with the expert who has rendered an unhelpful or damaging diagnosis. Can it really be argued that Dr. Jones's examination yielded invalid or incomplete results? What background knowledge can an attorney marshal to make clear to Dr. Jones what kind of examination would be useful to help others understand the meaning of the client's behavior?

Some attorneys use guides to mental health evaluations, but such guides describe only the components of the evaluation and cannot speak to the validity of the opinion formed by the evaluator. (See, e.g., John Blume, *Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Evaluation*, The Advocate 42-46 (Aug 1990).) For example, it takes years to refine the technique of conducting a mental health interview, an extremely complex social interaction that is difficult for laypersons to evaluate.

**Reducing unpredictability.** An equally difficult problem arises when the expert provides the attorney with an analysis favorable to the defense, but this analysis does not hold up in court – or actually backfires.

> *In another case, you hire a neurologist, Dr. Hopkins, to testify that your client is brain damaged. Dr. Hopkins takes the stand and describes the client's history of head injury. He carefully explains the results of the neurological examinations, including the electroencephalogram (EEG)*

*and even a magnetic resonance imaging (MRI). It seems like science at its best. Under cross-examination by the prosecutor, Dr. Hopkins acknowledges that this type of serious organic damage is not reversible. Unfortunately, the jurors are so effectively persuaded that they form the view that such severe damage, so carefully documented, describes the defendant as a "Frankenstein's monster," not amenable to treatment or restraint without danger to others.*

Deana Dorman Logan, in her excellent discussion of this problem (*Is It Mitigation or Aggravation?* CACJ/Forum 14-20 (Sept-Oct 1989) [*"Mitigation or Aggravation?"*]), suggests that the introduction of mental health evidence can cause jurors to either empathize with the defendant or see the evidence as further aggravation requiring aggravated penalties, including a death sentence, in order to ensure society's protection. In the case just described, the client was indeed brain damaged. How could the powerful scientific evidence of the injury be marshaled to help the criminal defendant? Or should this evidence not have been introduced at all?

**Consulting experts and testifying experts**

We classify mental health experts as either *consulting experts* or *testifying experts*. Consulting experts become part of the defense team and help the attorney develop the mental health theory that will be argued in the case. Testifying experts conduct evaluations specific to their field of expertise and testify to the results as a witness for a party.

*You have hired Rita Johnson, a licensed clinical social worker, to assist you in handling the mental health problems in your criminal case. Ms. Johnson carefully studies various social and mental health records of the client and then conducts several interviews with your client. The records reveal an extremely dysfunctional family background, including strong indications of childhood sexual abuse. Working with you and your staff, Ms. Johnson helps construct a developmental time-line of the client's life and a genogram (family tree). The time-line reveals serious inconsistencies and gaps, along with several early childhood head injuries and a long history of involvement with community mental health agencies.*

*While Ms. Johnson understands your desire to present the client as a paranoid schizophrenic, she has grave doubts that this is a valid diagnosis. She observes that the client has never received a thorough neurological examination and recommends that you hire a person with expertise in family theory and the evaluation of childhood traumas. She also recommends a neuropsychologist to test for brain injury and to provide a detailed report of the client's brain functioning. After reviewing these experts' reports, you decide to hire a neurologist to correlate the neuropsychological evidence. These experts testify at trial.*

Why should the defense spend more money and time on a mental health consultant when it seems less expensive and easier to limit oneself to mental health experts who will only evaluate and testify? Alternatively, why not hire a mental health professional who will both consult *and* testify? As discussed in some detail below, the consulting expert who does not testify is an important player with a unique role on the defense team.

**Correcting for the bias of the expert witness**

Social psychology research demonstrates that experts tend to assess clients only from their particular professional vantage points. As a result, clients will be diagnosed as suffering from problems the expert has the ability to detect and the resources to label and treat. (Dennis C. Turk and Peter Salovey, eds., *Reasoning, Inference and Judgment in Clinical Psychology* (The Free Press, 1988) [*"Reasoning, Inference"*]; Jurgis Karuza, Michael A. Zevon, Vita C. Rabinowitz, and Phillip Brickman, *Attribution of Responsibility by Helper and Recipients*, in Thomas A. Wills, ed., *Basic Processes in Helping Relationships* 107-29 (Academic Press, 1982).) A psychiatrist may be extremely skilled at developing a *Diagnostic and Statistical Manual* (DSM-II-R) diagnosis but have little idea about how family dynamics or environmental deprivations have shaped the client. A clinical social worker may have expertise in psychosocial and family dynamics issues but erroneously neglect the complex biological issues involved in the case.

This "dominant orientation" phenomenon can lead to several problems at the level of assessment:

1. The expert may uncover issues that pertain to his or her area of expertise but report no other finding. Thus, the report may describe accurately only a few dimensions of the client's personality and behaviors.
2. The expert, finding no sign of problems in his or her area of expertise, may report the absence of significant mental health issues and thereby mislead an attorney into believing that there are no helpful mental health explanations available.
3. The expert may identify various mental health issues but, believing many of them to be insignificant, may choose not to report them or remain unwilling explore them further.
4. The expert's analysis, while helpful, may need a broader context or corroborating findings from other mental health perspectives to fully and persuasively communicate the meaning of the client's behavior.

Let's say that in the first case described above, Dr. Jones was asked about the client's family background, but he was confident that family background, while worthy of notice, was not a sufficiently powerful explanation for the defendant's psychopathology. Dr. Jones refused to conduct more thorough family interviews or testify in more detail about the family background, saying it was "a waste of time."

A consulting expert would be vigilant for these situations and alert the attorney to the strengths and weaknesses of different mental health evaluation. The consultant can suggest other mental health evaluations that will complement and strengthen weak or incomplete evaluations. The consultant can also advise the attorney on ways to approach experts who are resistant to continued dialogue and analysis.

It is too easy for even the sophisticated attorney to miss the consequences of the mental health expert's particular professional orientation. A consultant can help the attorney by identifying the orientation of the testifying expert and discussing the use of other experts with differing expertise. The incisive testimony of the expert witness is irreplaceable, but it must be used with caution and only in the context of the entire mental health strategy of the case.

**Sorting out the roots of violence**

Perhaps the most important reason to work with a consulting expert is to allow the defense to thoroughly consider competing and complementary mental health theories of the case. Do not see this as an opportunistic stance; rather, it is based on a theoretical understanding of violence. Psychiatrist Dorothy Lewis has developed a compelling argument that there are multiple influences on the development of violent individuals. (*The Development of the Symptom of Violence*, in Melvin Lewis, ed., *Child and Adolescent Psychiatry: A Comprehensive Textbook* (Williams and Wilkins, 1991).) These influences include:

- *Biological contributions*: Predispositions to violence resulting from differences in genetics, hormones, neurotransmitters, and neuroanatomy as well as the interaction of all brain functions.

- *Experiential contributions*: Family dysfunction, inadequate nurturing, disrupted attachment, sexual and physical abuse, and other trauma experienced by individuals during childhood and adolescence. (See also Thomas W. Miller and Lane J. Veltkamp, *The Adult Non-survivor of Child Abuse*, 87(3) J. of the Ky. Med. Assn. 120-24 (1989).) We include psychosocial syndromes such as "battered wife syndrome" and "child-sexual-abuse accommodation syndrome" in this category.

- *Social and cultural contributions*: The impact of belonging to social groups such as gangs, living in high-crime neighborhoods, and exposure to violent media as well as the financial and emotional rewards for antisocial, violent behavior in our society.

The search for the etiology of violence has taken multiple pathways. Much of this research is still in its early stages, suggesting that our understanding of aggression and of violent crime in particular is limited. Unfortunately, this is not the stance many expert witnesses take when they testify – to the delight or chagrin of the attorneys trying the case. An individual clinician typically prefers one or two of these etiological explanations because of training, expertise, and core beliefs, but a thorough evaluation of the client requires that the attorney explore multiple explanatory pathways, *especially when the defense's mental health argument is initially being considered.*

**Helping to prepare a multipathway defense**

A consulting expert who is aware of the complexity of the situation can help the defense gain a more realistic view of the client. The exploration of many possible explanations for the client's behavior may prove frustrating initially, but it is an approach that can have long-term benefits. Trying to make your case with a simple, quick explanation may be disastrous, as the argument can often be destroyed by an effective cross-examination or refuted by a better-informed prosecution witness.

A carefully constructed multipathway theory may still be vulnerable to attack, but it can retain its basic integrity even if one dimension of the argument is refuted. If the attorney decides to present only one explanation, the earlier exploration of many pathways can still help the defense prepare to argue against completing explanations that may be used by prosecution experts.

**The client's story.** An argument against the multiple-pathways approach is that it is too difficult for the defense to integrate several explanations into a coherent, persuasive presentation. If we accept the current empirical findings of social psychologists, we understand that jurors process information most readily if it is in narrative form; that is, in the form of a story. (Nancy Pennington and Reid Hastie, *Evidence Evaluation in Complex Decision Making*, 51(2) J. Personality & Soc. Psychology (1986); *Explanation-based Decision Making: Effects of Memory Structure on Judgment*, 14(3) J. Experimental Psychology: Learning, Memory & Cognition (1988).)

Rather than developing simply a list of arguments, the attorney must develop a formulation, weaving the multiple mental health issues into the larger story of the client being told in the voir dire, opening statement, examination of witnesses,

and closing argument. In the following, we offer some strategies for constructing an effective mental health story.

**All behavior has meaning.** The most frequent approach to evaluating persons is to employ a bio-medical model that emphasizes psychopathology. While it is not our intention to recommend routine exclusion of the biomedical model, we believe that relying on it alone is a serious mistake. Even if the diagnosis is not as prejudicial as "antisocial personality disorder," emphasis on psychopathology tends to emphasize the differences between the client and the fact finders and to decrease the likelihood of an empathic connection.

In our experience, a biopsychosocial assessment that elicits the client's experience of the offense in the context of his or her life situation offers the key to the jurors gaining a more profound understanding of the defendant. This approach was recommended in the early twentieth century by Alfred Adler, who argued that "all behavior is purposeful." (Harold H. Mosak, *Adlerian Psychotherapy*, in Raymond J. Corsini and Danny Wessing, eds., *Current Psychotherapies* (Peacock Publishers, 4th ed. 1989).) Contemporary cognitive and phenomenological approaches emphasize that understanding even maladaptive coping behavior is possible when the clinician explores the "appraisals," or readings of the situation, made by the client, even when these appraisals may not be ordinary or prosocial. (Susan Folkman and Richard S. Lazarus, *Stress, Appraisal and Coping* (Springer, 1984).) We argue that no matter how bizarre or inexplicable behavior seems initially, *by understanding the subjective experience of the client and how his/her actions were an attempt to solve a problem or deal with a stressful situation,* the observer can begin to see the ultimate purpose of the behavior.

> *The prosecution presents evidence that your client murdered her husband with a gun, dismembered the body with an axe, and then buried the evidence. Careful evaluation of the client reveals a woman who had been beaten and terrorized by the victim for seven years and had witnessed him abusing their two young children. You lay out this history in some detail and present a thorough history of the client's impoverished development in a dysfunctional family-of-origin in which she was sexually abused by her alcoholic father. Your expert testifies that after seeking help from various social service agencies and receiving inadequate responses, the client killed her husband to save herself and her children from further abuse. The testimony includes a videotape of the clinical interview of the client describing her childhood, the marriage, and the overwhelming conditions that drove her to this self-protective act. You integrate this story under the rubric "battered wife syndrome" in the voir dire, opening statement, examination of witnesses, and closing argument.*

**Eliciting empathy for your client.** Another way to conceptualize this approach is to think of an empathy / compassion "equation" that includes the issues discussed by Logan (*Mitigation or Aggravation?, supra*) and the multiple dimensions we described above. Such an equation might look like this:

Family dysfunction &
Childhood traumas
+
Other psychiatric &
Neurological evidence
+
Client's subjective
purpose behind acts
+
Lack of support
network, help,
or treatment
=
Empathy & compassion
for the client

The consultant must help the attorney and the expert witnesses present this entire equation to the jury in order for the evidence to explain persuasively the client's behavior. Our experience has taught us that leaving out any one of these variables increases the risk that mental health evidence will be meaningless, fragmented, or even aggravating. Consider what happens in the following case when the equation is incomplete.

> *Your client is found guilty of shooting, stabbing, and driving over three elderly victims. During the penalty phase, the mental health experts testify that your client came from an extremely deprived childhood that included being battered, sexually abused, and addicted to drugs. You also demonstrate that child-protection services never developed a plan for your client and that, as a child, she was in five foster homes in seven years. Despite viewing a videotape of this interview and hearing sympathetic testimony by a family friend, the jurors voted for the death penalty. When one member of the jury was later asked about her decision, she said that she felt badly about the defendant's childhood but believed that so heinous a crime was beyond understanding and excuse.*

In this case, the client's childhood traumas included attachment disruption, sexual victimizations (including being sold into prostitution), introduction to drugs as a child, and repeated exploitation by others. However, the defense never explained to the jury *why* the violent crime occurred. Without a convincing link between the violent acts and the client's tragic life history, these offenses remained unfathomable and horrifying to the jurors – a lethal combination.

To ensure that jurors and judges understand the defendant compassionately rather than see him or her as a monster, the defense must take the following three steps when presenting mental health evidence in criminal cases:

1. Vividly describe and fully explain the client's family dysfunction and childhood traumas.
2. Explain *why* this violent behavior was purposeful for the client, that is, why the behavior occurred.
3. Explain what could have happened to prevent this tragic event from taking place.

In the example, step one was done well, but steps two and three were not done at all. The defense never emphasized that the defendant's drug abuse mediated the psychological ramifications of her childhood experiences and that her adult rage – disinhibited by drug use – was directed toward persons who were very much like those who had victimized her as a child and adolescent. Furthermore, the jury never fully understood that through mismanagement and ignorance, the institutions of local law enforcement, child welfare, and mental health not only failed consistently to protect the defendant but in fact exposed her to new victimizations. The defense needed to highlight clearly these recurring themes as a link between the defendant's life history and the violent acts the jury was being asked to examine.

Jurors can psychologically deal with a heinous crime if it is presented in the context of a compelling and coherent story. Even if this is not always a sufficient condition, it seems that it is a *necessary* condition for the jury to be able to empathize and connect with the humanity of the client.

Developing a mental health argument that integrates the defendant's life story and its relationship to the crime, while simultaneously grounding the argument in valid mental health theory, is a daunting enterprise. It requires time, money, competent consultation, and expert testimony. However, such a presentation can be extremely persuasive if it is well prepared and delivered. While each expert witness can present a piece of the story, the consulting expert assists the attorney in developing the theory that drives all the testimony and the narrative that integrates and explains it to the jurors.

Consultants can help exclude unnecessary information that may derail the defense, encourage spurious correlations, or foster overinterpretation of information. These "cognitive errors" can lead to invalid inferences that derail the defense team and, later, the jury. (See Paul E. Meehl, *Psychodiagnosis* (Norton, 1972); Turk and Salovey, eds., *Reasoning, Inference, supra*.)

The skilled criminal defense investigator who is able to track the long paper trail of a client's life provides the defense team with important clues to the mental health issues in the case. Due to the limited time and money involved, it is eventually necessary to direct the investigation and data analysis to specific areas. This is where the consulting expert comes in. The consulting expert can read this voluminous record and then recommend what further mental health investigation might prove most fruitful.

When the attorney, paralegal, and investigator brainstorm with the consulting expert, new ideas and a team consensus for future efforts often emerge. One forum for brainstorming is a team meeting to look at the client's developmental time-line and vigorously discuss issues from the mental health and legal points of view.

Collaborative preparation can encourage development of a streamlined argument and prevent presentation of too many expert witnesses. Cognitive psychology teaches us that presenting too much information can befuddle persons who are asked to perform complex tasks of memory and judgment. How many mental health experts should jurors hear? As many as can help them remember the client's story and integrate the variables in the empathy / compassion equation described above. No more, no less.

**Finding appropriate expert witnesses**

The consultant can help the attorney hire witnesses whose expertise will be applicable to the case. Having worked with the consultant to develop several possible mental health approaches for the case, the defense team can then seek witnesses with particular expertise.

Just as we would not recommend choosing a psychotherapist by calling the first number in the Yellow Pages, we recommend against choosing an expert based only on reputation or credentials. The consultant can help identify persons who are competent mental health practitioners *and* who will be comfortable with the overall mental health theory of the case. For example, the consultant can help the defense team decide whether to hire a clinical psychologist, neuropsychologist, neurologist, psychiatrist, psychopharmacologist, clinical social worker, or some combination of these specialists.

**Consultant as liaison between attorney and experts**

Because the consultant is familiar with the specialized language and "culture" of mental health experts, he or she can help the attorney and the experts to develop good working relationships. This liaison work can continue after the expert is hired, through the processes of evaluation, report writing, and testimony. The consultant can, for example, encourage busy, experienced forensic experts to be more invested in the case because they perceive the defense team as efficient, approachable, and committed.

The deliberate development of a relationship between the attorney and the testifying expert is a critical role for the consultant. By helping to resolve disagreements and misu

derstandings between the expert and the attorney, the consultant not only enhances communication but improves the expert's subsequent testimony. The more complex and difficult the case, the more likely difficulties will arise between the testifying experts and the attorney. A sturdy relationship is the only hope that the collaboration will survive these predictable conflicts.

**Legal and ethical aspects of using a consultant**

A mental health consultant's work is protected by the Sixth Amendment guarantee of counsel as well as the attorney-client and work-product privileges, because the consultant "has the same obligations and immunities as any member of the prosecution or defense team." (ABA Criminal Justice Mental Health Standards (1984) Standard 7-1.1©; *Miller v District Court*, 737 P.2d 834 (Colo. 1987).) Notably, the testifying expert's work is subject to some discovery (Standard 7-3.8), but the consultant'' work is beyond the reach of the court or the opposing party. (See, e.g., Federal Rules of Criminal Procedure 16(b)(2).)

These protections are critical to the full functioning of the consultant / attorney relationship and markedly distinguish the role of the consultant. If a consultant's work were subject to discovery, the possibility of frank dialogue between the attorney and the consultant would be nonexistent. The consultant thus is an invaluable resource, and can communicate, advise, and work out a strategy at length with the attorney.

When attorneys obtain expert assistance, they usually hire a testifying expert whom they may ask to double as a consultant because this seems more efficient or because economic constraints demand it. However,

> [d]ifficulties arise when professionals attempt to serve in the dual capacities of evaluator and consultant. Ideally, these roles should be separated so that the objectivity of an evaluation is not contaminated by a long-standing consultative relationship between a professional and an attorney.
>
> (Commentary to Standard 7-1.1©.)

It is also unwise to have a testifying expert involved with information or discussions that are consultative in nature, because consultative work is exposed to discovery. To maximize the value of the experts' assistance, separate individuals must perform the two distinct roles. Asking one expert to perform both potentially contradictory roles will create conflicts, introduce needless limitations, and force the defense into unsolvable dilemmas.

**Resources to hire a consultant**

Unfortunately, lawyers too often put little effort into trying to secure funds for experts and therefore seldom receive funding for an expert consultant or for a testifying expert. How can an attorney obtain the money to hire a consulting expert as well as a testifying expert?

A client rarely has sufficient resources (or a family with sufficient financial resources) to retain a consulting expert. More often, the client and his or her family and friends are indigent. Experts must be retained through outside resources.

One strategy is to recruit mental health consultants who work in academic settings, especially research and training universities. Some may be willing to assist because of a belief in the value of the work, the quest for valuable experiences for clinical teaching, or the need to develop research projects to meet the demands of "publish or perish."

The most frequent means used to obtain funds to hire an expert consultant is a request to a judge to order the funding authority – the county, state, or federal government – to supply the funds. Case law across the nation clearly instructs that a substantial *threshold showing* is necessary before a court is statutorily or constitutionally required to authorize the money and that the showing must demonstrate the following eight features:

1. Kind of expert required.
2. Type of assistance needed from that expert (investigating, testing, consulting, evaluating, testifying).
3. Name, qualifications, fees, estimated total costs.
4. Reasonableness of expected costs.
5. Basis for the request, showing that expert help is "reasonably necessary":
   a. objective, e.g., prior mental health history;
   b. subjective, e.g., observation of bizarre behavior by attorney;
   c. legal, e.g., relevance of mental state to culpability;
   d. competence and national standards requirements for effective representation.

1. Case law and statutes affording right to expert.
2. Unavailability or inadequacy of available state-employed and – funded experts.
3. Supporting information, such as affidavit of proposed expert or mental health records of the client.

(Edward Monahan, *Obtaining Funds for Experts in Indigent Cases*, 13(7) The Champion 10-18 (1989).)

Funds for both consulting and testifying experts are provided with increasing regularity when the attorney makes a competent threshold showing. (*Ake v. Oklahoma*, 470 U.S. 68 (1985).) *Ake* explicitly recognizes the necessity of access to

both testifying and consulting experts. As a guarantee of Fourteenth Amendment due process when the threshold showing has been made, the *Ake* court determined that an indigent defendant is entitled not only to an expert who would conduct a professional exam, help determine the viability of a defense, and testify but also to one who would "assist in preparing the cross-examination of a State's psychiatric witnesses" (e.g., a consulting expert).

**Characteristics of a consultant**

What type of person makes an effective mental health consultant for criminal cases? We recommend looking for seven main characteristics when you consider hiring a consultant for your case:

1. Expertise in the area of family theory and a biopsychosocial systems orientation. (George L. Engel, *The Clinical Application of the Biopsychosocial Approach*, 137(5) Am. J. Psychiatry 535-43 (1980).)
2. Expertise in detecting childhood trauma and a clinical understanding of how it affects persons later in life.
3. In-depth background in human development research and theory, along with a practical knowledge of psychopathology and the ability to "translate" this specialized knowledge for laypersons.
4. Understands human behavior as purposeful and sees even violent behavior as often an attempt to meet crises and to solve problems.
5. An interdisciplinary orientation and an understanding of the expertise of mental health professionals from disciplines other than his / her own.
6. Enjoys working with attorneys, investigators, and paralegals, and understands and appreciates legal ethics as well as the criminal justice system's valuing of the adversarial process.
7. *Perhaps most critical*: Sees the client as a human being who is ultimately comprehensible and deserving of the best mental health assistance and advocacy possible.

**Conclusion**

To successfully defend a client, an attorney needs to demonstrate how the defendant's mental condition was the proximate cause of the criminal act that was committed, and then be able to show that that condition is subject to remediation. A consulting expert can help attorneys develop a persuasive mental health theory of the case, choose competent expert witnesses, and develop a narrative that integrates the variables of the empathy / compassion equation described above.

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# Chapter 11: Social Histories and Forensic Mental Health Evaluations in Forensic Cases ©

**by Robert Walker**

**EDITOR'S NOTE:** *This article was commissioned by The Advocate to inform its readers of the standard of practice for social histories in capital cases where a defendant's life is at stake and where the constitutional focus is not only on the client's crime but also who the client is. It is likely that social histories of a lesser degree will increasingly be relevant in non-capital criminal cases where the mental state of the accused is informed by the context revealed by a social history.*

This paper explores the features of social histories in forensic mental health practice. The title refers to social histories but in fact the better term is biopsychosocial evaluation since it is a more comprehensive concept. In forensic practice, particularly in capital cases, the social history becomes the organizing representation of clinical content and thus must capture biological, psychological, and social characteristics of the individual.

There are three mental health evaluations that have use in forensic environments: psychiatric evaluations, psychological assessments and biopsychosocial evaluations. Statutes and individual court practices influence which of these three is relevant in various proceedings. The psychiatric evaluation typically focuses on the diagnosis of mental disorder or mental state of a defendant. The psychological assessment uses various instruments to outline and define personality traits, emotional or psychological disorders and intellectual capacity. The biopsychosocial is the integrative assessment of an individual that brings medical, psychological, social, familial, educational, economic and cultural factors into a comprehensive evaluation of the person. It can either precede other more specific evaluations or it can serve as the summative assessment that blends findings from other reports. Where the psychiatric is performed only by psychiatrists and psychologicals by psychologists, the biopsychosocial is performed by clinical social workers, psychologists and other nonmedical mental health professionals. When correctly performed, the biopsychosocial evaluation summarizes all the significant factors in a defendant's life and presents the most salient characteristics in comprehensible ways. This comprehensive quality accounts for the increasing importance of these evaluations in criminal proceedings - particularly for capital cases.

In clinical settings outside the forensic realm, the biopsychosocial evaluation summarizes the person's development and current living situation so as to set the stage for treatment. In fact, the objectives and methods of the treatment plan should arise directly from the findings of the biopsychosocial assessment. In clinical situations, the biopsychosocial is but a tool to support the treatment process; its only readers should be other clinicians and its contents should be understood solely in the context of treatment processes. Non-clinical uses of clinical information, however, appear to be on the increase. Disability claims and insurance claims call for the release of medical records and numerous other legal and quasi-legal proceedings drag clinical records into their processes. Furthermore, clinicians from all mental health disciplines find themselves drawn into courtroom proceedings to render opinions about their clients based on what has been learned during treatment episodes. What one learns in the context of treatment is likely to be very different from what is learned in forensic processes. The translation from therapist-helper to courtroom player creates considerable ethical quandary for the conscientious clinician (Strasburger, Gutheil, & Brodsky, 1997). There is perhaps wisdom in keeping the two realms distinct rather than allowing them to be blended into one all-embracing role for the clinician.

The use of a clinical document for other than clinical purposes is generally a misuse of the information.

What is at issue here is not the use of mental health experts, but the proper way to go about using biopsychosocial information in forensic settings. The recommended way to do this is *not to use existing evaluations which have been written out of context*, but to conduct evaluations with the forensic situation clearly defined as the purpose and audience of its findings. Nonmedical mental health professionals might feel intimidated by psychiatric presence in criminal proceedings. This discussion of the ingredients of a biopsychosocial is intended to increase the level of professional competence and personal confidence in these evaluations. *Thoroughness is the essential factor* and the clinician who pays attention to detail will have no reason for anxiety about other professional opinions that vary from the biopsychosocial. Well-developed psychiatric and psychological opinions should cover much of the same ground as that covered by the biopsychosocial evaluation.

### The Forensic Perspective

The term *forensic* is used throughout this paper as if it were a unitary notion. It is not; it covers a waterfront of legal and quasi-legal proceedings in criminal and civil areas. There are considerable differences in the form and content of forensic evaluations in these different environments. This discussion focuses on the criminal arena within which there are three distinctly different forensic perspectives that condition the nature and methods of the evaluation. This perspective

arises out of the legal context of the assessment. The three contexts include defense, prosecution and friend of the court.

As the reader reviews the purposes of the forensic biopsychosocial below, attention should be paid to the legal context of the evaluation. For example, the defense posture generally calls for more attention to the *individual and complicating* features of a case - the mitigating and aggravating circumstances. A prosecution perspective, on the other hand, will bundle the pathological descriptors that convey the degree to which the defendant is *different from "us", the jurors and officers of the court and how he is incapable of reform*. The friend of the court position most nearly approximates traditional clinical perspectives in that it appears to be more "objective" (an illusion) by not taking an adversarial role as do the two others. The "friend", however, can be drawn into the adversarial process upon rendering an opinion. The "default" perspective used throughout this paper is the defense role, but the reader should be alert to the different possibilities as each topic area is covered.

## The Purpose of a Forensic Biopsychosocial

The purpose of a forensic biopsychosocial is four-fold: 1) to present salient clinical features in a narrative context, 2) to present a plausible portrait of the person that invites empathy, 3) to offer a comprehensible context for the actions taken by the individual and 4) to assess the individual's potential for change or rehabilitation.

1) **The Narrative Context:** In clinical settings, professional descriptions of a "client" are often collages of information about his or her key life events, symptoms, thought processes and qualities of emotion and mood. The professional understands the structure of the information and has little difficulty moving from one domain of information to another. There is a *conceptual order* to the clinical document that follows agreed upon formats for describing the client's level of functioning. By contrast, there is merit to using a *historical or narrative structure* for presenting information in forensic evaluations so that jurors can begin to understand the *evolution of the person in the environment.* The narrative context does not mean that the evaluation must be written in a strictly historical way, but that the fundamental narrative structure of the individual's life is captured in the report. The narrative can be part of the summary of findings, where the clinician gives a meaningful view of the individual or it can be at the introduction of the evaluation. At a minimum, the clinician should use narrative to capture the presenting situation for the evaluation - namely, the events leading up to and including the crime.

From a defense perspective, the clinician should define the individual's psychiatric or psychosocial disorders in the context of the individual's history. The juror can begin to make inferences about causes and effects based on the narrative of events. Most of us understand our own lives in the context of our "story," the events that have occurred and the things we have done and, since jurors are generally "lay" people, it makes sense to build upon their accustomed ways of understanding life. Life events can begin to delineate mitigating and aggravating circumstances that can influence the court's understanding of the crime. From a prosecution perspective, the pathology will be stated in conclusive and absolute terms so as to portray the depth of disorder present in the defendant.

2) **Plausible Portrait:** The prosecution's presentation of facts in a criminal proceeding is designed to show how the defendant is *different* from the others in the courtroom. There is a circularity to its argument: the person's acts demonstrate his or her barbarity and the very barbarity of the individual helps explain why he or she could have done what he or she is accused of. The intent of the approach is to convince the juror of the "otherness" of the criminal, the demonic quality; it is designed to destroy empathic feelings, for if one can *identify with the criminal*, then punishment becomes harder to decide. Prosecution wants to reduce the defendant to an abstraction or a "thing" that is distinctly different from the juror. Defense strategies, on the other hand, attempt to diminish the willful quality of the defendant and so they either demonstrate the degree to which the defendant was a victim or they aim at establishing the image of a real person with whom the jury can identify. Juries have difficulty with portrayals that exaggerate the victimhood of the defendant. What is more compelling is a realistic portrait of the individual as someone with whom one can identify; it must be a *plausible* person - neither too demonic nor too helpless.

The applied behavioral sciences have tended to move away from the study of intentionality. Most clinical discussions of a client's behavior will focus on the various biochemical, social, environmental and developmental influences that can account for the client's actions. Intentionality is generally not a concern except with those individuals who are seen as being personality disordered. In these cases, the clinicians may attribute problems to intentionality.

Criminal justice, however, places a high degree of importance on intentionality since it is a formative ingredient in determining degree of criminality. The forensic portrait should capture the degree to which the individual truly has available choices and the degree to which he or she recognizes and acts on those choices.

3) **Environmental Context:** No one exists in a vacuum. The art of forensic assessments for the defense lies in conveying the texture of the defendant's world. Choices always seem abundant when the crime is reviewed in the courtroom. In the removed and rational environment of the trial, it is in fact difficult to imagine a defendant not having choices. One of the goals of the forensic biopsychosocial is to render the constraints of the individual's world. This is not an easy task,

since the evaluator might not have a good feel for the substance of the individual's environment and culture. *If the evaluation does not capture this quality of the individual, it will have missed a salient feature that is essential for the juror to understand*. The evaluation should define the specific features of the environment, both during the defendant's development and during the period when the crime was committed. The prosecution stance is that the defendant's environment afforded as many positive as negative choices.

4) **Rehabilitation Potential:** The evaluation should describe the individual's strengths or redeeming features that point toward positive change with appropriate support or treatment services. A very bleak and tormented life might show considerable potential for growth and development in spite of all the grim historical events. Prognostic statements should be framed in terms of realistic potentialities.

These four purposes guide the organization, the content, and tenor of the evaluation and, as mentioned above, they must be adjusted to the particular legal context of the evaluation.

### Procedural Guidelines

The preferred practice is to *use clinical procedures to produce forensic documents, not to make forensic use of clinical documents*. In other words, the forensic evaluation should be a *special procedure that is distinctly set apart from clinical functions per se*. The reasons for this include the ethical concerns about the degree to which the client understands the context for personal disclosures. An evaluation that took place as a part of treatment is quite different in its impact upon the client's decisions about disclosure. When the individual has made these disclosures as a part of treatment, there is generally a very different motivation from what one might see in forensic settings. One cannot assume that the disclosures made in the course of clinical discussion would necessarily be made in the forensic case. Ethical and legal dimensions of these evaluations must be followed in order to not compromise a client's privacy, liberty interests, or the professional's credibility. There are six major steps in conducting the forensic biopsychosocial assessment:

1) securing a proper court order or a contract (the context for the evaluation);
2) obtaining informed consent and permission to evaluate the individual;
3) obtaining proper releases of information and obtaining the records from relevant sources;
4) performing the evaluative interviews and observations;
5) reviewing the content and impressions with the individual (and counsel if this is a defense case); and
6) submission of the report and findings.

Item 5 might disturb some evaluators - particularly if there is a belief that the individual is going to try to exercise editorial control. This is not at all the intent; it is merely a way of keeping the process honest, accountable, and properly focused. If the evaluator cannot look the individual in the eye while giving the content of findings and opinions, then there is reason to be concerned. Given that the liberty interest or even life of the individual might depend upon those findings and opinions, it seems worth while to give the individual the opportunity to hear them first hand and at least respond to them.

### The Six Steps of Evaluation

**1. Proper Order or Contract - the Context for the Evaluation:** The evaluator needs to have clear understanding of the contract or order under which the evaluation is to be done. The evaluator should get a clear authority for the work before beginning. The evaluator should have a clear understanding with the attorney as to the desired goal and the methods of defense that the attorney is planning to use. Much grief can be avoided by having this frank discussion at the very beginning of the case, rather than later when a clash of values or approach has arisen. The clinician must establish the parameters of truthfulness that are not to be abridged in the process. Wise forensic practice flourishes neither in rigid ethical "purity" nor in meretricious opinions. The evaluator should assess the attorney's strategy to determine his or her degree of accord with it in ethical terms. It is not the business of the mental health professional to raise concerns about the purely legal dimensions of the case, but ethical issues can be cause for concern and they should be resolved prior to becoming heavily involved in the case.

**2. Informed Consent:** The defendant should be given clear and relevant information about the nature of the evaluation and the legal context within which it will be done. Often the individual has but a crude understanding of the processes involved in court proceedings and all of the evaluations that might be enlisted. The evaluator has an ethical duty to explain this in detail irrespective of what the attorney might or might not have done. The evaluator should also obtain permission to interview family members and other collaterals. Technically, this permission is not required, but, in the interest of preserving an ethically sound relationship with the defendant and family, it is advised to seek it. Once the interviewer has established contact with collaterals, there is a duty to obtain their informed consent and permission to participate in the assessment. The consent must be in written form with all signatures witnessed.

3. **Releases of Information and Review of Records:** The evaluator should obtain authorization to release any and all medical or psychological records from the defendant's previous providers to the clinician. This should include records from inpatient stays, residential care for substance abuse or other disorder, and any and all outpatient records.

Criminal records, evidence of placement in group homes, fostercare or other social service interventions in the individual's youth are helpful. The more information the clinician has, the better the evaluation.

4. **The Evaluation:** The actual evaluation might be conceived of as a process rather than a discrete interview. The evaluation consists of six major elements:

a) There will be numerous interview sessions. This allows for questioning from different perspectives and within differing contexts, thus giving the clinician the opportunity to check the reliability and consistency of critical responses.

b) Collateral interviews with family members and sexual partners are critical. If possible, these interviews should be conducted as home visits. Obviously, time constraints limit one's ability to do this, but much can be learned from seeing the defendant's home and from experiencing his or her culture in an immediate way. The perspectives gained from other family members are also crucial in forming meaningful impressions of the family of origin and the veridical strength of the defendant's version of this past. These collateral contacts also help in gaining information about the individual's current family and social relationships. When the case involves spousal homicide, the collateral interviews are essential as they can establish the vital context within which the crime was committed and can ramify the personal qualities of the defendant in ways that can be very helpful.

c) Police reports, investigative reports, witness statements and factual evidence should be reviewed by the clinician. This information should be viewed as simply one version of the reality - not the absolute truth to which one tries to get the defendant's responses reconciled.

d) The interviews with the defendant will involve taking the life and health history and doing a mental status examination. The full content of this part of the biopsychosocial will be reviewed fully in the balance of this paper.

e) The various reports and records from other providers should be integrated into the clinical assessment. Part of the task of a forensic biopsychosocial is to assimilate disparate professional opinions, histories of treatment and other assessments into a coherent picture. Differences of perspective should be accounted for and reconciled where possible. When this is not possible, the differences of opinion should be explained along with their underlying assumptions or biases.

f) Research data should be applied to any clinical opinions about the defendant. The clinician should even cite contradictory research findings and show how and why one perspective on this is chosen over the others. Citations should be from empirical research, not "authorities" who have propounded theories or voguish "disorders" in popular books. Theory has sometimes been helpful in welding together the many disparate pieces of information about a defendant's mental or emotional condition, but in the harsh cross examination environment of today, empirical findings will be far more potent.

### The Biopsychosocial Format and Content

**I. Identifying Information and Context of the Evaluation**: The clinician should state the individual's full name, age sex, race, marital status, address, and occupation and location where and when the interviews have been conducted.

*Example:* "Ms. Jane Logan Doe, a 27 year old white female, separated, who lives at 233 Locust Street in Lexington, Kentucky. She was interviewed on three occasions in the Metro Detention Center in Lexington, Kentucky on the dates of 21 November 1995, 3 December and 9 December 1995."

**6 ELEMENTS OF THE EVALUATION PROCESS**

1. Numerous Interviews of Client;
2. Collateral Interviews of Family, Significant Other Persons;
3. Review of Records;
4. Taking of Life and Health History, and Doing a Mental Status Exam;
5. Review of Reports of Other Professional Opinions of the Client;
6. Application of Research Data.

The location of the interviews can be of great importance, both to the clinical findings and to the conduct of the defense around those findings. Interviews that are conducted in correctional facilities can pose problems. Has the individual been as completely forthcoming as she or he would be in the outpatient world? The answer can be both "yes" and "no." The desire to tell someone something that might lead to freedom is very powerful and can produce distortion. Likewise, the lack of authentic privacy can inhibit full disclosure of matters that the individual thinks might result in either other charges or complications to the case. It is often difficult to ensure even a boundaried confidentiality in correctional settings since the clinician is not in control of the environment.

The evaluator should state the specific context for the evaluation. This includes a statement of the charges facing the individual, the status of the case at the time of the evaluation, the party who requested the evaluation and the questions that the biopsychosocial assessment has attempted to answer.

> *Example:* "Ms. Doe has been convicted of manslaughter and is currently awaiting sentencing before Judge Tenzing Norgay, XX Division, Jefferson Circuit Court in Louisville, Kentucky. This evaluation was undertaken at the request of her attorney and it addresses the mitigating factors behind the commission of the crime, including the impact of numerous previous traumas on her at the time of the commission of the crime."

**II. The Defining Reason for the Evaluation - Presenting Problem:** There are two principal presenting situations for defense-related forensic evaluations: 1) situations that call for opinions to guide the determination of guilt or innocence and 2) situations that call for information to assist in sentencing options. The first of these focuses more on the individual's moral and cognitive capacities to form intent where the second focuses more on mitigating factors and rehabilitation capacities. In setting forth the presenting problem, the clinician might use: 1) the defendant's view of the circumstances before and after the period of the crime, and 2) a summary of "objective" reports from the police or victims.

1. The clinician should elicit the individual's understanding of the circumstances of the referral and the reason for the evaluation. Secondly, the clinician should have the individual describe the circumstances of the crime as a way of gaining his or her understanding of the events and the "frame" that the individual is putting on the experience. The salient features of the individual's view should be recorded in his or her own words in quotes. The individual's accounting of the facts is important, but, perhaps, even more important to the evaluative process is the rationale that the individual gives to the events. The individual's attributions of intentionality to others can be significant as it can provide leads to family or social relationships that might have had significant impact on the individual's behavior. Reports of severe distortions of power and control are among the more meaningful elements that the clinician should pay heed to. The assessment of the individual's cognitive capacities must be integrated into the dimension of guilt ascertainment.

2. The clinician should either distill a brief account of the events as they are defined by official reports or simply give evidence of having reviewed witness statements, police reports and any other factual evidence. This is done as a way of grounding the evaluation and also as a way of showing the court that the clinician is aware of the "official" version of events and has not blindly followed the defendant into a swamp of distortion.

**III. Early Personal and Nuclear Family History:** This part of the biopsychosocial establishes the basic developmental and core family features from birth through adolescence. It encompasses the genetic, cultural, social, and interpersonal aspects of the early family environment and the role that these elements play in the formation of the adult character.

**A. *Genetic influences and intergenerational trends*:** The most effective way to obtain and represent all of the genetic loads on character formation is through the use of a *genogram.* This simple graphic tool lets the jury and other evaluators see the accumulative quality of genetic and intergenerational influences that are of a destructive nature. By representing two generations preceding the defendant, one can observe a pattern of biological factors that can become a part of mitigation in defense process. This is a two-edged sword, however, and must be displayed with caution as the genetic influences can easily be characterized as "wired in" and can be used to rationalize either death or long terms of incarceration since the prospects for change are seen as small. Biogenetic disorders have the advantage of being seen as outside the scope of individual intentionality and thus offer substantial mitigative strength, but caution is advised in cases where there might be a tendency to view the individual as beyond rehabilitation.

The genogram offers the clinician a device for selective representation of traits and trends in the family. For example, if the case involves a crime where alcohol or drugs were a factor, then the genogram can focus on the presence of drug or alcohol problems in the family. Likewise, seizure disorders, mental retardation, learning disabilities and other traits can be selected for their relevance to the issue at hand.

In order to construct the genogram in a convincing and competent manner, the clinician must have a thorough command of those disorders that show high comorbidity coefficients and a high degree of intergenerational transmission. The tracing of single disorders will catch but a small part of the ge-

netic pattern while sensitivity to comorbidites will identify the full array of potential limitations with which the individual was struggling. The clinician must also be alert to comorbidities that do not share obvious genetic or biological commonalties such as the co-occurrence of schizophrenia and PTSD. Clinical wisdom tends to look down the most traveled pathways; but forensic process often calls for innovative examination of less frequented associations.

**B.** ***Nuclear family characteristics****:* The nuclear family contains numerous elements of relevant history. Among the more important influences of the family is the degree to which violence was a part of the environment. There are two aspects of violence that are particularly relevant to the forensic biopsychosocial evaluation: 1) being a victim of violence as a child and 2) witnessing violence toward other family members. Both of these should be explored in any evaluation of defendants charged with violent offenses. Particular attention should be paid to the age at which the individual was first exposed to violent behavior as evidence suggests that the earlier the trauma, the greater the likelihood of damage to the formation of self. At later years violence damages emotional systems and behavioral learning, but, in early development, it acts directly on identity and self. Normal development calls for an interplay of natural biological processes with environmental nurturance: violence truncates natural potential.

Sexual abuse has effects on the development of self and self concept, the emotions, and behaviors that are similar to those of violence. The earlier the age of exposure, the greater the likelihood of damage to self. Later exposure is more likely to be correlated with Post-Traumatic Stress Disorder than to damage to the formation of self. The individual who was exposed to sexual abuse in childhood carries a heightened risk of being sexually or physically abused in adulthood. This is attributed to the victim's tendency to adopt survival techniques in childhood that become counter-productive in adulthood. The coping style of being avoidant or dissociative can lower the individual's ability to defend herself against the intrusions of a perpetrator.

The high degree of acceptance of sexual abuse as a factor in psychopathology has perhaps led to too simplistic a use of it in understanding the evolution of self and symptom. Too often, one discovers a history of "sexual abuse" with little or no specificity. The forensic evaluation that rests on this kind of simplification will probably be unconstructive. Physical and sexual abuse need to escape their simplistic labels. The biopsychosocial should define the *specific acts* that were perpetrated on the individual and leave the "abuse" term out of the evaluation.

With childhood sexual and physical abuse, the clinician should assess the degree to which the child was subjected to threat and fear. Research on psychological symptoms resulting from abuse suggests that terror is one of the more powerful contributors to pathology. Violent acts might have been infrequent and brief in duration, but a pervasive atmosphere of fear and intimidation, threat, and pernicious attitude toward the child can be profoundly damaging to the evolving sense of self. Persistent and pervasive fear is now understood as having effects on brain areas such as the hippocampus which is involved in storing and retrieving memories. The assessment of terror in the individual's life is one of the pivotal factors in understanding the individual's worldview and capacity to think, feel, and behave.

Another ingredient that is a significant contributor to symptoms and distorted self-formation is the element of *objectification* involved in sexual abuse. Paradoxically, we humans seem to be better equipped emotionally to deal with abusive acts that are *personally directed* versus those that are the result of merely using us as objects of gratification. The clinician should assess the degree to which the individual was subjected to a perpetrator's instrumental style of sexual or physical abuse.

As appealing as the signal events of abuse can be in the forensic evaluation, the combined influences of other factors such as neglect, substance abuse or dependence, and rigidity of parental beliefs and behaviors should be examined. There are few "single bullet" theories that can explain complex human behaviors and the successful forensic evaluation will pay heed to the multiplying effects of various factors rather than merely settling with the most obvious one. Sexual trauma at an early age (ages 4 - 7) combined with neglect offers one of the most potent ways to destroy the evolving self. Not unlike the recent attention to psychiatric comorbidities, the combined effects of destructive interpersonal and familial relations deserves close attention in the forensic evaluation. The question that arises from this inquiry is "what adversity did the individual face in meeting the challenges of development and what are the probable effects of the missing fundamental biopsychosocial 'nutrients' to that development?" A sophisticated assessment of the abuse phenomena will conflate 1) the history of specific abuse with 2) the elements of terror and instrumentality and with 3) the ambient environment of neglect.

In many forensic cases, the individual will have had foster placements during childhood. These placements, along with other early residential treatment placements should be explored in some detail. Early foster care can have ramifications on the degree to which the child found dependable and reliable attachments. Some foster placements are very positive and others merely repeat abusive or emotionally neglectful experiences for the child. It is probable that the individual's account of these foster placements is distorted, but whether true or not, these accounts represent the individual's perspective on this period of life. The unsettled nature of fostercare can have untoward effects even when the foster parents have been helpful.

With all of these history events, it is critical that the evaluation read "the client reports a history of this event at age X" rather than "at age X, the client experienced this event". The first version records the phenomenological where the second suggests fact. With all history issues, the report should consistently make a distinction between what is known versus what is reported by the individual. This is critical to the science of the matter, the ethics of proper evaluation, and the perceived accuracy of the evaluator.

As mentioned earlier in this article, the clinician should use great care in delineating the abuse history. A too morbid picture can easily lead to a juror's conclusion that the individual is hopelessly damaged and beyond rehabilitation. The attempt at portrayal of profound victimization can backfire into a depiction of pathology with which the juror cannot identify and toward which there is only a feeling of fear. Should the clinical portrait create a feeling of fear in the juror, then the aims of the defense will not be met while those of the prosecution will be.

***Procedural tips:***
The clinician who wishes to obtain a useful early history of personal and family events will adopt a noncommittal posture that makes untiring use of generally open-ended questions. Occasionally, in searching out antisocial antecedents, it is helpful to use presumptive questioning. Presumptive questioning asks the individual about events presuming they occurred - as in "Going back into, say, the first or second grade, what was the earliest fight you remember being in?" The presumption is that the individual had actually been in fights. If the individual was not in fights, he can easily deny it. This line of questioning however can lead to discovery of antisocial items by normalizing them in the interview. The clinician should be very cautious about even subtle displays of affect during this questioning process since it possible to influence the individual's account of sensitive matters. There should be very few questions that can be answered with "yes" or "no" and the clinician should not provide answers through the content of the question. The style ought to be so matter-of-fact as to not give the individual suggestions of desired content.

Interesting information can be discovered by asking the individual to describe how other family members might view events. This can lead to a quasi-objectivity where the individual shows the degree to which he is aware of others' view points. This can be done in the context of questions about key events in the individual's development.

> *Example:* "Could you describe for me what it was like in your family when you were in grade school? And what about before that? *Do your brothers/sisters see it the same way*? How do you think they would describe your family at that time? What was the hardest thing to deal with? What were the best things about your family? When you were a child, to whom did you feel closest? Why? How did you react to what was happening when X happened to you? How did your brothers/ sisters react when these things happened? *If I were interviewing your mother/father, what would they say about you at that time? How would they describe you?"*

When seeking additional information about the sequence of events, ask, "And then what happened?" instead of more close-ended (but seemingly obvious) questions like "And did he do this to you many times or only the one time?" The more indeterminate the question, the greater the opportunity for the individual to give authentic responses. Obviously, there are times when the clinician must hone in and probe for specifics through more determinate questioning, but as a general rule, the less restricted mode is recommended.

The *least* advised way to get abuse information is to ask, "Were you abused as a child?" The defendant situation provokes intense motivations to see self as a victim of others. For the clinician to walk into this with simplistic questions *is to do a disservice to the individual.* The task of the forensic evaluator when working for the defense is to avoid stereotypy; simplistic questions exaggerate the superficial traits of the individual and thus contradict the intent of the process.

**C.** ***Early development and personal events***. There are four domains that should be covered in this section: 1) prenatal factors (if known), 2) early childhood development and adaptations, 3) middle childhood and 4) adolescence.

1. The individual's prenatal conditions can be relevant to the understanding of cognitive ability, impulse control and other aspects of the adult personality. This information is obviously not easy to obtain in most cases and it can be subject to substantial distortion. It is, nonetheless, an important area for inquiry and, should there be any relevant findings, they should be identified in the report. Among the features that can be relevant are: pre- and perinatal maternal use of alcohol, tobacco, cocaine and marijuana. These substances have been shown to influence fetal and early childhood development of cognitive capacity, behavioral controls and emotion regulation. There is no certain relationship between the maternal use of these substances and impaired outcomes for the child, however, and clinical inferences from these data should be treated carefully. Again, as with abuse histories, a conclusive portrayal of severe neurocognitive harm caused by maternal drug use during pregnancy can lead to a juror's belief that the individual is incapable of change or rehabilitation.

   If obtainable, the individual's developmental milestones should be correlated with norms. Delays in development are not uncommon among individuals who are affected by violence and who perpetrate crimes. These findings,

when discoverable, should be referenced but used with care in forming clinical conclusions.

2. The early childhood of the individual can show traits that are significant to the clinical impression of the adult defendant. Early incidents of aggressive behavior - particularly when accompanied by injurious aggression - are among the more reliable indicators of antisocial personality formation. When these traits are accompanied by quasi-adult or truly adult sexual behaviors during early childhood, the likelihood of antisocial personality becomes all the greater. The combination of aggressive temperament and childhood exposure to family violence is a particularly robust predictor of adult antisocial personality. Other early childhood adaptations should be evaluated and compared to later behaviors.

   This can be helpful in sorting out the contributions of temperament and signal events in shaping later adaptive patterns. In general, the more persistent and earlier the trait (particularly the more antisocial ones), the greater the likelihood of its continuity through adulthood. There should be inquiry into symptoms of early childhood disorders such as enuresis, phobias, sleep problems, and communication problems.

3. As the child moves into school years, there are more measures of social and intellectual adaptations. Early social patterns should be assessed including: the types of friends, forms of socialization (one-on-one or small group), relations with adults, younger children, and older children (including exposures to harmful influences of older children). The clinician should be sensitive to the progressive features of the individual's intellectual adaptations and expressed abilities. Changes or halts in progress can be indicators of signal events in the child's life and can prompt further inquiry. The changes in content as grades increase can also be an explanation for gradual decreases in school performance and possible intellectual deficits. These "nontraumatic" factors sometimes seem less appealing than the more dramatic events of a defendant's presentation, but they call for close attention, particularly when the clinician begins assessing for cognitive functioning. It is useful to note whether there were close attachments to any parent or adults during this period of development. If the child grew up in an abusive environment, it can be helpful to learn whether he or she had the ability to garner surrogates from teachers, other adults, school counselors, etc.

4. Adolescence is an important watershed for markers of problem behaviors - particularly for the understanding of antisocial and personality disordered individuals. Personality begins its final "packaging" during this period of development and patterns of adaptation to pleasurable experiences, social, and other stressors and the challenges of responsibility are significant to the development of the adult personality. Among the themes to be explored are: educational attainments, the onset and character of sexual relationships, drug and alcohol exposures, and socialization.

   It is not uncommon to see changes in the individual's academic performance during adolescence. Lay wisdom attributes this to the various psychosocial dimensions of the teen experience, but the clinician should also be sensitive to the increased demand for abstract thinking in high school material. Poor academic adaptations can be indicators of poor parental support for education, disturbed home environments, fundamental cognitive inca-

**SOCIAL HISTORIES: CONTEXT AND EXPLANATIONS, NOT EXCUSES**

It is important to emphasize that mitigating evidence -including what I will say about the structure of capital defendants' lives and the nature of their social histories - is *not* intended to excuse, justify, or diminish the significance of what they have done, but to help explain it, and explain it in a way that has some relevance to the decision capital jurors must make about sentencing. Thus, nothing that I will say in the following pages is intended to in any way diminish or otherwise lose sight of the significance and human tragedy of capital violence. Quite the contrary, I do not believe we pay fitting tribute to the victims of these crimes by continuing to ignore their causes. Only if we look honestly at the lives of those who commit capital crimes - and cease to be blinded by the fictionalized, demonized caricatures the media feeds us - can we learn the lessons by which future victims can be spared.

Social histories, in this context, then, are not excuses, they are explanations... But no jury can render justice in the absence of an explanation. In each case, the goal is to place the defendant's life in a larger social context and, in the final analysis, to reach conclusions about how someone who has had certain life experiences, been treated in particular ways, and experienced certain kinds of psychologically-important events has been shaped and influenced by them.

- Craig Haney, *The Social Context of Capital Murder: Social Histories and the Logic of Mitigation*, 35 Santa Clara Law Review 547, 560 (1995)

pabilities, drug and alcohol use or, more likely, several of the above combined. This period of academic performance should be reviewed carefully and correlated to other events in the individual's life.

5. During adolescence the individual begins to develop interest in sexual relationships. For some adolescents this transition is gradual and tentative while for others it is abrupt and decisive. It can be very important to capture the emerging patterns of sexual relating in the adolescent. Partner battery and sexual assault begin to emerge in adolescence. The assessment should also explore the degree to which the individual evidenced dependency in early dating patterns.

   With adolescence, the pleasure centers of the brain begin to turn on and the individual is challenged to master these elemental drives. It is very informative to approach this period of development with attention to the individual's ability to inhibit the native impulses that are emerging. There are several factors that can assist the individual in doing this: cognitive processes (including internalized rules and mores), social constraints and parental supervision. Typically, among disturbed or antisocial populations, there are deficits in most of these three areas. They should be assessed carefully for they can provide cues about the degree to which the individual might have internalized controls that can be built upon in treatment. Drugs and alcohol are attractive mood modifiers to the adolescent and the clinician should evaluate for the presence of abuse and even dependence during this period of development. The drug and alcohol history will need close evaluation (see below) but important information can be obtained from the use of *presumptive questioning* about adolescent behaviors.

***Procedural tips:***
Presumptive questioning about drugs and alcohol can be very useful when the clinician suspects denial or over-endorsement of certain topic areas. The presumptive way of inquiring into drug taking behavior begins with questions like these: "What is the earliest time you remember using marijuana? Who first exposed you to marijuana [alcohol, etc.]? When you were first getting into drugs, which one seemed to have the greatest effect on you? What usually happened when you got high? Who were you usually with?"

This same style of questioning can be useful with sexual behaviors as well. For example, the clinician might ask: "What is the earliest time that you can remember in your childhood that you had sexual contact? Who was with you? What happened? What about other times after this? For how long did this continue?"

Presumptive questioning seems at first glance to be pre-judgmental. This is not at all the purpose of the approach. The purpose is to provide a permissive setting for the individual to disclose what he or she knows is wrongful or problematic behavior. It actually has the paradoxical effect of *normalizing the individual's world* and it conveys that the clinician understands that world. When the individual has not fought and/or has not had problematic sexual behaviors, he or she will report this and the focus can move on. *This form of questioning should only be used where the individual presents with defensive style and antisocial traits that need clarification.*

**IV. Adult History:** The history of adult functioning covers nine major areas: 1) marital and/or partner relationships, 2) parenting or caregiver roles and behaviors, 3) patterns of substance use and other compulsive behaviors, 4) educational attainments, 5) vocational attainments, 6) current living environment, 7) economic security and status, 8) social and recreational pursuits, and 9) religious or spiritual values.

**1. *Marital and/or partner relationships:*** The evaluation of partnering should encompass a history of relationships plus a depiction of current ones. There are seven major dimensions to the evaluation of marital and partner relationships: a) mate selection, b) role definition, c) expectations of the partner and relationship, d) attachment behaviors, e) conflict resolution, f) relationship dissolution, and, in certain cases, g) domestic violence and where indicated, h) lifestyle or sexual orientation. Throughout each of the seven, the clinician should be sensitive to patterns and themes rather just isolated facts. Relationships are, in some respects, difficult to assess due to the contributions of the other person (who might not be available to the evaluator). Patterns that repeat over several relationships, however, make for defensible inferences.

a. *Mate selection:* This item shows marked sex or gender differentials in forensic populations. Lay thinking assumes that both genders make active choices about partnering and that the resultant relationship is the product of free choice. This commonly held belief may need revision when working with forensic populations in general and in domestic violence cases in particular. The argument for mutuality of partner choice might have validity in middle class and nondisturbed groups of people. Furthermore, it might have meaning with males, who still today remain the seekers of partners, but it has questionable validity with females - particularly in lower socioeconomic groups who may *agree* to relationships rather than actively choosing them. Lower income women with less education have a very complex set of issues that affect mate choices. This might be an offensive notion to those who have sought increased independence of women in the past three decades, but the sad reality is that men still dominate the partner selection processes - *particularly in lower socioeconomic sectors of society*. The significance of this idea cannot be underestimated when domestic violence is a feature of the relationship. Among forensic concepts, one of the more enduring and perni-

cious ones is *the belief that domestic violence victims continually seek out abusive partners*. The clinician is strongly encouraged to discard this notion. A realistic appraisal of the woman's *actual choices in partnering* need close review; she very rarely has the range of healthy choices available that we believe she has. When we add to the formula some of the preconditions within which a poor woman operates, the situation takes on a grimmer prospect. If she is from lower socioeconomic strata, she earns little money and *has great economic need for a male wage earner*. If she has a child or children, this need is all the greater. As an uneducated, low wage earner, she less likely to be mixing with upwardly mobile males. Furthermore, the disparity between her wage and that of males in her class is very great. A recent graduate male MBA might earn more than an equal female MBA, but the difference is not likely to be as great as that between a minimum wage female and a male who is a skilled or semi-skilled laborer. The male wage is likely to be three to four times hers. Her mate selection is far from free in the sense that we usually like to think of it.

The concept of free mate choices has meaning with males and it is viable to use this in the biopsychosocial evaluation. In cases where domestic violence persists over multiple relationships, we can assume *not* that the woman is seeking abusive partners, but that *the man is seeking likely victims.* This notion should not surprise us; perpetration of abuse is closely allied with other deliberative steps toward domination of partners. Why would it not influence mate selection?

With the whole notion of mate selection, the clinician is cautioned to exercise care with the use of assortive mating assumptions. The literature on assortive mating is lengthy, but still heavily imbued with theory that is inspecific about the selection variables that might lead to mate choices. Mate choices should be examined in light of real economic and cultural factors, not merely psychological or romantic ones.

b. *Role definition:* The clinician will want to evaluate the roles that the defendant has taken in marital or partner relationships. Primarily, this involves an examination of the distribution of power and control among the partners. In addition, the clinician will need to assess the boundaries of partners with each other. Are there signs of enmeshment or disengagement? These two concepts, for all their theoretical frailties, still have some merit in appraising the degree to which individuals are constructively engaged in the relationship. Over involvement in the affairs of one can suggest enmeshment while withdrawal and avoidance can suggest disengagement.

***Procedural tips:***

The ascertainment of power and control is at times difficult. Rather than pursuing direct frontal questioning about this, the clinician might make use of some simple devices that give data from which inferences can be made. For example, one might inquire about who writes checks, who reconciles accounts, who "manages" the cash. Inquire about how decisions are made when an appliance breaks down, who decides about repair versus replacement, who makes the choice about replacement equipment. Who is responsible for the details of daily living in the home - cooking, cleaning, dishes, childcare and what division of labor exists here? Once the clinician has information about the handling of money and daily tasks, one has a relatively clear picture of the distribution of power and control. The response to concrete questions is generally more productive than the more abstract questions about roles in the relationship.

c. *Expectation of the partner and the relationship:* It is useful to understand what the individual expects from spouses or partners and what he or she sees as needs that should be met in the relationship. This sometimes must be framed in a historical way. *E.g.*, "When you first got married, what kinds of things did you think your wife should do for you?" and, "later on, did your thinking change about this?" - " How so?"

d. *Attachment in adult relationships:* The clinician should examine the ways in which the couple came together and stayed together. What was the attractive element and did the individual know what it was at the time? The clinician will need to examine the degree to which the individual appears engaged with his or her partner and the degree to which engagement is sustained through stressful events. Attractive force between the two can be a function of companionability, interpersonal need and sexual attraction. Sexual and romantic dimensions should be explored to ascertain the degree to which they motivated the forming of the relationship and the degree to which they play a part in the current status of the relationship. Sexual behavior needs detailed inquiry when there is evidence of sexual parameters to the crime, when there is evidence of sexual dysfunction, or where the defendant has raised a sexual concern about the relationship.

e. *Conflict resolution and communication styles:* The clinician needs to explore how conflict arises in the relationship, over what issues and by what methods are they resolved. Defendants might have need to either exaggerate or deny conflict in the relationship. This is an area in which collateral information is very important. Even in undisturbed relationships individuals exhibit substantial distortion about the kinds, causes and results of conflict. The clinician should use presumptive questioning in some cases with this issue. *E.g.*, "When you and your wife are really angry with each other, what's it usually about?" "When you are arguing with each other, what usually brings it to an end?" "Who brings it to an end?" "What is the usual way that you get control?" "How do you make others do what you want them to?" These ques-

tions might offend the sensitivity of some clinicians, but their purpose is to enter into the world of the individual who might use battering or control in relationships. Questions about conflict resolution often lead to domestic violence issues.

The clinician will need to form an impression of the communication styles of the defendant and his or her partners. This is perhaps more art than science, but an effort should be made to get a picture of the ways in which the couple communicate about positive as well as negative matters.

f. *Relationship dissolution:* The clinician should obtain a history of the individual's ending of relationships. It is useful to know whether there is mutual consent or whether the defendant or the other is usually responsible for ending the relationship. This item can be useful in forming inferences about dependency. It is also useful to know whether the dissolution was the result of violence or other infraction by the defendant such as extramarital affairs or other illicit pursuits versus a long pattern of not getting along.

g. *Domestic violence:* When there is reason to believe that domestic violence played a role in the defendant's life *a full domestic violence assessment should be undertaken.* This will involve a review of patterns of violence from either the perpetrator or victim perspective as indicated by the individual's situation. When the defendant is a victim of domestic violence, the full history of abuse should be explored in great detail since there is evidence that victims are likely to have histories of childhood abuse in addition to their adult experiences. Likewise, perpetrators typically have violent and abusive backgrounds. When domestic violence is a part of the defendant's presentation, this issue should receive prominent treatment in the biopsychosocial evaluation.

h. Sexual Orientation: The individual's sexual orientation should be referenced but clinicians are warned that it is not necessarily significant. Failure to note it can be very damaging when the prosecution attempts to use it in a stigmatizing way when the individual is gay or lesbian. The clinician should be familiar with cultural features of gay and lesbian cultures so that inferences about partnering can be informed. Gay and lesbian relationships have features that might appear pathological when viewed without an understanding of their differences from hetero couples. In general, clinical inferences arising from sexual orientation should be made with caution. Homosexuality offers an inviting target for seeing the individual as "different" from the jurors and officers of the court. The biopsychosocial can contextualize homosexuality in ways that let the jury see the individual, not the "gay" object.

**2. *Parenting and Caregiver Roles:*** The clinician should evaluate the various caregiver or parental roles that the individual has. Again, as with other topic areas, this should be done historically and in the current circumstances. Patterns of caregiving can be important in forming a clinical picture of the individual and they can be significant mitigating factors in the sanctioning process. The impression of criminality can be greatly diminished by a history of careful and concerned parenting in a situation of great adversity. Parenting is difficult to assess with only the defendant's information and thus collateral data is very important. Among the themes that should be explored are: the quality of the parental attachment to the child, the degree of involvement in the child's schooling and recreational activities, the methods for insuring the health, safety and security of the child, and the methods for handling discipline. Have the defendant's children been removed by Protective Services? For what period of time? Was this due to acts committed by the defendant or because of a failure to adequately protect the children from harm caused by others? What steps were taken by the individual to remedy the situation and did this result in a return of the children?

Other caregiver roles should be explored including whether the defendant is responsible for the care of adults who cannot provide for their own needs. This might include elderly relatives or adults with disabilities. If there are caregiver duties, what financial support helps the individual with this? Are there social security benefits involved? Has the individual been a responsible custodian of the resources for the disabled person or is there evidence of diversion for the individual's own benefit? Are there incidents of abuse of the dependent person? If so, how were these resolved?

**3. *Patterns of substance use and other compulsive behaviors:*** It is not uncommon for defendants to have drug and/or alcohol abuse histories. The assessment of these issues requires attention to detail as the ramifications of the different patterns can be of considerable importance in estimating the degree of impairment and rehabilitation potential. The clinician should view the substance use history from a developmental perspective since there is evidence that the timing of initiation of routine use constitutes a significant marker for the degree of addictive disorder. Exposure and recurrent use of psychoactive substances before age 14 appears to be strongly correlated with adult dependence or heavy abuse. Among the factors involved in the assessment of substance use are the following: a) the substances that have been used by the defendant and the quality of mental state that the substance provides (*i.e.*, satiation, stimulation, etc.), b) the age of first exposure and recurrent use, c) the quantity used, d) the frequency and concentration of used substance, e) efforts to control or stop the use of the substances, and f) changes or shifts from one substance to another. As a general rule, the earlier the use of substances, the greater the likelihood of entrenched addictive pattern and the less likely the recovery from it. This is particularly true for alcohol where studies have shown that early use in males

is correlated with paternal use and antisocial traits. These patterns require close assessment because the conclusions and opinions that result can be of such consequence to the individual.

In forensic evaluations, the cluster of behaviors typically associated with substance use (such as criminal conduct to procure or pay for substances) are as important as the use itself. Furthermore, the distinction between abuse and dependence is sometimes difficult to determine in forensic cases when the individual might have made many changes (at least temporary ones) since the charges. In these cases, the clinician is put in the position of determining what the level of use was some weeks, months or even years ago - a daunting task considering the potential distortions that the defendant and family can bring to bear in these circumstances. The substance use disorder should be examined in the context of all the features of the individual's lifestyle to help in determining the degree to which substances are central or peripheral in his or her life.

As part of the assessment of substance use, the clinician should also evaluate the defendant's risk factors for HIV infection. When the individual gives evidence of IV drug use, the risk potential for HIV infection should be considered as very high. This item should also be addressed when the defendant's overall risk status is evaluated.

In addition to substance use, the clinician should assess for the presence of other behaviors that possess addiction-like qualities. This includes compulsive behaviors that are hedonic such as gambling, risk-taking behaviors (fast driving), compulsive sexual acts and other behaviors that appear to have a compulsive quality that interfere with social or vocational pursuits.

**4.** ***Educational attainments:*** The clinician assesses educational attainments with an eye to three dimensions in the individual's performance: a) social and cultural influences on education interests and attainments, b) family pressures and disturbances that might have affected attainments, and c) intellectual ability. The clinician should track the individual's school performance through early grade school, middle school and secondary grades. It is useful to note the point at which the individual began to perform poorly. Math performance may change by the third grade when mathematics disorders tend to appear. Typically, overall academic performance more likely to change around late middle school or early high school years (grades 8-9). This is cause for further evaluation since there can be any number of inferences to draw from this. The failures can be due to any one or a combination of all of the three dimensions noted above. The clinician should pay particular attention to the cultural factors in the individual's nuclear home and community as this can be a very powerful determinant to educational performance. While clinicians are often reluctant to explore the issue of low intellectual functioning because of the potential for damaging labeling, it is nonetheless, a critical issue in forensic evaluations and should be addressed directly. It relates to the cultural and familial issues in that severe neglect in early childhood can have disastrous results on the development of intellectual ability and, where formal intellectual assessment instruments have been used, inferences about environmental factors might be constructive when there is evidence that habilitative services might exact some degree of growth. Problem solving capability is a critical ingredient to rehabilitation potential and this function is directly related to intellectual ability.

**5.** ***Vocational attainments:*** The individual's vocational history should be assessed with attention on the long and short-term patterns of employment. Is there evidence of a pattern of frequent job changes with intervals of unemployment in between? Is there, on the other hand, a pattern of sustained employment with ever increasing levels of responsibility? How does the individual end his employment and what are the reasons for leaving a job? Is the work gainful? Is the level of employment commensurate with the individual's level of educational attainment? The clinician should also assess the degree to which the work environment forms the socializing network for the individual. Work relationships have become among the strongest in our contemporary culture and the exploration of these can reveal important aspects of the individual's level of functioning. Many individuals will show very poor pre-employment skills including the social skills necessary for communicating with supervisors, co-workers, and the public. This also includes awareness of punctuality, attendance, conflict resolution in the workplace and other social skills.

**6.** ***Current living situation:*** "Current," as it is used here, means from the time of the commission of the crime to the present. The clinician should obtain a clear picture of the living environment within which the defendant lived at the time of both the crime and the signal events that led up to it. The home space should be evaluated for safety and privacy. Housing environments where there is a high incidence of drug related crime and shootings have obvious effects on the mental and emotional state of their inhabitants. Crowding in the home environment should also be examined. The clinician should evaluate the impact of the home and community on the emotional state of the residents. If the defendant is currently housed in a correctional facility, this should be noted along with the stressors that accompany such a setting.

**7.** ***Economic security and status:*** The defendant's economic circumstances should be elucidated in the assessment. The individual's income sources should be documented and compared or contrasted to expenses. The accounting for an individual's financial resources can lead to many other lines of inquiry on both the expense and revenue sides. This can include hints about gambling, extramarital affairs, drug abuse, prostitution and other illicit forms of income.

Spending patterns need to be evaluated although most clinicians tend to avoid this area of inquiry. If the individual has credit cards, the clinician should inquire about the amount of debt on them. Unsecured loans are common among poor people and the accumulated debt from these loans should be evaluated as to its extent and purpose. These loans are often taken out to relieve debts to other creditors and the combined interest should be noted. The clinician should also sum the defendant's entire known debts. In assessing expenses it is important to identify rent-to-own charges. Poor people frequently fall prey to these methods of purchase and can incur substantial debts.

The clinician should note whether the individual has any form of health insurance or whether he or she might be eligible for Medicaid or Medicare.

**8.** ***Social and recreational pursuits:*** The assessment should include reference to any form of social outlets that the defendant has by history. This would include the individual's circle of friends or peers (constructive or unconstructive), formal group allegiances, self help group participation, and any signal friendships. The evaluation should also note any recreational activities that the individual has pursued including sports, hobbies or paravocational activities.

**9.** ***Religious or spiritual values:*** The individual's religious values can be a significant contributor to behavior patterns, though not always in expected ways. Decisions about remaining in relationships, child discipline, sexual conduct and drug taking or drinking are the more likely areas that might show religious underpinning.

The logic of a crime might elude the examiner until he or she investigates the religious value system that can motivate extreme stances that then lead to crises. The juror might be perplexed about an individual remaining in a destructive relationship until he or she learns that the individual had the belief that eternal damnation follows from divorce or separation. Religious or spiritual beliefs are among the most powerful (if inconsistent and illogical) that a person has and the biopsychosocial should evaluate these with care.

**V. Risk Assessment:** The individual must be assessed for the degree of risk for 1) harm to self, 2) harm to others and 3) victimization by others. This tripartite risk assessment should be longitudinal and developmental where indicated. For example, in some cases the defendant will have a lengthy history of violence toward others while in other cases the violence is a new behavior. Violence and suicidality should be evaluated in the context of the individual's development and environmental factors and should be examined for duration over time. In doing this, the clinician is assessing whether the risk factors constitute *traits* of the individual versus *states* of mind that arose in reaction to unusually stressful events.

The risk assessment should cover both the period proximate to the commission of the crime and the present as this can help in defining the total context of the signal event. Typically, even "high risk" individuals show marked fluctuation of risk status and it is useful to describe these features accurately. Monahan and Steadman's (1994) inclusion of contextual risk factors is particularly important with forensic populations because risk status can vary considerably when supervised living is in place versus unstructured settings.The assessment of risk in forensic populations is a challenge since, almost by definition, these individuals are in the highest risk categories. The task of the clinician is to separate out the cultural, psychopathological (in the sense of true mental disorder), environmental, and personality factors. Suicidality and aggression are virtually inseparable from histories of childhood physical and/or sexual trauma so that risk in one dimension often leads to risk in others. *What is important is the clear delineation of the proportions of risk that surround the individual's life prior to the crime and subsequent to it.* This should include reference to those factors that might limit or diminish risk in the individual. For example, if the violence has only occurred when the individual has been intoxicated on alcohol, extensive treatment for the drinking problem might lower risk. If the individual has done well in structured environments and has only committed isolated acts of harm when living alone, then risk might be diminished by the use of structured residential programs.

**CAPITAL BIOPSYCHOSOCIAL HISTORIES REQUIRE TIME AND EXPERTISE**

Life history investigations [in capital cases] require between 200-500 hours of intensive work depending on the complexity of the case, accessibility of lay witnesses and records, and the extent of mental impairment of the client and lay witnesses. Some of the factors which come to bear on the length of time necessary to prepare a life history adequately include: the need to develop client and lay witness trust; the need to overcome the reticence of witnesses because of the sensitive nature of the information sought; the need to triangulate data to ensure reliability; the time required to locate and retrieve records and to locate and interview witnesses; the impairments of both clients and lay witnesses; the need to investigate at least three generations within the client's family; and the need to integrate massive amounts of data into a concise and understandable form.

- Lee Norton, Ph.D., *Capital Cases: Mitigation Investigation*, The Champion, Vol. 16, No. 4 (May 1992) at 45.

**1.** ***Harm to self - suicidality:*** Suicidality is difficult to assess with much objectivity in forensic cases since there are so many factors that propel the defendant toward a suicidal stance. These stressors can either fuel a genuinely lethal suicidal disposition or can merely motivate ploys to elicit sympathy. In either case, the science of prediction is insufficiently endowed to allow for dismissal of even the most transparent threats. It is, therefore, axiomatic that the clinician *should take all suicidal threats seriously* as if they were direct expressions of actual intent. To take seriously, however, does not mean that all threats or suicidal statements must lead to rescues and hospitalization. The burden placed on the clinician is to wade through the defendant's statements and arrive at reasonable safeguards that can diminish risk in the short run. *Suicidality is the one finding that can place a duty to care on the clinician even while in the process of merely evaluating the individual for forensic purposes.* Threats to others made in the context of the evaluation create duties to warn and protect, but the presence of suicidality creates the duty of care. This duty of care might be discharged by using any number of supports in the individual's family or residential setting along with medical and/or verbal therapies. The duty does not immediately impose a need to use inpatient care but it does mean that *some* reasonable plan of care is put in place.

There are three major components to the assessment of suicide: A) the predisposing factors, B) ideational patterns, and C) the actuality of the plan.

**A.** ***Predisposing factors:*** Suicidology literature identifies numerous disorders as being risk factors for suicide. Among these are: depression, alcoholism, drug dependence, personality disorder (particularly borderline and antisocial types), schizophrenia, familial history of suicide, impulsivity, chronic and disabling or terminal disease, history of severe childhood physical and/or sexual abuse, and recent severe personal losses (by divorce or death). The presence of any one or more of these disorders simply means that the individual's risk for suicide is increased.

Almost by definition, forensic cases will involve these disorders. As a general rule, the greater the degree of psychopathology, the greater the risk for suicidal lethality.

The history of abuse has complex associations with suicidality and should be assessed very carefully. With childhood sexual abuse self-mutilation is a likely adult symptom and the individual might represent his or her acts as suicidal in nature. Close investigation will generally show that the mutilative act, however, has very different dynamics from suicidal gestures or attempts. The dissociative processes involved with mutilation are generally referred to as *parasuicidal* thoughts and behaviors. The clinician should take steps to evaluate whether the defendant shows a pattern of self-mutilation or suicidality or both.

**B.** ***Suicidal ideation:*** There are distinct thought patterns associated with suicidality. These include both declarative statements of intent and automatic thought processes that form a template of negative beliefs in the individual. The clinician should examine both domains of thinking. The degree of lethality is associated with two factors: a) the degree of expressed intent and b) the degree of hopelessness. Research points particularly to the second of the two as being an important indicator of lethality. When the individual has a belief that under no circumstances can he or she be better off, then risk is high. The assessment of thinking can be guided by reviewing Beck's triad of thinking about self, world and future. The ideas associated with the future are the ones that cue the clinician about the degree of hopelessness. Expressed intent is also important and should be assessed by inquiring into the rationale and the individual's ideas of what he or she envisions happening after the act. Essentially, the clinician is looking for what the individual sees as the goal or outcome of the act. This can elicit the manipulative agenda that always needs assessing in the forensic suicidal situation.

**C.** ***Actuality of the plan:*** Expressed intent and rationale for the intent is important, but the clinician should also inquire about method of suicide. There are two ingredients to this: a) the degree of specificity and detail associated with the plan and b) the feasibility of the plan. The individual who has a high degree of detail in the plan, who knows, for instance how much Valium or Elavil is necessary to cause death, and who has the medicine, is at high risk. The individual who has but vague ideas about method and who has few means to obtain the methods for suicide is at lower risk.

**2.** ***Harm toward others:*** It should be self-evident that a forensic biopsychosocial should thoroughly explore the individual's risk for harm to others. The predisposing risk factors for this are much the same as for suicide with several additions: learning disabilities (particularly low verbal processing), closed head injury or other trauma to the brain, and ADHD. When the clinician assesses this area of the individual's history, a developmental approach is recommended. Violence rarely arises out of nothing; there are almost always many precursor behaviors or a history of violent acts that precede the current one. This item should be explored using the method of *presumptive questioning* mentioned above. The clinician should be inquiring into early violent or abusive acts as a way of determining the degree to which the aggression is integrated into personality versus a reaction to extreme circumstances. One of the better ways to do this is to ascertain how early the aggression is manifested in the individual. In general, the earlier the pattern, the greater the likelihood of its incorporation into personality and the

greater the likelihood of its future expression. The assessment of risk for harm to others should be expressed "high," "moderate" or "low" risk language as opposed to predictive statements. The risk should also be stated with contingencies. For example, the individual might have a low to moderate risk while on medication, but high when off it.

An individual's risk factors might diminish dramatically with removal from the particular community. The prediction of future acts, violent or otherwise, is poorly grounded in empirical data and, given the weightiness of decisions in forensic cases, predictive statements should always be guarded and qualified.

*Nothing in the forensic evaluative situation obviates the duties to warn and protect intended victims of threatened harm. Likewise, should the clinician discover abuse, neglect or exploitation of a child or a dependent adult as defined by statute, there is nothing about the forensic situation that overrides a duty to report.*

There are five dimensions of the assessment of violence or aggression: A) the biological and genetic influences, B) the early childhood exposure to violence either as a witness or victim, C) the developmental pattern of violence in the individual, D) the thought processes associated with violent behavior and E) the outcomes and consequences for violent conduct.

**A.** ***Biological and genetic influences:*** While many clinicians might be reluctant to consider biogenetic loading on violent conduct, it is nevertheless, a topic that must be explored. There is considerable evidence that pronounced antisocial traits have strong biogenetic transmission factors. This has also been demonstrated with a particular type of alcoholism that is associated with antisocial behavior. Where there is a family history of violence, alcoholism associated with antisocial traits, learning disability, ADHD, closed head injury or other trauma to the brain, and B cluster personality disorder, there is an increased likelihood of biogenetic predisposition toward aggressive styles of behavior. The clinician should make use of genograms to assess the extent of familial history of violence and aggression.

Another biological factor that should be incorporated into the risk assessment for harm to others is closed head injury or other brain trauma. The clinician might eschew much inquiry in this area because of dubious reliability of information and the lack of neurological expertise. While there are definite limits on the scope of this area of inquiry, the clinician should still take as detailed a history of potential head trauma as possible. This can be done by inquiring into bike accidents, automobile accidents, injuries from fights, drug overdoses resulting in loss of consciousness, alcoholic blackouts, arrest related head injuries, falls, swimming or diving accidents, inhalant abuse, and childhood physical abuse by a parent or caregiver. Mental retardation in combination with any of the above predisposing factors becomes yet another multiplier in the equation. In the mental status examination, the clinician will assess cognitive functioning in more detail. This information should obviously be correlated with the history of head trauma to form a thorough risk assessment of the individual.

**B.** ***Childhood experiences:*** The literature is complex on this matter as with most in the forensic areas, but, as a general rule, childhood exposure to violence is correlated with adult expression of violent behavior. While it is an unsupported hypothesis to suggest that childhood victims become adult perpetrators, it is nonetheless true that adult perpetrators have in most case been victims. The victimization can increase the risk that an adult will be violent. Again, as a general rule, the degree of physical violence experienced by the child *either as a victim or as a witness* tends to correlate with the degree of violence expressed by the adult. Brutalization seems to be an inculcated trait. Clearly, the combination of genetic predisposition with childhood exposure to violence is an indicator of very high risk for adult violent behavior.

When the defendant's crimes are sexual in nature, it is likely that there have been childhood sexual abuse incidents or the witnessing of sexual violence during childhood. It is rare, though possible, for adult sexual criminality to arise in the absence of childhood exposure to this behavior.

**C.** ***Developmental patterns:*** The clinician should, as mentioned above, use presumptive questioning to obtain a picture of early childhood violent acts committed by the individual. This history should be taken in a careful sequence with particular attention to preadolescent expression of violent behavior. As socialization patterns ramify in adolescence, the clinician should be looking for those anti-social acts that are most influenced by social environment versus those that pre-date gang or other social involvements.

**D.** ***Thought processes:*** The earliest literature on the antisocial personality identified thought patterns that marked these individuals as different from others. The clinician should examine the thinking behind violent acts to determine the degree to which violence is dissonant or congruent with self. Domestic violence victims, for instance, might find their own violent acts to be out of keeping with their view of themselves. This dissonance can be very important in forming an impression of lethality. In general, the degree to which violence is integrated into the view of self is correlated with the degree to which the individual is likely to persist in violent acts in the future.

**E.** ***Outcomes and consequences:*** The clinician, in taking a history of the individual's violent behavior, should note what the outcomes were. This refers to the actual harm done to others. Defendants can be forthcoming about fights they have had in the past, but generally need more probative questioning about the degree of harm or injury they have caused. Obviously, there is substantial difference between an individual who has been in several fights and who has bruised his victims, versus the one who has put three people in a hospital. When the defendant reports not knowing what harm he has caused, one can be reasonably sure of denial. The clinician should also assess whether weapons were used against others and, if so, what harm resulted.

***Procedural tips:***
Since the individual is likely to be defensive about harm caused to others, the clinician is advised to put questions in a more "objective" rather than personal frame. For example, one might ask, "When these fights occurred, who got hurt?" "What happened after the knife appeared?" "Where did the bullet go in?" "After the fight was over, what did you discover had happened?" These questions offer a slight deflection away from what might seem overly personal accusations and give the defendant a way to answer without seeming to agree with them.

The clinician will also want to assess what sanctions have resulted from previous violent acts. This will include an evaluation of the degree to which the individual has experienced consequences and learned from them.

**3.** ***Risk of victimization:*** The individual's risk for being victimized is an important part of risk assessment. This should include an assessment of risk while in detention where appropriate. Due to disorder, alleged offense or other factors, the individual might be at greater risk than others in correctional facilities. Likewise, the individual who is on bail during the evaluation should be assessed for risk factors in his or her home or residential setting. Domestic violence victims are likely to be at heightened risk unless they have made arrangements that protect their safety and security. When the defendant is a domestic violence victim who has then killed an abusive spouse, the individual's risk for harm from the husband's family should be assessed. As a general rule, the greater the history of abuse victimization, the greater the risk for future harm as well. This has been noted even with a history of sexual abuse. Rape victims, for instance, have a higher reported rate of previous sexual assault or abuse than do women who have not been raped. Survival patterns perhaps serve some important functions for victims, but they do not always safeguard against future abusive acts. The clinician should take the history of childhood victimization and evaluate the individual's current situation in context with that history.

***Postscript on risk assessment:*** The assessment of risk in forensic populations inevitably points toward two disorders that have high risk for harm to self and others: the Borderline Personality Disorder (BPD) and the Antisocial Personality Disorder (ASPD). While it is easy to arrive at these diagnoses with forensic cases, it is also easy to merely indulge in dismissive labeling and to use the diagnoses to serve as a shorthand for explaining all of the defendant's behavior. The clinician is strongly encouraged to avoid this. It is bad science and it is questionably ethical practice. These two diagnoses are among the most pejorative of all and their use implies a lack of "real" mental disorder. There is no doubt but that a clinician who sees a large number of individuals in forensic settings will find a significant number of antisocials and borderlines. The effective biopsychosocial, however, goes beyond the label to define the exact characteristics of the individual so that the reader can form a clear picture of the person rather than the cartoon that is the diagnosis.

It is further important to note that while traditional thinking about the suicidal disposition has defined it as distinctly different from a homicidal or aggressive disposition ("aggression turned inward"), there is now substantial evidence that the two are overlapping phenomena. In fact, all three dimensions of risk show overlap. An individual can be at risk of being victimized, be suicidal and homicidal as well. The astute clinician will explore all three domains of risk.

**VI. Mental Status:** The mental status assessment is a systematic representation of observed behaviors, thinking patterns and emotional qualities in the individual. This assessment consists of both informal and formal evaluative procedures. In assessing cognitive capacity it is useful to follow the standard mental status questions pertaining to memory, judgment and abstracting ability. The responses must be interpreted in the context of the individual's current circumstance and cultural background, however. There are eight components to the mental status assessment.

**1.** ***Appearance:*** The clinician should note the individual's appearance in concrete terms, paying attention to hygiene, grooming and appropriateness of clothing (appropriate to the individual's culture). The clinician should also form an impression of whether the individual appears his or her stated age.

**2.** ***Affect, emotion and mood:*** The clinician should identify the individual's generally sustained emotional tone and inquire about the individual's reported mood. The reported mood should be reconciled with observed affect. The individual's tenor of emotion and range of expressed emotion should be integrated with her or his history and presenting situation. The mental status assessment should pay attention primarily to the individual's qualities *at the time of the interviews*, but should view these findings in the context of the individual's history. Incongruities between expressed emotion and life situation or thought processes point toward the need for further evaluation.

**3.** ***Motor activity:*** The clinician should assess the individual's displayed motor activity. This includes the degree of agitation, restlessness or, conversely, the lack of usual activity. It will also include observation of tics, repetitive motions, unusual gaits and any other unusual postures or movements. In depressed persons, psychomotor retardation might be evident.

**4.** ***Speech and qualities of verbal expression:*** The clinician should examine the ways in which the individual links ideas and sentences, the volume of verbal activity and the vocabulary used by the individual. The linkage of sentences and ideas can evidence disorder in thought process caused either by affective disorder or thought disorder. The association of one thought with another can be heavily influenced by mania, depression or schizophrenia. The volume and quality of vocabulary should also be noted. The individual might make use of a very impoverished vocabulary or one that is marked by neologisms, words that are made up by the individual. The clinician will use care in making inferences about the vocabulary since the individual's culture can be the primary contributor to this rather than mental disorder. Does the individual produce a huge or very small quantity of words? Are answers typically elaborated on or merely answered with a word or two? The clinician, in evaluating this field should be attentive to the qualities of the expressive ability, not so much to actual content or meaning of the thoughts.

**5.** ***Thoughts, perceptions and beliefs:*** The clinician will assess the content and meaning of the individual's expressed ideas. This includes three components: a) expressed worries or preoccupations, b) perceptions and c) fundamental beliefs that have significant influence over behavior.

a) The clinician will elicit the individual's concerns, worries and any obsessions or pre-occupations if they are present. With individuals who have a history of substance use disorder, gambling, sexual deviance or compulsion, the clinician will want to elicit the content of obsessional thinking around these subjects. Traumatic content might also emerge as a persistent and intrusive set of ideas or worries.

b) The clinician needs to explore whether the individual has perceptual disturbances such as hallucinations or misperceptions of real objects. This will also include distorted perceptions of circumstances and social situations. Individuals with severe personality disorder will typically give evidence of marked perceptual distortions of social events and contexts. It is important to assess perceptions, however, within the cultural context of the individual. This can not be over-emphasized in domestic violence cases where the influences of the "Stockholm" syndrome exert profound impact on the individual's perceptual field

c) The individual's key beliefs and automatic thoughts should be assessed. Using traditional cognitive therapy approaches, the clinician can obtain the individual's most prominent automatic thoughts that guide emotion and behavior. The individual's basic beliefs about life, moral or religious beliefs, social custom and other features can be helpful in assessing either the individual's motivating principles or rationalizations. Strong biases or negative beliefs such as racist or sexist ideas should be noted if they are relevant to the criminal activity. It is also important to explore the individual's moral thinking. While this might seem ridiculous with anti-social personalities, it is, nonetheless, a useful area of inquiry. Many "antisocials" in the broader sense of the term have moral standards such as not "ratting" on fellow gang members or of not hurting children, etc. Years ago (under the DSM-II) these individuals were diagnosed with the label "dyssocial personality" and there is some value to the term. More importantly, however, it can be fruitful to learn whether the individual has moral values that direct some of his or her conduct. Kohlberg and Gilligan offer two sets of insights that can be very important to

**CLIENT'S HISTORY NEEDED FOR RELIABLE EVALUATIONS**

Many forensic evaluations are unreliable because the history upon which they are based is erroneous, inadequate or incomplete. All too often, the medical and social history relied upon by mental health professionals is cursory at best and comes exclusively from the client or possibly from the client and discussions with one or two family members.

This can result in a fundamentally skewed view of the relevant history because often the client, and even their family members, are very poor historians and may fail to relate significant events which are critical to a proper determination of an individual's mental state at the time of the offense.

For example individuals who are physically, emotionally and/or sexually abused often minimize the severity and extent of the abuse. Their view of what is "normal" and thus what should be related to a clinician is frequently impaired. Similarly, individuals with mental retardation or other organic brain impairments generally are unable to recall significant events regarding their medical history which may be critical to a reliable diagnosis. It is also well established that many mental illnesses, *e.g.*, bipolar mood disorder and schizophrenia, run in families and thus it is important to know the family as well as the client's medical and psychiatric history.

- John Blume, *The Elements of A Competent & Reliable Mental Health Evaluation*, The Advocate, Vol. 17, No. 4 (August 1995) at 7

forensic evaluations of domestic violence cases. Kohlberg's traditional understanding of moral thinking describes male patterns as rule following behavior while Gilligan has shown that women's moral thinking is relationship contextual. While men rely on codes of conduct (look at gangs again), women are more likely to solve moral issues based upon the nature of their relationship to the other person.

**6.** ***Cognitive status:*** The assessment of cognitive status and capacity is one of the more complex and worrisome features of the biopsychosocial assessment. The individual's cognitive capacity can be significant to a finding of guilt or innocence and can, to a lesser extent be relevant to sentencing. The individual's cognitive integrity is in some respects the heart of the biopsychosocial assessment as all of the individual's biological, social, developmental and environmental factors shape the fundamental cognitive abilities that govern how an individual navigates in the world. The clinician will want to ground observations in formal assessment questions and/or references to the individual's history. The cognitive status should be evaluated in the following areas:

a) *Level of consciousness:* When the individual is not alert, she or he should be assessed for intoxication or other phenomena that can alter consciousness.
b) *Orientation:* The clinician should explore the individual's orientation to self, place and time when there are indications of disturbance of thinking, as in schizophrenia or dementia. Orientation to time should be carefully judged if the individual is in an institution. Living in these environments destroys both reference to date, day of the week and even time of day and it destroys the significance of the passage of time. Orientation to time becomes, therefore, meaningless.
c) *Attention and concentration:* The individual's degree of attending should be assessed. This can be done by giving her or him an exercise such a subtracting serial sevens from 100 or repeating key phone numbers backwards. Impairment of concentration can be either indicative of serious mental disorder or simply high levels of stress and preoccupation. When the clinician observes attentional deficits, the individual's history should be consulted to see if there are situational or developmental factors relevant to this phenomenon. Initial indication of impairment should result in further testing to obtain a more discriminating picture of the condition.
d) *Language comprehension:* The individual should be able to identify phenomena or objects. If there is evidence of inability to do this, it might be an indication of serious cognitive impairment secondary to tumor, head injury or mental disorder. The individual's basic ability to read and write should be assessed. Does the individual comprehend the words and concepts used in the interview? Again, as with other aspects of the biopsychosocial, the clinician should be aware of cultural factors that can influence these findings.
e) *Memory:* The clinician should examine the individual's memoral capacity for short term, intermediate term and long term functions. All memoral impairments must be reconciled with history findings. Short-term memory is assessed by giving the individual three unrelated words to recall in three to five minutes. If the individual fails to do this, the test should be done again two or three times throughout the interview. Long term memory is assessed by obtaining information from the individual's past (as in several years ago). Intermediate memory tests should focus on events that are days to weeks old. Memoral disorder requires very careful assessment. Deficits can be either attributable to psychological (trauma) or neurological events (strokes, head injury, etc.) or psychiatric illness (schizophrenia). Forensic cases sometimes present the clinician with instances of selective memoral impairments where one set of events is remembered with clarity while others are not. The use of the term "selective" implies a deliberative act and should be avoided in all but the most egregious cases. Memory is a complex cognitive process and is influenced by many factors. *The safest clinical path is depict it accurately and thoroughly, but to be parsimonious in drawing causative inferences.*
f) *Fund of information:* The individual's fund of basic information about the world should be assessed, but in the context of his or her world. This might mean that the individual has an abundant fund of information about her extended family, but hasn't a clue who is president of the United States. One can ask the individual to give the number of nickels in a dollar and other money related questions. The clinician should move from personal spheres to public ones in assessing this area of cognition.
g) *Calculation:* Appropriate to the individual's level of education, he or she should be evaluated for basic arithmetical ability. Simple addition and subtraction equations can be used for this purpose. One can ask the individual to make change on imagined purchases.
h) *Spatial representations:* The individual should be asked to make Bender-Gestalt drawings on a plain white sheet of paper to detect signs of certain neurological deficits. These include simple geometrics as well as a clock face, cross figure and intersecting wavy lines.
i) *Abstraction:* The individual's ability to work with abstract ideas is an important part of overall cognitive capability and it should be assessed within the context of the individual's educational and cultural background. Abstraction is tested by the use of proverbs and reasoning exercises that call for the detection of similarities in named objects. One of the advantages of using proverbs is that they can be adjusted to different cultural contexts when indicated.
j) *Executive functioning:* The clinician should assess the individual's ability to plan future actions and to inhibit impulses. This is essentially an evaluation of frontal lobe

functioning in the individual. When the individual has a history of traumatic brain injury, this issue needs particularly close attention. Traumatic brain injury often affects the frontal and prefrontal lobes and this creates impairment of executive functions. The individual can be asked, "When you feel the urge to ____ [drink more, steal something, drive fast, etc.], what keeps you from doing it?" Or, "How do you plan out your time off from work?" "What is the furthest time in the future that you might plan something?" "How do you budget your money and how do you keep within your pay amounts?"

k) *Judgment:* The clinician should assess the individual's quality of judgment as evidenced in the traditional questions about why people pay taxes, why cars are licensed, what would he or she do with a stamped addressed envelope that was on the sidewalk, etc. The responses on these items give one the feel for the way in which the individual makes judgment decisions. After examining some of these more abstract questions, it can be useful to ask the individual to give some examples of actions he or she has taken that would be good examples of sound judgment. The individual's selection of items can be almost as informative as the content of the decision that he or she reports. As referenced above, the individual's moral thinking should be examined. It should be looked at descriptively and then should be evaluated for its degree of congruence with the individual's culture and society at large.

The mental status becomes all the more critical when the individual gives multiple history events that might suggest impaired cognitive ability. When there is a collection of these events, the clinician should use great care in capturing the specific qualities of the individual's thinking, feeling and acting and render those in the context of brain functioning. It is not uncommon in forensic populations to discover an individual born and raised in poverty who also has a likelihood of fetal exposure to alcohol, tobacco and/or drugs, physical and/or sexual abuse, poor educational supports and adult exposures to a variety of unconstructive environments. All of these factors can contribute to impaired cognitive ability and this is why it is so critical to assess this domain so thoroughly. The biopsychosocial should show the ways in which social and psychological factors influence biological ones and the other way around. Juries might be more compassionate with organic impairments than psychological or social ones, because they can appreciate how a damaged brain can influence behavior but few understand the obverse. It is less known that social and interpersonal environments can influence the development of brains. This can and should be explained through the use of simple developmental models that are easy for lay persons to grasp. (For instance, ask the jury what it envisions would be the result if we took a child's injured leg and wrapped in a cast from age 9 to 26? What would the functioning capacity be of that one leg when the person has become an adult? This is not unlike what happens when we "wrap" a developing brain in simple, neglectful environments - it simply does not develop the structures that others have for thinking.)

**VII. Medical Conditions:** The individual should be assessed for health problems with particular attention to those disorders that might have impact on mental functioning. Individuals with chronic and largely untreatable conditions can be subject to mood disorders, distortions in thinking and behavior problems. The biopsychosocial assessment should include a review of systems so that the clinician can detect unnoticed disorders that might require either a referral for treatment or that might influence a clinical impression of mental disorder. In the assessment of domestic violence, the clinician should pursue questions about the history of injuries incurred in these acts and the treatments that might have been received. Some individuals will give evidence of lasting impairments from these injuries because of the severity of attack and a spousal prohibition of seeking medical care.

The individual's health history cannot be taken by simply asking whether the individual has any physical problems. The inquiry must be formal and go through all organ systems. A health history or screening form of some sort should be employed. This can include basic information about family diseases that have strong correlation with genetic transmission. If, for instance the clinician is evaluating an individual who gives evidence of memoral vagueness and poor cognitive complexity and it is discovered that he or she has an extensive family history of early-onset Alzheimer's Disease, then the relevance of clinical findings takes on new dimensions.

**VIII. Functional Assessment:** Individual who present with significant levels of impairment and diagnoses of major mental disorder need to be assessed for their level of functioning. This is done because diagnosis and clinical descriptors alone fail to capture the degree to which disorder interferes with the individual's life. A functional assessment identifies those areas daily living that are impinged upon by disorder or condition. It must include the findings from the assessment of physical as well as mental health. Self care, shopping, tending to financial matters, securing medical and other treatment services, using transportation, keeping house, maintaining social contacts, all form a part of the functional assessment.

The clinician should also assess the individual's adaptive strengths that can be built upon in either treatment or rehabilitative care. The individual might have demonstrated capacities that have either been ignored in the psychiatric or psychological evaluations because they are not overtly clinical in nature. Even simple social skills or avocational interests should be reviewed for their potential as positive factors in the individual's future.

**IX. Integrative Assessment and Clinical Impression:** The integrative assessment of the individual needs to account for all the disorders and significant findings of the preceding headings. What this assessment does is pull the elements together into a comprehensible whole that makes sense of all the comorbidities and problems from the history. This is the place in the evaluation where the themes mentioned at the beginning of this article become important. The integrative assessment should build a plausible portrait of the individual and place the individual's decisions in the context of real life stressors and real environmental factors. The salient must be delineated from the plethora of details and it must be rendered in plain and clear ways. Labels may be used - but with caution. They can have the opposite to the intended effect. Instead of summarizing, they can have the effect of overriding all of the complexities that the biopsychosocial has developed.

The integrative assessment should show how all the parts of the history work together to produce a life with which others can identify. Severity must be shown, but made familiar, not bizarre. If there is substance abuse, it must be woven into the fabric of the individual's existence, not left hanging as a separate and independent pathology.

Lastly, the integrative assessment draws inferences about the degree of freedom within which the individual lived. It delineates constraints in the person's life; constraints caused by cognitive impairment, by heritable mood disorder, by poverty, by being the repeated victim of battery, etc. It renders the individual as one *who is making decisions, but in a very limited world of options*.

**X. Recommendations:** The clinician should state those services or settings from which the individual might take benefit. This is most important in sentencing processes where the court must consider rehabilitation potential. It is foolish to offer prognoses given the level of impairment of most forensic cases, but a description of services that the individual can benefit from is a realistic undertaking. These recommendations should be specific and should relate clearly to the salient features of the individual. They should be feasible and not idealistic.

## Conclusion

The biopsychosocial is a complex evaluative tool that can bring greater depth and realism to the handling of forensic cases. In defense strategies, it can form the backbone of the humanistic defense where the pain and suffering of the defendant can be translated into meaningful food for thought in the juror. One of the ironies of the process is this: in order for the assessment to adequately render the humanity of the defendant, it must first make use of the most detached clinical processes. Strong feelings (positive or negative) on the part of the examiner in the assessment phase can lead to distorted findings and these distortions can have profound consequences for the life or freedom of the defendant and for the conscience of the clinician.

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# Chapter 12:
# The Goals of Mitigation Interviews©

**by Lee Norton**

Interviews can be viewed as conversations with specific purposes. In social work, the purpose may be *informational* (selective gathering of life history material related to physical, social, emotional, cognitive functioning), *diagnostic* (to assess mental or social status), or *therapeutic* (to bring about a desired change). (Kadushin, 1990).

**Informational.** Most mitigation interviews fall within the category of gaining information. More specifically, the mitigation interview is intended to obtain information which helps others understand the client's actions in a context which militates the offensiveness of those actions. We are trying to gain information but, more important, we are trying to achieve *understanding*.

**Diagnostic.** A secondary goal of the mitigation interview is diagnostic. We must know the social and mental status of the person we are interviewing in order to discern whether we will be able to gain any substantive information and, if so, to what extent. The goals and limits of an interview with a person who suffers from mental retardation or schizophrenia or alcoholism are often quite different from an interview with an individual who is unimpaired and exhibits good insight. In extreme instances, the interview is completely diagnostic; that is, the goal of the interview is purely to gain data about the person's psychopathology with no hope of gaining important life history information. While the diagnostic interview may provide no substantive information, it can be a rich source of insight about the influences which have shaped the individual's perception, judgment and behavior. Diagnostic data may inform us about whether our client is able to assist in his or her own defense, or it may tell us that our client was raised by a person so debilitated by mental illness as to render the person incapable of being a competent caretaker and role model.

**Therapeutic.** Many times the nature of the information we are seeking necessitates that the interview take on a therapeutic quality. When we hit upon painful or traumatic content, we must slow the pace of the interview and deal with the resulting emotions and reactions. Here we must "hear the suffering" and respond with compassion. (Othmer, *et al*, 1994). In most instances, simply allowing the person to "tell the story" - perhaps for the first time - magically relieves the pain. Silence can be the best balm. "Creating a space" for the person to separate themselves from their pain and to see it more objectively is often the most effective therapeutic intervention. Other times, the person needs reassurance and acceptance. Painful memories are usually accompanied by great shame and embarrassment. Conveying to the person that their pain is real and reasonable sometimes enables them to see their experiences from a healthier perspective, with the knowledge that they were not responsible for the harms that came their way. In more acute cases, *cognitive restructuring* is a powerful technique to ameliorate the person's suffering and offer them a tool with which to self-soothe. It consists of providing a new, more positive way to view or interpret an experience or belief. For example, a client or lay witness may recount witnessing his mother's murder, emphasizing what he perceives to have been his failure to save her. This belief likely creates a deep sense of self-hatred and shame, emotions which may be so overwhelming as to prevent him from fully describing the event (details are critical to an adequate psychosocial assessment). Acknowledging the person's feelings of helplessness, terror and confusion is integral to working through the pain which may well have kept them emotionally paralyzed since the time of the atrocity. However, it is sometime useful to go a step further, providing the person a different perspective of the event. For example, pointing out that they were a small child, indeed helpless in the face of such an unimaginable act of violence; explaining the predictable and unavoidable effects of trauma, and highlighting the things the person may have done (sought help, called 911, protected the other children, tended to wounds, etc.) which by any standards, were noble and heroic, may reduce their anxiety and give them a way of understanding their behavior. Acquiring a more positive view often enhances the person's self-image and opens doors to psychic content which may otherwise remain inaccessible.

### The Importance of Rapport

The relationship between the interviewer and the witness is the conduit through which information and its meaning is exchanged. (Kadushin, 1990). Positive relationships are more likely to produce honest, detailed responses to inquiries. There are a number of components of positive relationships, perhaps the most important of which is *trust*. The client or lay witness must believe that the interviewer has integrity and that his or her intentions are sincere. Integral to trust is acceptance and suspension of judgment. Generally, individuals will lower their defenses and disclose sensitive information to the extent they feel the interviewer's aim is not to judge or assign blame, but solely to understand. Gently communicating to the person the belief that, most of the time, most of us are doing the very best we can, diminishes anxiety, creates an atmosphere in which the person feels free to reveal otherwise embarrassing information, and increases the probability that events will be recounted more accurately and uncensored.

Positive relationships are also created by *interest*, a genuine desire to get to the bottom of the issue, know the end of the

story or simply learn more about the person and what they are discussing. Interest is communicated verbally, by asking probing and clarifying questions, and non-verbally, by alertness. Maintaining eye contact, sitting slightly forward in one's seat, and responding with gestures intended to promote the conversation (nodding, moving one's hand to suggest "Go on, I'm with you.", etc.) all represent heightened attention. Individuals are much more likely to maintain a flow of conversation if they are speaking to an interested audience.

Most positive relationships are characterized by a degree of *warmth*, or commitment to the needs of the interviewee. (Kedushin, 1990). It involves communicating concern for the needs of those being interviewed, so that they do not feel they are merely a repository of needed information. Warmth is conveyed by the quality and content of speech as well as by nonverbal cues. Engaging in informal conversation about the interviewee's health, children or current goals are all effective means of communicating a caring attitude, as is attending to the person's affect or physical needs. A grimace may indicate the person is recalling something painful, or that they are physically uncomfortable. An inquiry into the person's immediate welfare goes a long way in establishing a caring atmosphere.

Few positive relationships exist absent a strong degree of mutual *respect*. Respect involves behavior which supports self-esteem, (Kadushin, 1990), and dignity. Responding to an individual's innate value and worth - no matter how abject their current status - and extending to them the social courtesies afforded associates and friends, has the effect of *calling forth* hidden goodness and competencies. It is remarkable to watch a person transform from a surly, resistant curmudgeon to a helpful and invaluable source of information when treated respectfully and kindly.

For those reasons and more, devoting sustained energy to developing rapport with clients and lay witnesses is one of the most critical aspects of mitigation interviews.

### The Physical Environment

Usually, one has little latitude as to where interviews with clients are conducted. The typical setting is a small, poorly ventilated room with equally bad acoustics. Often there are numerous interruptions, and sometimes interviews are abruptly terminated by staff. In some instances a little kvetching goes a long way, and the detention facility will make efforts to improve conditions. More often than not, these circumstances must be accepted and accommodated as best as possible.

Esthetics aside, there are a few non-negotiable requirements for adequate client interviewing. Privacy is paramount and must not be com-promised. For obvious reasons, it is unacceptable to interview a client in the presence of a correctional officer or other inmates. Most of the time this issue can be won without litigation, but on occasion it is necessary for the attorney to legally challenge interview policies.

Full access is also necessary. All too often, attorneys and mental health professionals are expected to conduct interviews through a glass or mesh partition, using a telephone. This policy must be challenged on the basis that it prevents observing the client as he moves naturally and unencumbered; communication is stilted and cannot occur spontaneously; and the barrier can be interpreted - consciously or unconsciously - by the client as signifying the professional's fear of the client; or, alternately, the partition can *engender* a sense of unease and anxiety.

An associated issue concerns restraints. Whenever possible, the client should be interviewed without restraints of any kind. This may not be possible. Especially in prisons, clients are often required to wear either handcuffs or leg shackles, and, in some instances, both. The use of restraints should be challenged when it compromises the client's comfort to the point he cannot communicate comfortably and undistracted. This is especially true when the client is forced to wear a waist belt to which his hands are tightly fastened. It is impossible to conduct a lengthy interview under such conditions and gives rise to serious ethical considerations.

Issues concerning the physical environment for lay interviews are different from those associated with client interviews. Though it is common to interview at least some family members and friends in jails and prisons, most witnesses are not incarcerated. Lay interviews should be conducted within the home in order to assess the home and gather diagnostic information. *In vivo* interviews allow one to evaluate dimensions such as socioeconomic status, the number of individuals living in the home and the degree of privacy afforded each, the quality (including safety) of the community, and the psychodynamics among individuals residing in the home. One can observe a number of cues which, taken together, vividly narrate the client's story and are rich sources of inquiry: each picture on the wall has a story to tell; holes in the doors may reveal a violent fight the night before; clothes sitting in a tub of cold water means there is no hot water and no funds for the laundry mat; the strong organic stench (associated with lack of hygiene) could imply mental illness, mental retardation or other variables; empty liquor bottles and the stench of gin can be evidence of chronic alcoholism.

An added benefit of home visits is that individuals often feel more relaxed in their own surroundings. A sense of security can compensate for the vulnerability which results from describing painful or embarrassing experiences. Moreover, individuals are more likely to reveal their true personalities in their own homes, rather than present distorted public *personae*. Equally important, home visits allow the interviewer to achieve or enhance rapport. Holding a baby, helping to fill out social services papers or sharing a cup of coffee make the interviewer appear less threatening and more a participant in the process and the group. Indeed, by the third visit, lay witnesses often come to welcome the interviewer and see him or her as a temporary member of the community.

It is not uncommon that family members - either in an effort to be supportive or out of a sense of "comfort in numbers" - initially congregate together to be interviewed. This practice is undesirable and should be avoided whenever possible. One of the problems with group interviews is that they leave lay witnesses open to misleading cross-examination. (Isn't it true you all got together and came up with these stories? That you "refreshed" each other's memories about his so-called slowness and mental illness?). Group discussions also give rise to increased defense mechanisms which inhibit candid disclosure of important information. For example, in the interest of "protecting" various family members, individuals who were molested may attempt to insulate others from knowledge about the abuse by tailing to reveal information, downplaying its significance, or flatly denying the abuse occurred. Client families are often so dysfunctional and bound by intricate webs of secrets that they engage in historical revisionism in an effort to maintain an idealized image of the family and preserve the current equilibrium - *even if it means sacrificing the client's welfare*. It is almost impossible to achieve an accurate understanding of events and relationships when family members are together. Only by speaking with them one-on-one and building positive relationships with each can one hope to unearth the truth.

Home visits produce such critical information about the client and his story that failing to include them in the psychosocial history is like trying to describe a country one has never seen.

### The Interview Process

**Beginning.** In many respects, the interview begins before two people meet. (Kadushin, 1990). The interviewer generally has some information about the person who will be interviewed - from records or other witnesses - and begins to formulate the goals of the interview and the information needed. If the individual knows about the interview in advance, he or she will likely have ideas - many of them false - about its purpose. When the interviewer's biases and/or the witnesses' fears pose inhibiting variables, it is necessary to spend proportionately more time building relational bridges and finding a way to *join* with witnesses. Engaging in social amenities helps reduce suspicion and anxiety. Factual information enables witnesses to feel a greater sense of control. Explaining to witnesses the goals of the interview and how they might be of help also facilitates efficiency by directing their attention to relevant topics. Thus, it is important in any mitigation interview to begin with detailed descriptions of who the interviewer is; who the attorneys are and the relationship of the interviewer to the attorneys; the interviewer's understanding of the legal status of the client and the purpose of the legal efforts; and how the information the witness may have (whether that be the client or lay witnesses) can help achieve the legal goals.

**Barriers.** The interviewer may experience numerous barriers before gaining any substantive information (which is one reason that interviews can take several hours). This is especially true for lay witnesses. They may fail to appear for an interview, requiring subsequent efforts to reschedule the meeting. They may be late to the interview, leaving the interviewer sitting in unfamiliar surroundings indefinitely. Or, they may be away from home visiting friends or drinking at a bar so that the interviewer must first locate them. Such frustrations are aggravating and may influence the interviewer's attitude and behavior. It is important to regain one's composure before interacting with a witness. If this isn't possible, try again another day.

In the home, the interviewer may be forced to contend with loud conversations, fighting or clattering about in the kitchen; t.v's and radios blaring; or repeated interruptions from the telephone or friends dropping in. The witness may have controlled the seating arrangement so that it is difficult to see or hear (Kadushin, 1990), or continually hop up and down to get drinks, cigarettes, tend to food on the stove or children in the yard. In short, the interview may have to proceed amidst chaos. Don't give up. In most instances, tenacity and a continued attitude of empathy and concern defeat the greatest odds. When witnesses perceive the interviewer's unwavering commitment, they generally align with the goals of the cause and become remarkably cooperative and generous.

**Types of Questions.** Interviews consist of a balance between open- and closed-ended questions. Open-ended questions (What do you remember about John?) can be likened to a broad net which gathers everything in its path. There are a number of advantages to open- ended questions.

They produce spontaneous responses which reveal witnesses' mind sets and points of reference. They suggest to witnesses that the interviewer is interested in anything they want to discuss; allowing witnesses the discretion to direct the interview often produces fruitful areas of inquiry the interviewer had not considered. Relinquishing partial control of the interview to witnesses communicates respect and engenders positive feelings about and greater participation in the interview.

Open-ended questions allow the interviewer to observe how witnesses prioritize information about a given topic.

Open-ended questions are more likely than closed-ended questions to result in affective content; responses include how an individual *felt* about a certain event or experience. This permits catharsis, which alleviates pain and allows the individual to continue talking unhindered by intrusive thoughts and emotions.

The drawbacks of open-ended questions include that they often produce lengthy, vague responses filled with irrelevant information. (Othmer, 1994). For witnesses with cognitive deficits, open-ended questions are confusing and overwhelm-

ing; open-ended questions increase their anxiety and leave them at a loss as to how to respond. Impaired individuals require greater structure and guidance and should be asked more closed- than open-ended questions.

Open-ended questions are time-consuming. Ample time should be allotted to complete open-ended interviews, and the interviewer needs to be well-rested and prepared for the considerable expenditure of energy involved in this lengthy process.

Closed-ended questions are used to get specific, detailed information. They are often used when the interviewer has an understanding of the main idea, but lacks clarity. They narrow the scope of tangential responses, enable the interviewer to regain control of the interview, and provide direction when the interviewer is unsure how to proceed. Closed-ended questions can slow the pace of the interview, reduce emotionality and impose greater focus on important facts. (Kadushin, 1990). Closed-ended questions help stimulate recollection and keep witnesses on the task at hand. They are ideal for obtaining genealogical information and creating timelines. Closed-ended questions can tell an interviewer whether a witness suffers from memory deficits or attentional problems that may signify more serious conditions.

Closed-ended questions may inhibit spontaneous responses, produce false-positive responses (Orthmer, 1994), and fail to yield a narrative data.

The type of question used depends on the goals of the interview and the nature of information sought. The open-ended question is useful for establishing rapport, seeking diagnostic data, exploring emotions, and seeing a topic from the perspective of others. Closed-ended questions are more likely to produce specific, linear information and are useful in checking facts and testing competence and veracity. A common interview format is to start with broad, open-ended questions and gradually become more focused and specific.

**Ending the Interview.** Ideally, interviews wind down naturally. There are more pauses and less new avenues to pursue. When the interview begins to produce redundant information, the witness seems tired, and interest is waning, one has likely reached a point of diminishing returns. This point will vary from witness to witness depending on their situations and deficits. It should be remembered that one can usually conduct follow-up interviews in order to gather additional information. In fact, in most instances a series of interviews is required to work through defenses and reach more sensitive content.

As the interview comes to a close, the interviewer should convey to witnesses the way in which they have assisted the client, and an understanding that this contribution may not have been without psychic cost. Witnesses should be asked whether the interviewer has their permission to contact them again and, if so, when and where. The interviewer should ask about witnesses' schedules and find out whether there are alternate locations or numbers at which they may be reached.

Before leaving, the interviewer should provide witnesses with information concerning how to reach the attorneys and encourage the witnesses to contact the attorneys if they have questions or want additional information. Witnesses should be made aware of any trial or hearing dates and informed of changes as they occur.

## Summary

Knowing what to ask and how to ask it is as much an art as a science. Developing good interviewing skills requires practice and feedback. We can use an awareness of the components of successful interviews to guide our practice and increase our skills. There is no meaning outside of context; hence, a chief role of the professional interviewer is to develop a context of trust and commitment to learning the truth about our clients. Conducting mitigation interviews brings us face to face with unfathomable pain, which is absorbed and affects each of us. By telling our clients' stories we bear witness to human devastation and in so doing we create a ripple of healing which begins in each of us.

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# Chapter 13: IN SEARCH OF PSYCHOLOGY: A JURISPRUDENT THERAPY PERSPECTIVE ON SEXUAL OFFENDER RISK ASSESSMENT ©

**by Eric Drogin**

Psychologists have grappled for decades with a basic, sobering reality of our profession: absent certain specialized circumstances, we can't predict the future. It makes us feel only a little better to reflect to ourselves, "well, who can?" Incidentally, when we mention this aloud, it doesn't make judges feel any better at all.

It's easy to see why clinicians welcome claims that newly developed instruments will enable us to perform reliable and valid "risk assessments" regarding persons convicted of sexual offenses. It's easier still to understand how judges are willing to accept that the administration of these psychological tests will lead to accurate determinations of potential dangerousness – particularly when these evaluative procedures are mandated by statutory law. Perhaps easiest to understand, however, is the mounting frustration of all participants in this process who come to believe that these measures are not "administered," nor "psychological," nor even "tests" in the sense we have employed such terms in the past.

In a recent issue of *The Advocate*, I commented on the emerging doctrine of "Jurisprudent Therapy" and provided the following definition:

> "Jurisprudent Therapy" [is] an extension of the "Therapeutic Jurisprudence" model proposed by Professors David Wexler and Bruce Winick. Whereas the "Therapeutic Jurisprudence" (or TJ) perspective analyzes substantive law, legal procedure, and legal roles to determine whether their effects are therapeutic, neutral, or antitherapeutic, the "Jurisprudent Therapy" (or JT) approach considers the extent to which mental health science, mental health practice, and mental health roles are jurisprudent, neutral, or antijurisprudent. [1]

In other words, after over a decade of research specifically geared to bringing the work of lawyers and judges into line with the dictates of social science, it is increasingly recognized that psychiatrists, psychologists, and social workers must do their part to ensure that their own impact on the legal system comports with foundational principles of justice and freedom.

This point of view is forcefully reflected in such cases as *Daubert v. Merrell Dow Pharmaceuticals, Inc.* [2] and *Kumho Tire Co., Ltd. v. Carmichael*. [3] Trial attorneys are thus encouraged – even compelled — to ask: "are psychological theories, their clinical and policy-making applications, and the people who develop and provide them making a fair, just, and legally supportable contribution to the lives of the people they are intended to serve?" [4]

Kentucky's current scheme for the assessment of "sex offenders" (*see* KRS 17.500 *et seq.*) provides an excellent example of how this perspective can be brought to life. The law mandates the use of certain actuarial measures in order to determine the degree of "risk" associated with the background of a given "offender." The two core instruments may be characterized as follows:

> The Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) consists of only four components: the number of prior sexual offenses, the offender's age at release, the gender of the victim, and the offender's relationship to the victim. The RRASOR's predictive accuracy (r = .27) is none too impressive.
>
> The Minnesota Sex Offender Screening Tool – Revised (MnSOST-R), by contrast, is a 16-item measure boasting considerably higher predictive accuracy (r = .45). One drawback, however, is that the MnSOST-R is extraordinarily difficult to score, particularly without ready access to the delicate, item-specific exclusionary rules employed and constantly revised by the instrument's developers. [5]

One should not assume that these measures, even when employed by psychologists, are somehow "administered" to individual offenders. In fact, both the RRASOR and the MnSOST-R are *purely* actuarial devices. They are scored entirely on the basis of available, archival data. A third instrument, the Violence Risk Appraisal Guide (VRAG), has a "clinical" component … but this turns out to be the Hare Psychopathy Check List – Revised (PCL-R). The PCL-R is claimed to be subject to considerable inter-rater reliability issues, absent expensive and rarely-accessed specialized training.

Any errors or omissions in an institutional record are likely to detract from a given instrument's accuracy in a particular case. Attorneys should give serious consideration to the correctional sources from which this information is obtained,

and the training and background of the personnel providing this material to the designated evaluators.

If actuarial approaches are truly superior to clinical judgment (as the research consistently suggests they are), then why are "psychological" experts employed to conduct them? It is here that a Jurisprudent Therapy analysis attaches: these actuarial assessments are cloaked in the guise of "clinical" practice (to a litigant's advantage or detriment, depending on a particular judge's regard for clinicians), obscuring their true nature, and thus complicating the fact-finder's ability to gauge their import and value as scientific evidence. [6]

These observations should not be construed as gratuitous criticism of the psychologists chosen to perform these evaluations in the Commonwealth of Kentucky. These valued colleagues have availed themselves of skilled consultation from within and without the state, often possess considerable experience from providing services in other forensic contexts, and work under extreme time and workload pressures. The reliability and validity of their contributions will be limited, however, like those of any professional, by any deficiencies in mandated measures, as well as difficulties in interpreting the statistical and/or psychometric properties of instruments employed.

A few examples from Kentucky's recent mandatory 32-hour Sex Offender Risk Assessment Advisory Board (SORAAB) training serve to illustrate this point. In the first, a clinician performing evaluations to gauge the likelihood of adolescent recidivism admitted directly to conference attendees that all currently available measures designed for that population had only "face" validity, concluding that "we're back to just going by our judgment."

Another presenter, asked by a fellow psychologist to explain why materials touting the efficacy of the RRASOR claimed an ability to "capture .27 of variance" while also describing a "predictive accuracy [of] r = .27," admitted that he was unable to explain this assertion.

Still another presenter, when a trainee noted that in one instance a higher MnSOST-R score was actually *less* predictive of re-offending than a lower one, dismissed this phenomenon as a minor statistical anomaly, and intimated that researchers were avoiding making such data readily accessible to courts because it might lead to allegedly groundless criticism of the instrument in forensic applications.

Again, attorneys should note that much important, useful, and clinically and forensically valid information was imparted at the above-referenced training conference. No one should fail to recognize the effort necessary to keep up with the immense caseloads faced by SORAAB evaluators. This having been acknowledged, however, both prosecutors and defense counsel should be in a position to undertake a measured, stepwise analysis of the sources, nature, and generalizability of the data employed in these evaluations. [7]

One source of guidance in this regard is the codes and guidelines from which psychologists derive ethical standards for professional conduct. They include specific reference to ways in which testing must be conducted and interpreted. Foremost in influence among these resources are the *Specialty Guidelines for Forensic Psychologists* [8] and the *Ethical Principles of Psychologists and Code of Conduct* [9]. In addition, recently promulgated regulations concerning psychological practice in the Commonwealth of Kentucky may be found at 201 KAR 26:115 *et seq*.

Another organizing tool for attorneys exploring the reliability and validity of any forensic measure is Professor Kirk Heilbrun's seminal 1992 article on "The Role of Psychological Testing in Forensic Assessment," [10] a core workshop and board preparation training reference for the American Academy of Forensic Psychology. The key points of this resource may be summarized as follows:

1) The test is commercially available and adequately ***documented*** in two sources. First, it is accompanied by a manual describing its development, psychometric properties, and procedure for administration. Second, it is listed and reviewed in *Mental Measurements Yearbook* or some other readily available source.

2) ***Reliability*** should be considered. The use of tests with a reliability coefficient of less than .80 is not advisable. The use of less reliable tests would require an explicit justification by the psychologist.

3) The test should be ***relevant*** to the underlying legal issue, or to a psychological construct underlying the legal issue. Whenever possible, this relevance should be supported by the availability of validation research published in refereed journals.

4) ***Standard administration*** should be used, with testing conditions as close as possible to the quiet, distraction-free ideal.

5) ***Applicability*** to this population and for this purpose should guide both test selection and interpretation. The results of a test (distinct from behavior observed during testing) should not be applied toward a purpose for which the test was not developed (*e.g.*, inferring psychopathology from the results of an intelligence test).

6) ***Objective tests*** and actuarial data are preferable when there are appropriate outcome data and a "formula" exists.

7) ***Response style*** should be explicitly assessed using approaches sensitive to distortion, and the results of psychological testing interpreted within the context of the individual's response style. When response style appears to be malingering, defensive, or irrelevant rather than honest/reliable, the results of psychological testing need to be discounted or even ignored and other data sources emphasized to a greater degree.

Attorneys who employ such resources when wading through sexual offender assessments "in search of psychology" may quickly find themselves in uncharted territory. While articles such as this provide tips for general exploration, they are no substitute for consultation with behavioral scientists who may provide assistance relevant to the unique variants of a specific case. u

**NOTES**


**[1]** Eric Drogin, "WAIS Not, Want Not?": A Jurisprudent Therapy Approach to Innovations in Forensic Assessment of Intellectual Functioning, *Advocate* 4-5 (September, 1999). *See also* Eric Drogin, "Evidence and Expert Mental Health Witnesses: A Jurisprudent Therapy Perspective," in *New Developments in Personal Injury Litigation* 295-333 (E. Pierson, ed., 2000); and Eric Drogin, "The Behavioral Science Committee: A Foray into Jurisprudent Therapy?" *Bull. L. Sci. Tech.* 9-10 (October, 1999).

**[2]** 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed. 469 (1993).

**[3]** 526 U.S. 137, 119 S.Ct. 1167, 143 L.Ed. 238 (1999).

**[4]** Eric Drogin, "From Therapeutic Jurisprudence … To Jurisprudent Therapy," 18 *Behav. Sci. L.* — (2000, in press).

**[5]** Eric Drogin, "Sexual Offender Risk Assessment and Scientific Evidence: A Jurisprudent Therapy Perspective," *Bull. L. Sci. Tech.* 3-4 (December, 1999).

**[6]** *See* Donald Bersoff, "Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law," 46 *SMU L. Rev.* 329 (1992).

**[7]** *See* Eric Drogin & Curtis Barrett, "'But Doctor, Isn't that Just Your Opinion?': Contributing to the Decision-Making Process of the Forensic Psychologist as Expert Witness," *Advocate* 14-20 (May, 1996); Eric Drogin & Curtis Barrett, "*Daubert v. Merrell Dow Pharmaceuticals* and Scientific Evidence: A Note of Caution," 7 *Ky. Prac. Advances* 3-4 (1996); and Eric Drogin & Curtis Barrett, "Forensic Mental Health Assessment: Moving from Examination to Evaluation," *Advocate* 129-33 (January, 1996).

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# Chapter 14: Pre-trial Evaluation Program
# Kentucky Correctional Psychiatric Center

**by Gregory S. Taylor, Director of KCPC**

**KCPC Purpose.** The Kentucky Correctional Psychiatric Center (KCPC) began operations in September 1981. The purpose of the institution is described in the Mission Statement as follows: "The Kentucky Correctional Psychiatric Center provides state-wide, forensic psychiatric services including pre-trial assessments, treatment for competency restoration, and inpatient care for severely mentally ill persons who are accused or convicted of felony crimes or require a secure environment."

**203% Increase in 15 Years.** The demands of the pretrial aspect of this mission have grown progressively since its inception. In FY 85/86 there were a total of 352 court orders for competency and/or criminal responsibility evaluations. In FY *00/01* the number of orders had climbed to *1065.* In the past fifteen years, a 203% increase in the number of orders has occurred. The flow chart attached describes the various steps by which a court order is processed.

**$281 per day, In-Patient.** It would be impossible to perform this volume of evaluations solely on an inpatient basis. In a farsighted decision in 1986, KCPC and the Department for Mental Health and Mental Retardation Services staff developed a program to conduct evaluations on an outpatient basis. The goals of this approach were to keep patients in their local communities, spread the increasing workload over a larger number of evaluators, decrease the waiting list of patients to be admitted to KCP save the expense of a costly inpatient hospitalization ($281.00 per day), and reduce the amount of time required to produce a completed evaluation. An occasional occurrence which may delay the outpatient evaluation process involves patients placed on bond status. These patients sometimes do not keep their appointment for evaluation and requires evaluation to be rescheduled.

**$800 for Out-Patient.** Currently, the Department for Mental Health and Mental Retardation Services has agreements with eleven community mental health centers to perform these outpatient evaluations. The total amount projected to be spent on outpatient evaluations in FY01-02 is projected to be $405,000. Following is a list of the centers, the individuals performing evaluations, and the counties they serve.

**Bluegrass Regional Comprehensive Care Center**
**Dr. Martin Smith**

| | | | | |
|---|---|---|---|---|
| Anderson | Fayette | Lincoln | Scott | Jessamine |
| Bourbon | Franklin | Madison | Boyle | Powell |
| Woodford | Garrard | Mercer | Clark | |
| Harrison | Nicholas | Estill | | |

**Comprehend, Inc.** - Dr. Barbara Jefferson

| | | | | |
|---|---|---|---|---|
| Bracken | Mason | Lewis | Fleming | Robertson |

**Cumberland River Comprehensive Care Center**
**Dr. Vincent Dummer**

| | | | |
|---|---|---|---|
| Bell | Knox | Clay | Laurel |
| Harlan | Rockcastle | Jackson | Whitley |

**Life Skills Comprehensive Care Center- Dr. Robert Sivley**

| | | | | |
|---|---|---|---|---|
| Allen | Edmondson | Metcalfe | Warren | Butler |
| Barren | Hart | Monroe | Logan | Simpson |

**Four Rivers Comprehensive Care Cente- Dr. Robert Sivley**

| | | | |
|---|---|---|---|
| Daviess | Henderson | Ohio | Union |
| Hancock | McLean | Webster | |

**Northern Kentucky Comprehensive Care Center**
**Dr. James Esmail**

| | | | |
|---|---|---|---|
| Boone | Grant | Campbell | Kenton |
| Carroll | Pendleton | Gallatin | Owen |

**Pathways. Inc. - Dr. Walter Powers**

| | | | | |
|---|---|---|---|---|
| Bath | Lawrence | Boyd | Menifee | Montgomery |
| Carter | Rowan | Greenup | Morgan | Elliott |

**Pennyroyal Regional Comprehensive Care Center**
**Dr. Robert Sivley**

| | | | | |
|---|---|---|---|---|
| Ballard | Christian | Lyon | Todd | Hickman |
| Caldwell | Crittenden | Marshall | Trigg | Hopkins |
| Muhlenberg | | | | |

**Four Rivers Regional Comprehensive Care Center**
**Dr. Robert Sivley**

| | | | | |
|---|---|---|---|---|
| Ballard | Fulton | Livingston | Hickman | Marshall |
| Calloway | Graves | Carlisle | McCracken | |

**Seven Counties Services – Dr. J. Robert Noonan**

| | | | | |
|---|---|---|---|---|
| Breckinridge | Jefferson | Oldham | Bullitt | Henry |
| Larue | Shelby | Grayson | Marion | Nelson |
| Spencer | Hardin | Meade | Trimble | Washington |

**Adanta Group - Dr. Horace Stewart**

| | | | | |
|---|---|---|---|---|
| Adair | McCreary | Casey | Pulaski | Green |
| Clinton | Russell | Taylor | Cumberland | Wayne |

**Mountain Comprehensive Care Center**
**Dr. Vincent Dummer**

| | | | | |
|---|---|---|---|---|
| Floyd | Martin | Johnson | Pike | Magoffin |

**Kentucky River Comprehensive Care Center**
**Dr. Vincent Dummer**

| | | | |
|---|---|---|---|
| Breathitt | Letcher | Knott | Owlsey |
| Lee | Perry | Leslie | Wolfe |

**Training & Referrals:** In-service training is offered by KCPC to outpatient evaluators on a regular basis. They also have access at any time to hospital staff to consult on a specific patient or address any issue. Patients evaluated as needing longer term observation and/or treatment may be referred as an inpatient to KCPC by the out-patient evaluator. For example, when the evaluator determines that a patient is not currently competent to stand trial but can benefit from treatment, the patient will be admitted.

**50% Out-Patient.** The number of cases evaluated on an outpatient basis for FY 00-01 was 528. This is out of a total of 1065 orders for evaluations.

**Increase Expected:** This program has proven efficient and effective in addressing the growing volume of court ordered evaluations. It is anticipated that the value of the program will only increase as the demand for such services continues to grow. ■

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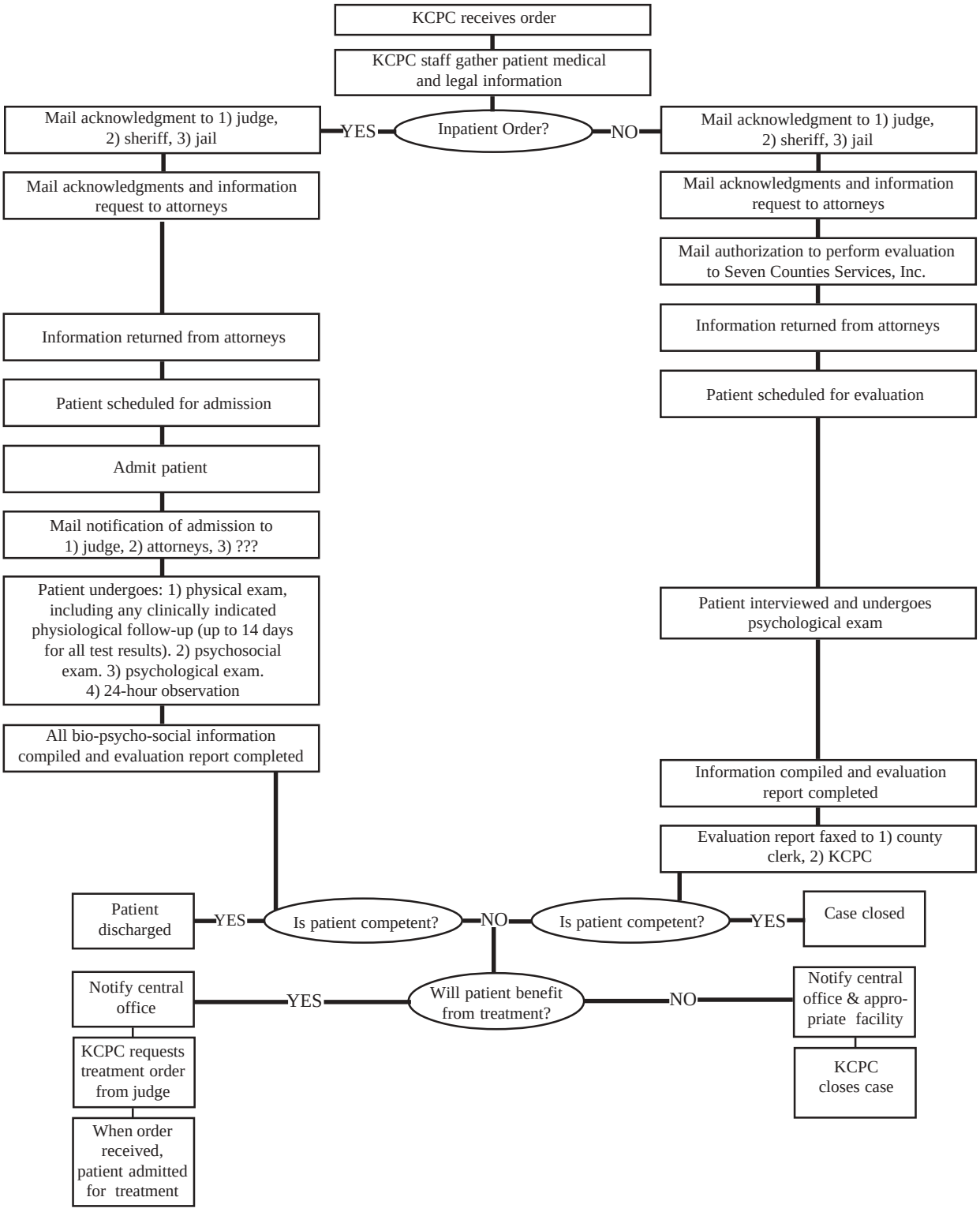
**COURT ORDERED EVALUATION PROCESS**



# Chapter 15: Competency to Stand Trial
## Assessment Instrument

| | DEGREE OF INCAPACITY | | | | | |
|---|---|---|---|---|---|---|
| | Total | Severe | Moderate | Mild | None | Unratable |
| 1. Appraisal of available legal defenses | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Unmanageable behavior | 1 | 2 | 3 | 4 | 5 | 6 |
| 3.Quality of relating to attorney 123456 | | | | | | |
| 4. Planning of legal strategy, including guilty plea to lesser charges where pertinent | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Appraisal of role of: | | | | | | |
| a. Defense counsel | 1 | 2 | 3 | 4 | 5 | 6 |
| b. Prosecuting attorney | 1 | 2 | 3 | 4 | 5 | 6 |
| c. Judge | 1 | 2 | 3 | 4 | 5 | 6 |
| d. Jury | 1 | 2 | 3 | 4 | 5 | 6 |
| e. Defendant | 1 | 2 | 3 | 4 | 5 | 6 |
| f. Witnesses | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Understanding of court procedure | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Appreciate of charges | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Appreciation of range and nature of possible penalties | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Appraisal of likely outcome | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Capacity to disclose to attorney available pertinent facts surrounding the offense including the defendant's movements, timing, mental state, actions at the time of the offense | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Capacity to realistically challenge prosecution witnesses | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Capacity to testify relevantly | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. Self-defeating v. self-serving motivation (legal sense) | 1 | 2 | 3 | 4 | 5 | 6 |

**INSTRUMENT MEAN = 3 * EXAMINEE MEAN _____**

Examinee _____ Examiner _____

Date: _____

* Do not count scores of "6"

DEFENDANT: _____ SSN: _____ DATE: _____

# COMPETENCY TO STAND TRIAL

## SAMPLE QUESTIONS*

All questions will not be appropriate in all cases. Use only as examples.

1 APPRAISAL OF AVAILABLE LEGAL DEFENSES:

a How do you think you can be defended against these charges?

b How can you explain your way out of these charges?

c What do you think your lawyer should concentrate on in order to best defend you?

2 UNMANAGEABLE BEHAVIOR:

a Do you realize that you would have to control yourself in the courtroom and not interrupt the proceedings?

b When is the only time you can speak out in the courtroom?

c What to you think would happen if you spoke out or moved around in the courtroom without permission?

3 QUALITY OF RELATING TO ATTORNEY:

a Do you have confidence in your lawyer?

b Do you think he's trying to do a good job for you?

c Do you agree with the way he's handled or plans to handle your case?

DEFENDANT: _____

4 PLANNING OF LEGAL STRATEGY INCLUDING GUILTY PLEAS TO LESSER CHARGES WHERE PERTINENT:

a If your lawyer can get the prosecutor to accept a guilty plea to _____ (lesser crime) instead of trying you for _____ (current charges), would you agree to it?

b If your lawyer decides not to have you testify, would you go along with him?

c Is there anything that you disagree with in the way your lawyer is going to handle your case, and if so, what do you plan to do about it?

5 APPRAISAL OF ROLE OF:

In the courtroom during a trial, what is the job of:

a Defense Counsel

b Prosecuting Attorney

c Judge

d Jury

e Defendant

f Witnesses

6 UNDERSTANDING OF COURT PROCEDURE:

a Who is the only one at your trial who can call on you to testify?

b After your lawyer finished asking you questions on the stand, who then can ask you questions?

c If the prosecutor asks you questions, what is he trying to accomplish?

7. APPRECIATION OF CHARGES:

a What are you charged with?

b Is that a major or a minor charge?

DEFENDANT: _____

c. Do you think people in general would regard you with some fear on the basis of such a charge?

8. APPRECIATION OF RANGE AND NATURE OF POSSIBLE PENALTIES:

a. If you're found guilty as charged, what are the possible sentences the Judge could give you?

b. Where would you have to serve such a sentence?

c. If you're put on probation, what does that mean?

9. APPRAISAL OF LIKELY OUTCOME:

a. What do you think your chances are to be found not guilty?

b. Does the court you're going to be tried in have authority over you?

c. How strong a case do they have against you?

10. CAPACITY TO DISCLOSE TO ATTORNEY AVAILABLE PERTINENT FACTS SURROUNDING THE OFFENSE INCLUDING THE DEFENDANT'S MOVEMENTS, TIMING, MENTAL STATE, AND ACTIONS AT THE TIME OF THE OFFENSE:

a. Tell us what actually happened, what you saw and did and heard and thought before, during, and after you are supposed to have committed this offense.

b. When and where did all this take place?

c. What led the police to arrest you and what did you say to them?

11. CAPACITY TO REALISTICALLY CHALLENGE PROSECUTION WITNESSES:

a. Suppose a witness against you told a lie in the courtroom, what would you do?

DEFENDANT: _____

b. Is there anybody who is likely to tell lies about you in this case? Why?

12. CAPACITY TO TESTIFY RELEVANTLY:

Evaluate individual's ability to verbally communicate during examination, rather than specific content in answers to specific questions.

13. SELF-DEFEATING VS. SELF-SERVING MOTIVATION (LEGAL SENSE):

a. We know how badly you feel about what happened - suppose your lawyer is successful in getting you off - would you accept that?

b. Suppose the prosecutor made some legal errors and your lawyer wants to appeal a guilty finding in your case - would you accept that?

c. We know that you want to plead guilty to your charge - but what if your lawyer could get the prosecutor to agree to a plea of guilty to a lesser charge - would you accept that?

# Chapter 16: Neuropsychological Evidence in Criminal Defense: Rationale and Guidelines for Enlisting an Expert ©

by Marilyn M. Wagner

### What Traditional Psychology Misses

The use of psychological evidence in criminal cases is well-established. Clinical psychologists are frequently called upon to testify to the identity and expected consequences of mental disorders such as major depression, schizophrenia, and personality disorders, and how they or conditions of chronic stress, physical abuse, substance abuse, etc., may affect an individual in such a way as to precipitate criminal behaviors, diminish intent or responsibility, or mitigate the circumstances of a criminal act.

Traditionally, the emphasis has been on the impact of these "functional" or emotional factors on issues of criminal behavior, with little regard to mental disorders that result from brain dysfunction. Among these organic disorders are disease entities such as tumors, cerebrovascular disease, and progressive dementias, but they also include acquired brain injury from perinatal insults and other circumstances that lead to mental retardation, effects of chronic alcoholism, and traumatic brain injuries.

Can the same degree of behavioral control demanded from individuals who are without functional psychopathology be expected of someone who has suffered a traumatic brain injury, has had surgery for removal of a tumor, or has a seizure disorder? As it turns out, it cannot.

The presence of a "traditional" functional disorder is not necessary for the conditions of "mental illness" to be met. Brain damage independently affects behavior in unique, significant, and oft-times dramatic ways, and in areas of behavior highly correlated with criminal behavior. Brain dysfunction, regardless of the source, may result in impairments of memory, language, cognition, or behaviors that have significant implications for criminal-legal standards of behavior.

Only in the past 10 years or so has research accumulated which establishes a connection between brain damage and the increased risk of violent behavior due to the impairing of inhibition of violent impulses (Volavka, Martell & Convit, 1992). High base rates of brain damage have been found in violent offenders versus non-violent offenders (Langevin, et al., 1987; Martell, 1992; Nachshon & Denno, 1987; Silver & Yudofsky, 1987). Similarly, a study of both adult and juvenile offenders (Lewis et al., 1986) found evidence of brain damage on neuropsychological testing in the majority of death row inmates.

The relevance of brain damage to criminal behavior has only recently emerged as an area of forensic attention (Anchor, et al., 1985; Hall & McNinch, 1988). There is now a large body of research in the neurobehavioral literature associating specific brain lesions with specific behavioral effects (Lezak, 1995). However, most psyhologists are neither trained or experienced in the nature of brain injury and its complex effects on behavior. The result is frequently that factors of brain injury are not considered in forensic evaluations.

### The Relationship Between Brain Damage and Criminal Behavior

That the brain is a very complex organ for processing information and generating behavior is not a point of argument. How it goes about doing this has constantly been debated and modified to take into account new information in neuroanatomy, neurophysiology and neuropsychology.

Although there are many aspects of brain function and dysfunction that are unresolved, it is generally agreed that the brain processes information in several different ways. Some areas of the brain are very specifically associated with certain behaviors. For example, the hypothalamus, a small structure on the basal surface of the brain, controls drive states such as hunger, thirst, and sexual behavior. Damage to the hypothalamus, depending on the specific area lesioned, can result in compulsive eating leading to obesity, in severe changes in sexual drive, or in any number of other abrupt changes in appetitive states.

Some behaviors recruit multiple areas of the brain, integrated into a functional, collaborative network. Motor responses require several areas of the cortex, subcortical structures known as the basal ganglia, and the cerebellum.

Finally, the brain is thought to function as a whole during certain complex activities, such as the processes we typically label as "thinking."

There are several brain structures and groups of structures that, when damaged, generate behaviors which may be associated with criminal behavior:

**Temporal Lobe.** The temporal lobe is a major division of the brain's lower lateral surface (cortex) in both the left and right hemispheres. Among the cognitive functions it mediates are memory and learning. It is also part of a large system of brain structures known as the limbic system which regulates emotional behavior. Damage to the temporal lobe can be associated with distinct loss of memory for events, impaired comprehension of language, and with aggressiveness and violent behavior (Devinsky & Bear, 1984; Stone, 1984).

**Limbic System.** In addition to the temporal lobe, the limbic system consists of brain structures below the surface of the brain. These subcortical structures are involved in the more primitive

aspects of emotional behavior. Damage to any of a variety of limbic system structures may result in marked aggression or violence, hypersexuality, or rage reactions. Sudden loss of control over aggressive tendencies, such as in explosive episodes, with minimal stimulation, can be found in limbic system lesions.

**Frontal Lobe.** This is the large, most anterior area of each hemisphere's surface that lies behind the frontal bone. It is considered to be the most complex structure in the brain; it is not fully developed until adolescence, and it is involved in the mediation of judgment, self-regulation of behavior, executive control (planning, organization of behavior), and personality. Damage to the frontal lobes is associated with gross disturbances in judgment and reasoning, disinhibition of impulses (*e.g.*, aggressive and sexual), and in personality changes. Frontal lobe damage is especially relevant to criminal-legal situations, as it impairs those cognitive functions associated with an individual's self-regulation of behavior, which may result in irrational decision making, the inability to inhibit behavioral impulses (sexual or aggressive), or the inability to accurately evaluate the consequences of one's behavior through reasoning. A finding for decreased criminal responsibility in a defendant requires that the individual lack the capacity to *appreciate* the criminality of the action (involves comprehension and judgment), and be unable to *conform* his conduct (self-regulation of impulses).

Damage to other areas of the brain, while not directly related to aggressive behavior or impulse control, can nevertheless greatly impair a defendant's cognitive capacity relevant to state of mind forensic issues such as competence, responsibility, and intent. The cognitive capacity required to comprehend court proceedings, make reasonable decisions, and recall court proceedings from one day to the next depends upon intact brain function.

Martell (1992b) noted that in one instance of criminal cases converted to civil status due to a finding of incompetence, 70% of the defendants were found to have documented brain damage. Both specific and diffuse damage to any number of structures in the brain could result in the interruption of those functions. In addition, cognitive impairment secondary to brain injury may be raised as a mitigating factor during the sentencing phase of a trial.

## Prognosis and Treatment Potential in Brain Damage

A separate but related issue involves how the presence of brain damage, once established, relates to the disposition of the defendant. Relevant factors to be considered in disposition are questions of possible progression of brain damage with resultant behavior deterioration, prognosis for recovery or improvement, and whether management or treatment of impaired behaviors is possible.

Some brain damage is progressive. It will worsen over time, with aberrant behaviors and cognitive deficits intensifying and additional impairments emerging. Progressive dementias, including Alzheimer's disease, the sequelae of tumors, and the cognitive effects of chronic alcohol abuse show such progressive deterioration of functioning.

Other conditions, such as traumatic brain injury, the sequelae of neurosurgery, and developmental insults, are stable, *i.e.* the cognitive and behavioral damage will not deteriorate further, and depending on the length of time since injury, may improve slightly or significantly. Even in cases of damage associated with prolonged alcoholism, abstinence typically leads to moderate improvements in functioning.

Depending on the etiology of the damage, some behavioral and cognitive dysfunctions are treatable, or at least partially reversible. Violent or aggressive episodes may be able to be controlled by anticonvulsant medication. Generalized behavior dyscontrol is amenable to both medication (typically tegretol) and behavioral management strategies in structured environments. At least on some occasions, individuals can be taught alternative responses to aggression via a structured regimen that assumes the problemsolving role for the individual, with eventual improvement in self-regulation. Mere abstinence from drugs and alcohol can have a profound positive effect on impulse control, as these substances are notorious for their intense disinhibiting effects on persons with brain injury.

## The Unique Role of Neuropsychology

The burgeoning area of neuro-imaging techniques has greatly enhanced medicine's ability to detect areas of CNS damage. Yet, the physical identification of structural neural damage does not, of itself, establish the emotional, cognitive, or behavioral effects of such damage that relate to criminal behavior, nor does it address the level of impairment.

Neuropsychology is that branch of psychology whose focus is on these very behavioral consequences. A neuropsychology expert is able to present quantifiable, normative data about the relationship between physical aspects of brain damage and its behavioral consequences, in sharp contrast to traditional reliance on professional opinions deduced merely from clinical interview impressions, or mental status examinations. Neuropsychological evaluations utilize a large variety of psychological tests to assess the degree of disruption in cognitive functions, both in isolation (as in focus of attention), and collectively, in more complex behaviors, such as in abstract reasoning or the planning and organization of activities.

These tests and test batteries have been extensively researched and validated. In some cases, neuropsychological assessment has even been shown to be more sensitive as a detector of brain damage than neuroimaging (Barth, et al., 1986).

Traditional clinical psychology practice does not address the issues of behavioral consequences specific to brain damage.

Until recently, few training programs in clinical psychology included any instruction in neuropsychology. Likewise, patients and defendants historically have not been evaluated from the perspective that brain damage might be a factor in their behavior. As a result, many diagnoses of functional disorders given were unwarranted, or behavior was not associated with mental illness at all. In many cases, brain injury takes a subtle initial toll, especially when the damage is incurred at an early age. Later, problematic behaviors may be attributed to other causes. The advantage of a neuropsychological evaluation over traditional psychological testing is that *both* functional and organic bases for behavior are investigated.

Neuropsychology is in a unique position to detect and track changes in an individual's cognitive capacity. In cases where change in neurobehavioral status is anticipated, baseline and serial testing may be conducted to verify such changes in status to evaluate the potential for restoration to competence, according to *Jackson v. Indiana* (1972).

### Determining When A Neuropsychologist As Expert Is Warranted

Not all criminal cases demand a neuropsychologist as expert. The neuropsychological evaluation is more time consuming than traditional psychological assessments, and therefore more expensive. Limited availability of adequately trained neuropsychologists also preclude their inclusion in many cases. However, there are some conditions under which investigating from a neuropsychological perspective is strongly indicated. In order to determine if the use of a neuropsychological expert is desirable in a specific case, the following questions should be posed concerning the defendant:

1) Were there any developmental events (perinatal or childhood in origin) that (could have) involved CNS injury, whether or not they were considered important at the time?

   Thinking about brain injury has changed so drastically over the past two decades, that it is not unusual for fairly significant CNS events to have been discounted and ignored (Lezak, 1995).

2) Have there been any events leading to loss of consciousness or disorientation, even if hospitalization did not occur? Motor vehicle accidents, incidents of physical abuse, assaults, and combat injuries are good examples of these events.

3) Is there any documented disorder involving brain damage (*e.g.*, head injury, stroke, seizures, Alzheimer's Disease, mental retardation)?

4) Is there a history of significant alcohol abuse or polysubstance abuse for several years or more?

5) Is the criminal behavior completely out of character for the defendant?

6) Is there a pattern of problems with impulse control, memory dysfunction, or violent behavior?

Positive responses in any of the above categories would suggest proceeding to involve a neuropsychologist who would then determine if there is sufficient reason to suspect the presence of brain dysfunction in a defendant and whether a neuropsychological evaluation is indicated.

### The Evaluation Process

Once a neuropsychological evaluation is deemed appropriate, it will be necessary to provide the neuropsychological expert with the following documents prior to the evaluation:

1) Medical records documenting any injury involving the CNS, significant illness, and/or ER visit;

2) School records of grades, testing, behavioral problems;

2) Records of any previous psychological problems, testing, or treatment;

4) Psychosocial history.

The expert will also find helpful information describing the crime, the defendant's behavior at the time of arrest, the defendant's account of the crime or their actions of the day in question, the defendant's behavior prior to the crime from the perspective of a family member or someone familiar with them, and access to a close significant other for possible additional interview.

Clearly define for the expert, in advance if possible, what issues in the defense the neuropsychological evidence will address (*e.g.*, competence, intent, or diminished capacity). Neuropsychological evaluations usually consist of a core of tests used in all cases, and additional tests that are included to more comprehensively evaluate any areas of cognition that are especially critical to the issues in question.

Knowledge of the defendant's history, the criminal behavior in question, and the legal issues specific to the case will aid the neuropsychological expert in determining the total content of the evaluation.

Expect to need to discuss the assessment findings with the expert at length, both to help clarify for the attorney the significance of the results for the specific issues of the case, and because the nature of the findings themselves might precipitate additional issues to be investigated that the expert might not be in a position to anticipate.

In cases where a finding of incompetence is expected, and potential for restoration to competence is an issue, serial assessments should be anticipated and tentatively scheduled.

With positive findings, the expert may recommend the addition of neuro-imaging or another medically-related assessment, if they are not already in the record. There are dual purposes for this. First, it could (but will not always) corroborate the neuropsychological evidence and thereby strengthen the conclusions of the behavioral sequelae (see Barth et al., 1986). Secondly, many circumstances of brain injury require medical intervention, and if not previously detected, would need to be medically evaluated for the benefit of the defendant.

### Considerations

The relative newness of this type of expert testimony may precipitate some questions regarding admissibility and relevance. There is case law both supporting (*People v. Wright*, 1982) and challenging (*GIW Southern Valve Co. v. Smith*, 1985; *Executive Car & Leasing v. DeSerio*, 1985) the neuro-psychologist's role as a medical expert in cases of brain injury.

In addition, neuropsychological assessment is open to the same challenge as is leveled at traditional psychological evidence. Namely, that this type of testing, *i.e.* indirect measurement of behavior, is not at parity with physical medical evidence. However, a neuropsychology expert can provide quantitative as well as qualitative evidence regarding the presence, specific nature and consequences of brain injury, describe its relevance to legal standards of behavior, provide a prognosis for improvement or further deterioration, and in some cases, suggest options for treatment or management of negative behaviors.

There is no physical medical evidence that can address these dimensions. For this reason, it is not surprising that the discipline of forensic neuropsychology is fast gaining status and acceptance as a source of valid and compelling evidence which speaks uniquely and directly to the difficult questions connected to criminal proceedings.

### Cases

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# Chapter 17: PTSD in the Forensic Setting

by Douglas D. Ruth, M.D.

The American Psychiatric Association opened a flood of controversy when it formalized the diagnosis of post-traumatic stress disorder (PTSD) upon the adoption of the third edition of the *Diagnostic and Statistical Manual (DSM-III)*[1] in March 1980. The decision to define this illness came when tort actions were being reshaped by increased awards for exemplary damages, establishment of liability for psychic damages, and expanding the radius of injury[2], setting the stage for vigorous courtroom use of such a diagnosis. Much of the problem in the forensic use of PTSD arises from the fact that, as with other psychiatric disorders, making the diagnosis relies to some degree upon the self-report of the patient, who often stands to gain if he earns the diagnosis. Among several concerns was the fear that copies of the diagnostic criteria would fall into the hand of litigants, claimants, or defendants who would simulate the symptoms.

In October 1980, for example, the Veterans Administration authorized compensation for PTSD, delayed type. Service organizations, outreach groups, and other sources distributed brochures describing the symptoms and provided printed checklists. The VA faced an "unprecedented challenge" created by the growing number of claims received and exaggeration and falsification of data, leading the VA psychiatrists who revised the examination process to comment, "Rarely before have many claimants presented themselves to psychiatric examiners having read printed symptom checklists describing the diagnostic features of the disorder for which they seek compensation."[3] (Lest this should be viewed as critical of veterans, though, it should be recognized that most deserving veterans apparently do not apply for benefits. In 1989 only 4% of the veterans estimated to suffer PTSD had applied for compensation.)[4]

The susceptibility of this disorder to misdiagnosis is illustrated by the aftermath of the sinking of the fish processing vessel *Aleutian Enterprise* in the Bering Sea in 1990. Twenty of the 22 survivors filed personal injury claims, 19 of whom were examined by a total of 15 psychiatrists and psychologists. Each was given the diagnosis of PTSD. Some were evaluated by more than one psychiatrist of psychologist, but in each instance the same diagnosis was given by each examiner.

Most of these clinicians did not corroborate the plaintiff's self-report by interviewing collateral witnesses nor reviewing medical records, which contained contradictory data. This figure yielded a conservatively-estimated incidence of PTSD among the 22 survivors of 86%, very much higher than that of most civilian disasters of traumata (this being classified as "chronic" since symptoms persisted beyond 6 months). The percentage of survivors suffering symptoms of PTSD exceeded that of similar maritime disasters that occurred prior to the publication of PTSD diagnostic criteria (although the diagnostic criteria were not published prior to 1980 and were not available to earlier litigants, the percent of survivors suffering specific symptoms should not have varied, though the diagnosis would differ). When these survivors were interviewed after settlement,[5] several admitted to symptom sharing and coaching by attorneys that influenced their behavior as they pursued their claims. This included attorneys describing to them the symptoms of PTSD, advising them not to return to work, and to seek professional help and make frequent appointments in order to bolster their claims. One attorney forwarded his client money for expenses so that he would not feel the need to settle early.

The disease of post-traumatic stress disorder has been referred to as "medicolegal quicksand"[6] and a "forensic minefield."[3] Features of the disorder leave it susceptible to abuse on an unprecedented scale. However, it provides a coherent explanation for the relationship between certain behaviors or symptoms to an antecedent, causative event or injury, often where previously no such relationship could be visualized since the earlier nomenclature did not address the phenomenon that was occurring. Furthermore, unlike most other psychiatric disorders, the diagnostic criteria of PTSD, by characterizing the stress that caused the disease as being of such intensity that "would evoke significant distress in most people," could be viewed as absolving the victim of blame, thus sparing him or her the stig.

The diagnostic criteria have changed somewhat in later editions.

### Clinical Features

The most recent criteria are abstracted as follows:[7]

### DSM-IV Diagnostic Criteria for PTSD

A. (1) An individual experienced, witnessed, or confronted events that involved actual or threatened death or serious injury or threat to physical integrity of self or others, and
(2) His response involved intense helplessness, fear, or horror

B. The event is persistently re-experienced in 1 or more ways:

(1) recurrent intrusive recollections
(2) recurrent distressing dreams
(3) acting or feeling as if the event recurs (including hallucinations, flashbacks, dissociation)
(4) psychological distress upon exposure to cues resembling the event
(5) physiological reactivity on exposure to cues resembling the event

C. Avoidance and numbing in 3 or more ways:

(1) avoiding thoughts, feelings, conversations associated with the trauma
(2) avoiding activities, etc., that arouse recollections of it
(3) partial amnesia for the event
(4) diminished interests
(5) detachment or estrangement from others
(6) restricted affect
(7) sense of foreshortened future

D. Increased arousal in 2 or more ways:

(1) insomnia
(2) irritability
(3) impaired concentration
(4) hypervigilance
(5) exaggerated startle response

E. Duration of B, C, and D is more than 1 month

F. Clinically significant distress or impairment occurs

The symptoms of the disorder are well-described in the diagnostic criteria listed above. The course can vary markedly from one individual to another or from time to time in the same person. One might have few or no symptoms for years or, at the other extreme, become so ill as to require hospitalization. Seemingly benign cues in the environment might trigger symptoms because of their resemblance to elements experienced at the time of the psychological trauma (*i.e.*, the sound of helicopters or the odor of diesel fuel in the Vietnam combat veteran or the odor of burned rubber in an automobile accident victim).

A *delayed* category of PTSD has been recognized in which symptoms might not emerge until long after the stressful event (after 6 months by definition, sometimes after years or decades in practice), creating the potential for unique forensic pitfalls.

The patient may suffer financially when anxiety, impaired concentration, or distraction from flashbacks interfere with job performance. Irritability, restricted affect, detachment, and avoidance might limit employability and hinder personal relationships. Complications such as depression, panic attacks, phobias, and substance abuse add to the burden. Response to flashbacks and behavior during dissociative episodes might result in destructiveness, violence, and criminal behaviors.

Some observations suggest that the victims of trauma might reiterate the very harm they suffered. Abused children often reenact the incidents in play or fantasy or, eventually, by abused their own children. Male sufferers of abuse are known to become violent among their peers, and a high incidence of childhood sex abuse is found among prostitutes.[8]

## The Ubiquitous Diagnosis

PTSD has served the legal community tirelessly. In addition to its more popular uses in personal injury, administrative, and criminal law, it has provided a basis for compensation in claims of harassment and discrimination in the workplace, evidence for termination of parental rights, and in immigration law, it has supported the assertions of immigrants that they will be persecuted if they are returned to their native countries.[9] Since the adoption of *DSM-III*, the portion of occupational disease claims classified as stress-related rose 800% from 1979-80, and the number of such claims in California climbed 700% from 1981-91. One state judge was awarded compensation for a stroke he alleged arose from being overworked by his excessive caseload of workers' compensation claims.[10]

## Prevalence

Estimates of the rate of occurrence of PTSD are subject to sampling bias, changes in the definition over time, and other sources of inaccuracy. Every-one who suffers a trauma as defined above does not suffer PTSD. It is estimated that from 39%[11] to 3/4[12] of the general population in the United States has been exposed to a traumatic event that met the stressor criterion for PTSD. The estimated lifetime prevalence for PTSD in the general population is 9%.[11] The lifetime prevalence for PTSD following certain civilian trauma are as follows: rape, 80%; life threat, seeing others killed, physical assault, 25%; accident, 12%.[13] The lifetime prevalence for former WW II prisoners of war has been estimated at 66.4%.[14] Other data provide a *current* prevalence of PTSD in WW II ex-POW's of 55.7%.[15] Perhaps the actual lifetime prevalence is actually higher than 66.4%, or perhaps this very high current prevalence is a reflection of the low rate of recovery for POW's.

## PTSD in the Criminal Courtroom

PTSD has not seen in criminal courtrooms the popularity it enjoyed in the civil arena. In an impressive study of nearly 1,000,000 indictments in 8 states, Callahan and associates[16] found that an insanity plea had been entered in 8979, thus estimating a frequency of insanity pleas of less than 1% of indictments. Studying 8163 of those further (excluding those indicted prior to 1980), Applebaum and others[9] found that PTSD was diagnosed in only 28.

Those defendants with PTSD diagnoses, compared to those with other diagnoses, were less likely to have been arrested as juveniles, were less likely to be incompetent to stand trial, were less likely to be detained after trial, and were more likely to be released on probation or other status.

The utility of the diagnosis in criminal defense was illustrated in *State v. Heads*.[17] Mr. Heads broke into his sister-in-law's home in search of his estranged wife and fired a number of shots from two weapons, one of which struck and killed his

sister-in-law's husband. He was convicted of murder in 1978. Following a series of appeals unrelated to PTSD and after adoption of the term by the APA in 1980, his diagnosis was realized by psychiatric experts who previously had not been able to understand nor explain his behavior. He was found not guilty by reason of insanity on retrial in October 1981.

Four types of PTSD phenomena have been identified as playing a role in criminal behavior:[18]

1. dissociative states, or fugue states, or altered states of consciousness such as those driven by flashbacks, including states triggered by stimuli related to the crime scene which resemble those associated to the original traumatic event. Examples would include survivors of combat (*e.g., State v. Heads*) or of prior physical abuse (*e.g., State v. Fields*[19]). These defendants might appear to relive a prior violent episode, might have overreacted violently to minimal provocation, and might be described as exhibiting "explosive" behavior. This same category would include defendants who, misperceiving a current situation as posing a great threat since it resembled an earlier threatening traumatic experience, used excessive force in presumed self-defense, or those who reflexively enacted previously-learned defensive violence.

2. "compulsive" behaviors during which the defendant seems driven to seek dangerous or stimulating and quasi-military situations. An example is that of *U.S. v. Tindall*.[20] Tindall was a Vietnam veteran helicopter pilot who was denied a civilian pilot's license. He sought risky hobbies, such as skydiving and stunt flying, and established a dangerous drug-smuggling operation with former combat buddies, reestablishing their wartime relationships.[18]

3. "survivor guilt" reactions whereby a survivor of prior trauma in which others have suffered or died undertakes criminal activity that offers little chance of success or appears to provoke retaliation from others and seemingly might involve an effort to get caught and punished or killed. An example might be that of *State v. Gregory*.[21] A former platoon leader described guilt feelings after surviving an ambush in 1969 in which other soldiers died. After 3 suicide attempts, he held several hostages in a bank (with no attempt at robbery) where he fired numerous rounds at sources of noise such as air vents, but not at the hostages, whom he treated gently. His examining psychiatrist explained that he wanted to have protected his patrol as he had "protected" the hostages, and that in Vietnam he had seldom seen the enemy and could only fire at the sounds they made in the foliage.[18]

4. behavior associated with abuse of alcohol or drugs used in an effort to self-treat PTSD symptoms. Both veterans[12] and civilians[22] with PTSD suffer a higher incidence of substance abuse than those without PTSD.

**Assessing the Behavior**

Several characteristics of flashback-induced behavior such as indicated in the first scenario of the four listed above have been described:[23]

1. The behavior is unpremeditated and sudden.
2. It is uncharacteristic of the individual.
3. There is a history of prior traumatic events reenacted in the episode.
4. The defendant might suffer amnesia for all or part of the episode.
5. Current motivation is lacking.
6. Stimuli surrounding the behavior in question may be reminiscent of the original traumatic experience(s).
7. The defendant is usually unaware of how his criminal behavior reenacted earlier traumatic experiences.
8. The victim is often fortuitous or accidental.
9. The defendant has or has had other symptoms of PTSD.

It is helpful, when forming an opinion as to the likelihood that certain behavior is "PTSD-driven," to consider whether the criminal activity can be viewed as a logical extension of the traumatic experience (*i.e.*, self-protection or anxiety reduction).[24] Behavior that is unpremeditated and the absence of concealment weigh in favor of PTSD. A history of property crimes, as opposed to assault crimes, weighs against the conclusion. But no single item of evidence is conclusory.

In fact, defenses based upon PTSD have been launched even in the face of several exceptions to these rules of thumb. In *State v. Fields*[19], the defendant's attorney argued a defense of unconsciousness based upon testimony that the defendant suffered PTSD from abuse in childhood and that he was in a dissociative state when he fatally shot another man. The victim was apparently well known to Fields as he dated and physically abused Fields' sister. Thus, Fields not only saw current motivation, but one could question whether the victim was "fortuitous." Evidence was presented that Fields, just before the shooting, made arrangements for a friend to cash his numbers ticket and hold the money for him, should he win, as he expected he might be away for some time, raising some question of premeditation.

**The PTSD Defense**

Erlinder[18] suggests that the language in *DSM-III* provides the rationale for entering into evidence details of the defendant's past in an effort to demonstrate the effects of his prior traumatic experience upon his behavior, as well as the testimony of others who have suffered similar trauma. He views the defense plan as the corroboration of the facts with as much objective data as possible (*i.e.*, records and collateral wit-nesses) and helping the factfinder to comprehend the effect of the defendant's traumatic experience.

In some instances, upon recognition of a PTSD diagnosis, charges have been dropped, settlements have been negotiated before trial, or treatment has been recommended in lieu of prosecution. These diversions seem more likely to be attainable when injury has not occurred and when treatment is accessible.[18] The diagnosis of PTSD has been used in the defenses of negated specific intent, diminished capacity, self defense, and automatism.[9] Even after sentencing, the diagnosis has been used to support petitions to reduce or reconsider sentences.[18]

The Insanity Defense Reform Act of 1984 and other changes in insanity defense laws have left the use of PTSD in a NGRI defense more difficult, but the more severely impaired individuals should still qualify for this defense.[25]

### Making the Diagnosis

As with other psychiatric illnesses, the diagnosis of PTSD is principally made by clinical interview and therefore depends upon the subjective account of the individual under evaluation. The challenge of evaluating such a claimant demands much skill of the clinician. Forensic experience is invaluable in limiting bias and susceptibility to manipulation. As there is often some value placed upon this diagnosis, an objective means of confirmation would be of use. Some transient, measurable physical changes occur in this disorder such as elevation of pulse and blood pressure when exposed to reminders of the stress; but these changes usually are not of such an extreme as to cause an abnormal physical examination, are not specific to PTSD, and sometimes are under conscious control of the individual. The examiner looks to see if the diagnostic criteria of a psychiatric diagnosis including that of PTSD are met, or discounted, and gathers other information to satisfy the reasons for referral, *i.e.*, in a civil action data necessary to assess causation, damages, and prognosis, and in criminal cases, information necessary to form opinions as to competencies in the various stages of the judicial process and mental status at the time of the alleged crime. Characteristics of PTSD in regard to criminal behavior as noted above are sought in the assessment.

Collateral interviews provide the best source of corroborative information. Informants who can describe the claimant or defendant before and after the traumatic experience, and thus document the changes he or she has undergone as a result, should be sought, as well as those who can describe the experience of the individual during the stressful event in question. In a civil case, the plaintiff might experience relapses of symptoms when he encounters reminders of the traumatic event. Co-workers might observe visible changes in the individual when he attempts to return to the workplace where an accident occurred, for example, or family members might observe signs of stress when an automobile accident victim tries to drive again or travels near the scene of his accident. A bedpartner might confirm the complaint of insomnia or of pathological behaviors during sleep. Friends or family members can document interpersonal distancing and affective changes. Medical records and psycho-therapy notes should be studied to see if the history is consistent, but with the understanding that an embarrassed or amnestic patient might not have disclosed much information in a rushed examination, and that sensitive information might be shared only late in the course of therapy after a sense of relative comfort has been achieve, or after events have freed repressed memories, contradicting denials made during earlier sessions. The examiner should not assume that such apparent contradictions are signs of dishonesty.

In the criminal case, police reports, depositions and affidavits should be read, and witnesses who can describe the defendant's behavior and surroundings before, during and after the crime should be interviewed. In addition to searching for signs of premeditation, efforts of concealment, and signs and symptoms of mental illness and emotional decompensation, the examiner should also listen for clues that the behavior is in keeping with the "PTSD-driven" behaviors as noted above and for descriptions of cues that might have triggered PTSD symptoms in the defendant.

A thorough psychosocial history should be taken and searched for events that meet the "stressor" criteria. Extensive childhood maltreatment might contribute to substantial behavioral symptoms without any one isolated event being identified as the causative trauma.[26]

If symptoms suggest a medical or neurological illness, then a physical or neurological examination is done and appropriate diagnostic procedures are scheduled.

Various structured interviews and rating scales have been designed and administered to groups suspected of having the diagnosis in efforts to develop some objectivity and reproducibility (for reviews see Watson[27] and Keane[28]). Several of these instruments yield a high level of agreement with each other when patients with suspected PTSD are tested. Most suffer 2 flaws, though:

1. In the absence of ultimate proof of diagnosis, there is no way to determine if the tests in-crease diagnostic reliability, and

2. Most of the instruments are obvious and easy to manipulate.

Keane[29] pulled together 49 items of the MMPI (Minnesota Multiphasic Personality Inventory) to create a new scale which he standardized. When given in the context of the MMPI, it shares the advantage of measurements of validity and test-taking attitudes (though Keane has, in fact, tested the utility of the PTSD subscale alone, absent the full MMPI), but this subscale also lacks ultimate proof of reliability, and it appears to have failed to detect malingerers.[30]

Still, these instruments are inexpensive, harmless, an easy to administer. The examiner enjoys some reassurance if their interpretation matches his diagnosis; and, if it differs, he might be warned to explore further.

### Psychophysiologic Testing in PTSD

Several physiological changes occur in patients with PTSD. These include insomnia, hypervigilance, and elevated pulse and blood pressure. When patients are startled or confronted with reminders of their prior traumatic experience, transiently but quickly the pulse, blood pressure, muscle tension, and skin conductivity rise. These changes have been measured in the laboratory in combat veterans,[31,32] in civilian trauma victims,[33] and in survivors of automobile accidents.[34] Under laboratory conditions and with monitoring devices attached the subjects were exposed to stimuli that resembled their stressor (*i.e.*, sound track from combat film, verbal scripts describing their accident, mental imagery) or loud tones to trigger a startle response. As a group, the PTSD patients tended to undergo greater physiological changes when confronted with such stimuli and to return to their baseline levels more slowly than control groups or patients with other diagnoses. It was hoped that these changes could find use as more objective means of diagnosing PTSD, as the patient could not easily control them.

However, while *group* differences can be demonstrated, the overlap of measurements between the PTSD and control groups were so great that it is difficult to see how any one individual could be categorized into one group versus another (*i.e.*, standard deviations were very large). Further, when 16 non-PTSD subjects were asked to simulate the responses of a PTSD patient, 25% could do so successfully.[35]

Pitman[35] described the sole instance, as of the writing of his article published 1994, in which admissibility of such testing was questioned. The judge disagreed with defense counsel's motion in limine that the test results should be excluded. But when defense counsel objected to the question of whether the probability of the diagnosis could be estimated from the test data, the judge ruled that more foundation for the testimony was required. The question was not pursued.

### Treatment

Since symptoms of PTSD often resolve spontaneously within a few weeks, episodes that are diagnosed soon after onset and in which the symptoms are not intense and are improving might not require treatment. When treatment is indicated, the goals include reduction of symptoms, prevention of complications, helping the patient to resume functioning in as many areas of his life as possible, and helping the patient to incorporate the experience into the context of his life. Since the traumatic experience, or the symptoms in its aftermath, often leave the patient feeling humiliated, guilty, and damaged in his self-esteem, providing an empathetic atmosphere that encourages accepting of the patient's disclosure is therapeutic, as is helping him to understand the "normalcy" of his symptoms, given the impact of the traumatic experience.

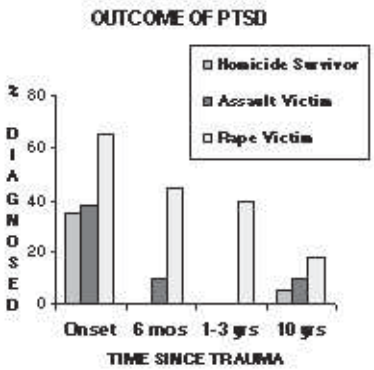
Several drugs have been prescribed for PTSD and have been demonstrated to have some positive effect. These have included anti-depressant medications, including imipramine, amitriptyline, Prozac, Zoloft, and others, anti-anxiety drugs including Xanax and Klonopin, anti-convulsant or anti-seizure drugs such as Tegretol and Depakene, and drugs that reduce sympathetic nervous system excesses (such as in the hyperarousal symptoms) including propranolol and clonodine.[11,36,37]
In addition to relieving anxiety, panic, depression, and insomnia and other sleep pathology, the anti-depressant drugs can relieve the core intrusive symptoms such as sleep disturbance, re-experiencing, and flashbacks independent of any anti-depressant effect. Their impact might not be seen for up to 8 weeks in chronic PTSD. Anti-anxiety drugs such as Klonopin and Xanax can relieve symptoms of anxiety, panic, and disturbed sleep. Unlike anti-depressants, they carry the risk of addiction and thus their use requires extra judgment, appropriate warning to the patient, and attempts to taper the dose periodically.

Treatment has to be individualized and timed according to the patient's clinical status and his location along the course of his illness.[38] Earlier, when exposure to the traumatic scene or cues that trigger symptoms is intolerable, the patient must be separated from those stressors. Doing so might require interaction between the clinician and the patient's attorneys, employer, disability insurance carrier or other agency.

Various non-pharmacological psychotherapies have been offered. These have involved cognitive approaches, relaxation techniques, and behavioral approaches including re-exposure of the patient to his stressors or cues that resemble it, either literally or through imagery. If the patient can tolerate re-exposure, usually after anxiety and hyperarousalsymptoms have diminished, and recontact with the noxious stimuli is desirable, he might be re-exposed in a gradual fashion, perhaps by use of a technique of "systematic desensitization." Sometimes a decision is made to re-expose the patient abruptly, either literally ("in vivo"), or figuratively by use of imagery, through processes called "implosive therapy" or "flooding." Complications of such re-exposure might include relapse of symptoms, depression, panic attacks, or substance abuse.[36,37]

### Prognosis

To estimate the prognosis of a disease that might not emerge for months or years and whose course might vary depending upon the nature of the causative stressor may seem as futile as trying to predict the final length of a coiled spring when no one knows how tightly it is to be wound. Such information is useful, though, to assess damages in civil cases and in criminal law to demonstrate that a stressor might influence behavior years after its occurrence.




Many victims experience enough symptoms to make the diagnosis of PTSD shortly after trauma but recover within 4 weeks, and the diagnosis is not given by definition. Many others who meet the diagnostic criteria recover within 4 to 6 months.

Since PTSD can persist for years or decades, prospective measurement of the outcome over such a long term is often impractical. Estimates have been made by administering questionnaires to identified groups, *i.e.*, veterans or former POW's, or by re-interviewing victims of past disasters from whom data was collected earlier and is still on record. As does the prevalence, the prognosis appears to vary in relation to the severity of the stressor. Usually the figure reported is the percent of individuals who still meet all the criteria to make the diagnosis. Of a group of ex-WW II POW's, 50% met the diagnostic criteria within one year of release, and 29% still qualified for the diagnosis 40 years later.[39] Of survivors of the Buffalo Creek, West Virginia flood in 1972, 44% suffered PTSD when assessed in 1974. The figure fell to 28% when reexamined in 1986[12]. A graph of the declining rate of diagnosis among some groups for which such information is available is found in Figure 1.[40]

These data, changes in the percent of groups who still meet the diagnostic criteria, do not necessarily reflect changes in the intensity of symptoms. In the Buffalo Creek disaster noted above, a symptom rating scale was administered to survivors with PTSD during the initial assessment in 1974 and again in 1986. Scores fell from an average of 3.9 in 1974 to 2.7 in 1986, representing a 30% decline in the 12 years.

## Conclusions

Since the disease of post-traumatic stress disorder is caused by specific traumatic events, some of which are manmade, and it may result in loss or disability and may contribute to criminal behavior it has found its way into various forensic settings - probably more than any other disorder. Publication of the diagnostic criteria and of the disease process have served the legal community well in providing an explanation of the relationship between the stressor and the subsequent suffering or behavior, thus allowing the delivery of justice by clarifying many cases that otherwise would have remained obscure. The attorney for a PTSD sufferer might have a difficult client as irritability, amnesia, lack of awareness of the diagnosis, and unwillingness to discuss the prior traumatic experience might challenge rapport, and detachment, emotional numbing, and affective blunting might preclude sympathy. Though PTSD shares with other psychiatric diagnoses the disadvantage of lacking a truly objective diagnostic test, abuse by malingering can be limited with adequate care in the evaluation.

Considering the very small number of insanity pleas based upon PTSD and the prevalence of this disorder, it is probably underused as a defense. The disease lends itself to a number of defense theories or rationales for mitigation. Since it is treatable, diversion to treatment in lieu of incarceration should offer a gratifying disposition in many cases. The fact that defendants who pled NGRI on the basis of PTSD are probated more often than other defendants indicates that the courts have felt some comfort with dispositions that do not require incarceration.

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# Chapter 18:
# Checklist of Client Behavior Evidencing Mental Impairments
## (Based upon Logan, *Learning to Observe Signs of Mental Impairment*)

### REALITY CONFUSION

__ Reports hallucinations

- __ Hearing Voices
- __ "Seeing things" (people, objects, unformed images such as flashes of light)
- __ Smelling things not there
- __ Tactile (feelings of being touched by someone/something not there)
- __ Gustatory (false perception of taste)

__ Misperceives harmless image as being threatening
__ Irrational fears, *i.e.*, leaving his cell, heights, spiders, snakes
__ Seems confused about people or surroundings
__ Consistent false beliefs. *i.e.*

- __ Lawyers out to get him
- __ Guard/another person in love with him
- __ Food being poisoned
- __ Being controlled by outside forces
- __ Others are talking about him

### SPEECH AND LANGUAGE

**Nonsensical Speech**

- __ Speech which is incoherent at times
- __ Use of new word formations (not slang)
- __ Use of "non-words"
- __ Use of non-sequiturs
- __ Conclusions based on faulty promises

**Half Answers**

- __ Brief, unelaborated answers to questions
- __ Monosyllabic answers to questions
- __ Language tends to be vague, repetitive, stereotyped
- __ Answers are lengthy but actual information is little
- __ Speech seems like "empty philosophizing"

**Off Track**

- __ Changes subject in the middle of a sentence in response to another stimulus
- __ Answers questions in an oblique or irrelevant way
- __ Pattern of speech seems "disjointed"
- __ Ideas slip gradually off-track from one oblique thought to another
- __ Speech pattern which is circuitous, indirect or delayed in reaching its goal

  Includes many tedious details
  - __ Seems "long-winded"
  - __ Requires that you interrupt in order to finish business
  - __ Starts on one subject, then wanders away and never returns
  - __ Persistent, inappropriate repetition of words, ideas or subjects once the discussion begins

**Rapid Speech**

__ Talks rapidly and is hard to interrupt
__ Sentences left unfinished because of eagerness to move on
__ Continues talking even when interrupted
__ Often speaks loudly and emphatically
__ Talks too much and interrupts others

**Delayed or Interrupted Speech**

__ Speech is very slow
__ Excessive wait before answering or responding
__ Difficulty finding right word to use
__ Stops in the middle of a thought and after some silence cannot remember what he was talking about
__ Says his "mind went blank"

**Sound-Related Problems**

__ Recognizable mispronunciations
__ Substitution of inappropriate word
__ Slurred speech
__ Speaks in a monotone even when discussing emotional material
__ Talks in excessively formal or stilted way
__ Language may appear "quaint or outdated"

**Other Language Problems**

__ Writing is very small
__ Writing is prolific
__ Has trouble reading
__ Spells poorly

## MEMORY AND ATTENTION

__ Has trouble remembering childhood data
__ Has trouble recalling things that happened in past few months
__ Has trouble remembering things in last few days
__ Has trouble recalling events surrounding crime or trial
__ Has trouble remembering people's names
__ Reports "memories" which do not correspond to documentation
__ Seems to "fill in" details of faulty memory
__ Sometimes appears to be "lying" about events in his life or events surrounding crime
__ Has extraordinary ability to recall
__ Problems concentrating
__ Attention drawn to irrelevant or unimportant stimuli
__ Loses train of thought
__ Problems with attention and concentration on emotionally-charged issues

## MEDICAL COMPLAINTS

__ Exaggerated concern over health
__ Self-wounds or wounds suspicious in origin
__ "Accidents"
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Excessive sleeping
__ Change in eating habits
__ Loss or decrease in appetite
__ Blurred vision
__ Need to squint or move closer when reading
__ Hearing problems
__ Ringing in ears
__ Headaches
__ Dizziness
__ Nausea
__ Excessive tiredness

## EMOTIONAL TONE

__ Worry, fear, over-concern for present or future
__ Mistrust, belief others harbor malicious or discriminatory intent
__ Sorrow, sadness, despondency. pessimism
__ Irritability, belligerence, disdain for others, defiance
__ Impotence
__ Extreme, heightened emotions
__ Flatness in emotional tone. near absence of emotional expression
__ Sudden changes in mood which are disproportionate to situation
__ Inappropriate laughter

## PERSONAL INSIGHT AND PROBLEMS SOLVING

__ Low self-esteem
__ Exaggerated self-opinion
__ Overrates level of ability
__ Unrealistic goals; failure to take disabilities into account
__ Denial of mental problems
__ Difficulty planning ahead
__ Poorly organized
__ Difficulty thinking as quickly as needed
__ Difficulty changing a plan or activity when necessary
__ Difficulty in accurately predicting consequences
__ Easily frustrated
__ Impaired ability to learn from mistakes

## PHYSICAL ACTIVITY

__ Restlessness
__ Fidgety
__ Kicks leg often/moves arms around a lot
__ Overly talkative
__ Unusually quick reactions
__ Hyper-alert to what is happening in visiting room; constantly looking around, checking behind himself
__ Slow movement, slow speech
__ Slow reaction in movements or while answering questions
__ Balance problems
__ Clumsiness, poor coordination
__ Tense posture and/or facial expression

## INTERACTIONS WITH OTHERS

__ Unresponsive family
__ No regular visitors or letters from others
__ No participation in yard activities
__ Discontinuation of yard activities
__ Lack of social greetings to fellow inmates in visiting room
__ Awkward or inappropriate interactions with others in visiting room
__ Willingness to “go along with” or cooperate in almost any way
__ Deficiency in relating to others; lack of spontaneous interactions
__ Socially inappropriate comments and/or actions (including sexual or aggressive)
__ Trouble understanding that some of his behavior is inappropriate

**OTHER OBSERVATIONS**

# Chapter 19: Learning to Observe Signs of Mental Impairment©

by Deana Dorman Logan

## Introduction

Criminal defendants can pose a lot of challenges for their lawyers. Primary among the problems, of course, are the brutal facts of the crimes. In addition, our clients tend to go to great lengths to "aid" the police in solving the crimes through confessions, statements to "snitches" and other such actions.

Beyond these crime-related challenges, criminal defendants commonly engage in other behaviors which sometimes seem designed to terminally stress the patience of the assigned attorney.

These problematic behaviors can manifest them-selves in a number of ways familiar to defense team members. One example is those occasions when you visit the client in his jail or prison setting, and he refuses to come out for the visit, blowing several hours of time that could have been spent constructively working on his case. Also, there are those times when the client does come out but rather than giving you specific answers to the critical questions you arrived with, he stands up, starts pacing back and forth, and rants and raves about some totally irrelevant gibberish. You are then forced to leave after a couple of hours feeling like nothing was accomplished.

Another example comes in the form of a motion to remove counsel, a complaint to the judge about "what a terrible lawyer you are," how you have "refused to listen to him" and "called him vile names," all as a "part of a conspiracy to do him in." You, then, are forced to walk that delicate line between acceding to such unfounded charges or further damaging a delicate relationship. A final example is that point in discussing the case when a client laughs as he talks about what happened to the victim.

In fact, during each of these typical scenarios, plus the myriad of similar encounters, the client is giving valuable information about significant mental impairment. These seemingly irrelevant or annoying interactions are often more meaningful in fully preparing a case than those times when a client is able to sit quietly and appropriately describe his actions the night of the crime. Most clients who commit violent

felonies, particularly capital crimes, suffer serious mental problems. These affect a wide range of legal issues, including mens rea (for the instant crime as well as priors), voluntariness of statements to police or other state officers, waivers, competency to stand trial, ability to testify meaningfully and accurately, and other competencies, as well as mitigation.

Preparation for the mental health evaluation of a criminal defendant requires not only full documentation of the family medical and psychiatric history,[1] but also careful observation over time of the client himself. Since we cannot afford to hire mental health experts to spend the time necessary to get a thorough picture of the client's behavior in a variety of settings across a wide expanse of time, the task must fall to those who have continued access to observations - the defense attorneys, mitigation specialists and investigators.

This paper is an attempt to outline for the defense team the types of behaviors identified by mental health professionals as significant signs of psychiatric problems, so that critical observational skills can be learned. Most of the behaviors discussed are general signals of mental disorder rather than definitive symptoms of one particular psychiatric illness.[2] These signs, if properly noted by the legal team and passed on to the mental health expert, will help guide the expert to make a more accurate evaluation.

To understand the significance of these observations, it seems helpful to use the analogy of a personal visit to a physician. When you have a medical complaint, you do not go to a doctor chosen randomly, walk in and simply say, "Tell me what is wrong, doc." You try to note the symptoms methodically over some period of time (*e.g.*, dizziness on standing, "heart burn" a couple of hours after eating, numbness down left arm for a couple of weeks). For patients who are too young or too ill, a caretaker must do such observation. These monitored symptoms are then submitted to the doctor, who carefully analyzes them in the context of a full family medical history. With this expansive process, augmented by necessary laboratory testing, an accurate diagnosis and treatment plan can more likely be achieved.

In the criminal justice arena, we must do no less in our preparation for a mental health evaluation of our clients. Also, because the clients' impairments preclude accurate self-monitoring, the defense team must act as the observational caretakers for the mental status symptoms of the client. These noted signs and symptoms will lend invaluable guidance to the doctor later asked to do the mental health evaluation.

## Cautions to Note

There are some important cautions to observe in undertaking the task of learning to monitor these symptoms. First, although the signals are described in behavioral terms, the scientific name is also listed in most instances. Lawyers need not, and in fact should not, try to master the art of accurately applying technical names to particular actions. This is more likely to be counter-productive because of errors of assignment. The im-

portant task is spotting notable behaviors and passing on the observation. The scientific names are provided only as an aid in understanding mental health professionals as they engage in their own jargon.

Second, in these days of wide-ranging access by prosecutors through discovery, defense attorneys should always be cautious in preserving any critical information in written memoranda. This is particularly true for observations such as those discussed here which may or may not be accurately noted and interpreted by the defense team. Probably the safest route is to make only such cursory notes as will enable the observer to remember particular behaviors.

Finally, although defense team members should learn to note potential signs of mental problems, they should never presume to label the clients' performance or behavior "normal." This is a very dangerous practice Any mistake in observation must favor the client. When the lawyer makes an error by spotting what appears to be a symptom of mental illness, the behavior will get examined by the expert with training to accurately interpret it. Then it can be disregarded if it is not important. However, when a lawyer or investigator labels an area of behavior as "normal," the expert may inappropriately accept that lay analysis and fail to apply a trained eye to a critical area of evaluation. For example, lawyers too often overestimate a client's intelligence simply because he is savvy about the criminal justice system. Also, race bias can lead lawyers to dismiss significant signs of mental impairment as "normal" for those from certain cultural arenas such as "the ghetto" or "the barrio." If these errors by lawyers are accepted as fact by the mental health professional, gross underestimation of impairment may result in serious detriment to the client.

### Reality Confusion

The most dramatic signs of mental illness which might be encountered by the defense team are the overt psychotic symptoms which show some confusion regarding reality. (See Figure 1.) Hallucinations, a sign of both psychosis[3] and brain damage,[4] can involve sights, sounds, smells, physical sensations or tastes. Although these may not be a routine part of the legal team's inquiry, any time hallucinations are mentioned or hinted at, the subject should be pursued. Counsel should also look for any evidence that the client is responding to internal stimuli, such as inappropriate smiling, nodding and giggling. An expert will be interested in any reports or suspicions of hallucinations and will want to know what they are like, when they come, and how long they have been experienced.

Although hallucinations are dramatic when recognized, a client's reference to them may be so subtle as to avoid detection. One of my clients told me he was having trouble with his vision. At first I ignored this clue, believing he meant he needed new glasses when, in fact, he was alluding to recurring visual hallucinations. Another attorney said she missed references to auditory hallucinations because she lacked a good family history. Her client several times mentioned things his auntie was telling him. Only later did she realize his aunt had died when he was five years old.

Spontaneous remarks by the client should also guide the legal team to pursue the possibility of phobias,[5] and delusions (consistent false beliefs),[6] other general signs of mental impairment. Phobias are fairly obvious signs of mental problems as are some delusions (*e.g.*, belief his food is being poisoned). One delusion, however, is sometimes easy for counsel to miss because it is perceived as a personal attack on the lawyer. Clients with the false belief that their attorneys are out to get them often prompt defensive behavior in their counsel rather than recognition that persistent beliefs along this line may be a signal of psychosis or paranoia.

In addition to following up on the spontaneous occurrence of the preceding psychotic-like symptoms, counsel should also be alert to physical observations of disorientation. During a visit, clients who seem confused about the physical surroundings or the persons in the room may be exhibiting what is termed disorientation.[7] This observation should also be noted for later discussion with a mental health expert once a thorough, documented history is available.

### Signals of Mental Impairment in Speech

Many of the general signs of psychiatric problems can be observed in speech. (See Figure 2.) In fact, oral language is a particularly sensitive manifestation of thought processes and brain dysfunction. Signals of mental impairment in speech can be broken down into several categories. One grouping includes speech patterns that seem nonsensical or nearly so. These include the rare problems of "word salad" or speech that is basically gibberish (even though at times it may sound like sentences). Also in this category is the use of neologisms or non-words. These client-created "words" are distinct from slang - words and phrases used colloquially by certain subgroups of society. One must be careful not to dismiss what may be a signal of a thought disorder by assuming it to be unfamiliar slang of the client's cultural group.

Illogicality is another speech signal of the nonsensical variety. Although proper words are usually used in appropriate syntax, in illogicality, the reasoning is flawed. This term is applied to use of non-sequiturs and conclusions based on obviously false premises.

Another category of speech signals occurs when a client has a pattern of giving only half-answers to questions. Half answers can be monosyllabic or brief, unelaborated answers termed poverty of speech and poverty of thought. They can also include answers that are lengthy in terms of number of words but deficient in information. The client is saying nothing or droning on. This poverty of thought or poverty of content of speech may seem like "empty philosophizing."[8] A final type of half-answer is that which is oblique or irrelevant to the actual question. This is referred to as tangential speech.

One of the most intriguing categories of speech signals involves those that might be termed "off- track." The speaker begins to answer one question but somehow moves off that topic. One way of getting off track is to be easily distracted by a nearby stimulus (*e.g.*, the lawyer's jewelry) and then jump from the subject at hand to a discussion of the new stimulus. When this happens routinely it is referred to as distractible speech or distractibility,[9] a general psychiatric sign as well as a specific marker of attention-deficit hyper-activity disorder,[10] bipolar disorder,[11] and fetal alcohol syndrome.[12]

Another type of off-track speech, harder to discern, is when the speaker starts on one topic but slowly slips from one thought to another. The transition thought is related but only obliquely. For example, in answer to a question about where he went to school, the client may begin with the name of one of the schools. However, instead of focusing on completing the answer to that question, he may slip to why he didn't like school (homework) to what he would rather do than go to school (explore caves) to what one could find in caves (interesting little insects) and so forth. At some point he may remember he has gone afield. This type of disjointed, slow slippage of topic is referred to as derailment. The listener may not even notice the slippage until he looks down at the question of schools attended. A close relation to derailment is loss of goal, another off-track speech signal. Here the speaker starts on one topic and wanders away, never to return. Loss of goal does not occur only in a question-answer format but can arise in spontaneous speech as well.

Another off-track speech signal is the answer which is long-winded, circuitous, and filled with irrelevant details. This circumstantiality often causes an interviewer to feel impatient and may well require interruption in order to finish the task. Preservation, the repetitive use of words, phrases or ideas, can cause similar reactions of impatience. The speaker says the same thing over and over, varying only somewhat the wording he is using. These several off-track signals are obviously related and sometimes overlapping. The defense team should not seek to properly label each one but rather to note the unusual speech behavior in the client and pass it on to the expert. (*E.g.*, "He can't seem to stay on one topic.")

The next type of speech signal might be termed "speedy." This is the loud, emphatic, rapid, over-eager speech that is hard to interrupt, which experts call pressure of speech or pressured speech.[13] Related to pressured speech is the tendency of those with attention-deficit hyperactivity disorder to talk too much and interrupt others.[14]

Delayed or interrupted responses is another type of speech signal. This includes (a) speech that is generally very slow; (b) responses that come only after unusual delay, termed psychomotor retardation;[15] and (c) delays in response because of difficulty in finding the proper word to use, termed lack-of verbal fluency.[16] Each of these can be a signal of brain damage.[17] Delayed or interrupted speech also includes blocking. In blocking, the speaker stops in the middle of a thought and forgets what he was saying, a "mind went blank" experience.[18]

The final category of speech signals is sound related. This includes mispronunciations or inappropriate word substitutions (paraphasia), slurred speech (dysarthria),[19] and speech which is delivered in a monotone despite the charged nature of the topic (aprosody).[20] A less serious sound related indicator is stilted speech, language which seems quaint or excessively formal. For example, "I thank you very much for the Coca-Cola" rather than the more natural "Thanks a lot." These problems have been identified as general signs of mental problems,[21] as well as signals of potential brain damage.[22]

Speech is often a difficult area of observation by legal staff because of the tendency to disregard impediments to understanding the content of the message. Thus, for instance, lawyers are likely to mentally correct the client's mispronunciation so that the conversation can continue and then forget the problem with pronunciation. Similarly, when a client's speech seems to move "off track" in any of the several ways suggested in Figure 2, the lawyer is likely to get annoyed and then either stop listening or interrupt and require that he answer the question posed. In either case, the lawyer loses the opportunity to note and analyze the aberrant behavior. Whenever there is an interview or conversation with the client, the defense team should be alert to these speech signals of mental impairment. Warning lights should go off when you feel that the conversation is hard to conduct, is "going nowhere," is confusing to you or the client, is annoying you, or boring you because he is "droning on."

In the end, careful observation of a client's speech problems will require two members of the defense team. While one person carries on the conversation with the client, the other is free to watch the client more closely. These roles of observer and conversationalist can trade off during the interview. Later, after the client is gone, the two defense team members can discuss the observations and, thus, more carefully characterize the behavior for the expert.

Abnormal language markers can be particularly difficult to observe in clients for whom English is a second language. In those cases, counsel should contemplate seeking assistance from one who is fluent in the client's native language. Not only would this provide assistance in the linguistic nuances of the language but also give insight into important cultural factors in speech. For example, short, unelaborated answers which appear to be poverty of speech could be a cultural indication of respect for professionals.

### Other Language Problems

In addition to speech, there are several other language problems which indicate potential mental impairment. (See Figure 2.) Written correspondence with the client is not only essential to sustaining a close working relationship but it also offers clues to mental functioning. Through analysis of writings one

can spot not only many of the thought problems already discussed but also clues such as spelling problems, very tiny writing (micrographia)[23] and prolific, voluminous writing (hypergraphia) which can be signals of brain damage. Counsel should be careful, though, in assuming that letters from the client are actually written by him. It is not uncommon for inmates to get help from others with their reading and writing. Thus, some inquiry should be made of the client regarding who helps him with his work.

Finally, the lawyer should routinely assess the reading ability of the client. Reading level is important not only in planning how you can communicate best with the client in the future but also in understanding such legal issues as waivers, statements, and competency to stand trial.

One obvious time to test reading ability is when reviewing a legal document. Rather than simply handing it over to the client, tell him you'd like to go over it carefully with him. Don't ask him if he can read it or whether he'd like you to read it to him. This will only embarrass him and prompt a denial. Instead suggest you go through it paragraph by paragraph so you can answer any questions the client has and clear up any confusion you have. Then ask him to read the beginning. If he stumbles just a little, help him with a word and see if he can continue. If he continues to have difficulty, step in and volunteer to do the reading yourself. There is no need to prolong his agony because now you have the answer you need - the client has serious reading problems. Dyslexia, reading disability, can be a sign of brain damage.[24] Obviously, none of this exercise is necessary if you already are aware of a learning disability or mental retardation.

Even if the client can pronounce most of the words in the pleading, he may not comprehend their meaning. Thus, counsel should also check to see what the client understands the writing to mean. Any kind of test like this for pronunciation and comprehension will cause embarrassment for all but the best educated and most confident of clients. Counsel should be sensitive to this discomfort.

### Memory Problems

Memory is a complex set of mental functions which requires noticing the stimulus, making some sense of it, transferring the thoughts or images to a mental storage area and finally calling the thoughts or images back up into consciousness at the required time. Impairment or interference at any of the critical points will result in "memory problems." Difficulties with memory are recognized as important signs in psychiatry and neurology and can be clues to a variety of mental illnesses.[25] Memory problems have also been shown to specifically signal mental retardation,[26] brain damage, depression[27] and attention-deficit hyperactivity disorder.[28] Memory problems can also be related to long-term drug and alcohol abuse. Knowledge of either memory difficulties or substance abuse should prompt the defense team to investigate the possibility of the other.

Most crime-related discussions with the client, as well as questions about his background, will allow the defense team to note the memory facility of the client. In analyzing the behavior for use by the expert, it is helpful to sort out what particular types of things the client has trouble remembering. (See Figure 3.) For example, does he have clear memories of most areas of his life, but trouble with details of the crime, or recollections of his father, or some other particular subject? Memory loss can sometimes be a defensive function following psychic trauma, barring the painful experiences from conscious recollection. Zeroing in on whether the memory problem is global, covering all areas, or specific to some time period or subject will be of great help to the mental health expert.

The best marker of organic brain dysfunction is recent memory. Thus, the defense team should note the client's memory function in casual conversations regarding recent news events as well as in specific case-related discussions.

Another potential memory related area is the annoying problem of client "lies." Time is wasted on "wild goose chases" in investigation and strain is put on the relationship. In fact, the "lies" can be important general clues to mental impairment, signaling a variety of psychiatric conditions.[29] Lying is also common behavior for those with fetal alcohol syndrome.[30] In addition, what appears to counsel to be a lie could, in fact, be an attempt to honestly, but erroneously, fill in the gaps in a faulty memory.[31] This is called confabulation.[32] Thus, it is important to keep open the real possibility that "lying" is helpful as a signal rather than just another block in the road to proper case preparation. A good mental health expert will always want to know what is at the core of a client's difficulty in telling "the truth."

### Attention and Concentration Problems

One of the components of the complex memory system is attention to and concentration on the important stimuli. (See Figure 3.) If one cannot stay focused long enough to take in the information, obviously memory will fail. This area of memory problems will show in many types of conversations with clients, not just those which require him to recall distant events. The defense team should be alert to client difficulties in staying focused. Attention and concentration problems can signal brain damage,[33] mental retardation,[34] post-traumatic stress disorder,[35] attention-deficit hyperactivity disorder,[36] fetal alcohol syndrome,[37] and other psychiatric problems.[38]

### Medical Complaints

A wide variety of medical complaints, including exaggerated concerns about health (hypochondria),[39] can signal mental impairment. (See Figure 4.) Wounds or "accidents" may actually reflect self-mutilation or suicide attempts.[40] Sleep problems (insomnia, nightmares, hypersomnia) can be a general psychiatric symptom[41] as well as a specific marker of brain damage[42] or post-traumatic stress disorder,[43] bipolar disorder and major depression.[44] Appetite changes can signal a variety

of mental problems as well.[45] Vision and hearing problems can also be signs of brain damage, as can headaches, dizziness, nausea and excessive tiredness.[46]

Defense team members should observe the client for signs of medical problems and routinely inquire into how he is feeling, sleeping and eating. These inquiries should be a consistent part of any interview, phone call or written correspondence with the client. In addition, counsel should teach the client to give notice whenever he is taken to a doctor, given lab tests or prescribed medications. Medical problems often have psychiatric components, side-effects and consequences. Thus, it is essential to any mental health evaluation to have knowledge of medical problems. Since many criminal defendants forget or fail to tell their lawyers about medical contacts, a request for records should be made to jail or prison authorities at regular intervals.

### Emotional Tone

The emotions of the client can also be signals to underlying mental problems. (See Figure 6.) During any interview and in correspondence from the client, the defense team should look for signs of worry, mistrust, sorrow, irritability and impatience. Each of these can be clues to several types of mental illness[47] as well as brain damage.[48] Excessive unhappiness is common in those with fetal alcohol syndrome.[49]

Counsel's attention should also be directed to the general tone of the client's emotions. Notice whether he tends to have heightened, extreme emotions (excitement), flat or near absence of emotions (flat affect) or suddenly changing emotions (emotional stability). These can be general psychiatric signs[50] as well as specific clues to brain dysfunction,[51] post-traumatic stress disorder and schizophrenia.[52]

Finally, one of the most disturbing emotional responses (at least to the lay public) is inappropriate laughing. Counsel needs to understand that clients who laugh while discussing what happened to the victim or how they were victimized themselves by child abuse, for example, are exhibiting signs of mental impairment. A mental health expert with a thorough medical and social history, reports of careful observation, and their own clinical observation and testing results can properly analyze this behavior.

### Personal Insight

The inability of the client to accurately appraise himself may offer other clues to mental illness[53] as well as brain damage,[54] and mental retardation.[55] (See Figure 6.) These problems can be seen as feelings of low self-esteem[56] or inflated, exaggerated ratings of personal ability. The client can also signal underlying problems with unrealistic goals which fail to take into account any disabilities. This will often show up during conversations about future plans.

A final problem in this area is denial of any mental impairment even after poor performance on formal testing. One of the most difficult conversations with clients comes after psychological testing, when they push to know the results. When they are informed they are brain damaged or mentally retarded, they often refuse to accept that, claiming errors in testing, or they feel devastated and vow to work harder to improve. It seems ironic that the lay public assumes criminal defendants malinger and manufacture mental problems when, in fact, they more typically work hard to hide them.

### Problem Solving

One of the ways counsel can assess personal insight problems is to weigh the client's self- assessment against his problem solving skills. (See Figure 6.) Difficulties with planning, organizing, quick thinking and predicting consequences not only may show exaggeration of abilities but also a variety of serious mental problems,[57] including, but not limited to brain damage,[58] mental retardation,[59] and attention-deficit hyperactivity disorder.[60] Clients who are easily frustrated[61] or who fail to learn from their mistakes[62] are also giving clues to possible mental illness, brain damage and mental retardation.

### Physical Activity

Observation by counsel of the client's physical activity level will also be helpful to the mental health expert. (See Figure 7.) Restless, fidgety, overly talkative behavior (agitation) as well as unusually quick reactions, can be a general sign of mental impairment[63] and a specific indicator of attention-deficit hyperactivity disorder.[64] The client who is hyper-alert to everything happening in the room, who constantly checks behind and around himself, may be exhibiting hypervigilance, a sign of post-traumatic stress disorder.[65]

Slowness can also signal problems. Slow movements and slow speech (psychomotor retardation) as well as slow reactions can be both a general psychiatric sign,[66] as well as a marker of brain damage.[67]

Balance,[68] gait, and coordination problems[69] should also be noted. One of the most obvious times to assess balance and coordination is when the client is entering and leaving an interview. Take the opportunity to watch how he walks as he approaches and exits, how he handles himself as he sits down and stands up. Fine motor coordination problems are another marker of brain impairment. Counsel should watch how the client handles fine motor tasks such as picking up small objects, turning pages, and opening food wrappers.

Another physical signal may come from the tension shown in the clients face or his posture.[70] The defense team should note whether the client is physically relaxed or stiff in appearance and, if tense, whether that is a stable physical characteristic or comes on during sensitive discussions.

### Interactions with Others

A final arena of important observations by the legal team is the client's interactions with others. Routine inquiry should be made regarding any visitors or correspondents. This is important to monitor not only as a way of tracking potential witnesses but also as a way of assessing social isolation, a signal of mental problems including depression, prior child abuse and post-traumatic stress disorder[71] and schizophrenia.[72] Similarly, one should always ask about whether the client is going out to the exercise yard or taking part in other physical, educational, religious, or craft activities in the institution. Find out how it is that he structures his free time. Lack of interest in activities can signal bipolar disorder, major depression, post-traumatic stress disorder as well as schizophrenia.[73]

Sometimes counsel has the chance to meet with the client in an open visiting room with other inmates and their visitors. This is an opportunity to notice whether the client fails to socially interact or is awkward or inappropriate with other inmates or staff. These signals can be clues to a variety of problems[74] including depression, attention-deficit hyperactivity disorder[75] and fetal alcohol syndrome.[76]

Women lawyers and investigators may run into distressing social interaction problems with their clients who make inappropriate sexual or intimate remarks or gestures. This behavior is dangerous to the professional relationship because of the resentment it may prompt as well as the misperception it may create for the custodial or prosecutorial staff. Thus, lines must be clearly drawn in order to curb the behavior. Yet while struggling for the appropriate way to curb the problem, one should not lose sight of this further signal of the client's mental impairment.[77] The disinhibition reflected in such actions should be distinguished from being a "jerk." Instead it shows his inability to comprehend social convention.

### Conclusion

Defense counsel, mitigation specialists, and investigators have probably always noted the most glaring signs of mental problems, such as spontaneous reports of hallucinations and obvious delusions or false beliefs. However, counsel can also gather a host of more subtle but critical data by learning to notice aberrations in the client's speech and language functions, his memory and attention deficits, as well as the pattern and content of his medical complaints. Also, clues to mental problems can be noted in the client's emotional tone and his insight and problem solving skills, as well as his physical activity and social interactions. Each of these areas should be monitored by the defense team so that when the time comes for a mental health evaluation, these observations, as well as a thorough medical and social history, can be provided to the experts.

### FOOTNOTES

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**Reality Confusion**

| **Signs** | **Scientific Name** |
|---|---|
| Reports hallucinations<br>- Hearing voices<br>- Seeing things (people, objects, unformed images such as flashes of light)<br>- Smelling things not there<br>- Tactile (feelings of being touched by someone/something not there)<br>- Gustatory (false perception of taste) | Hallucinations |
| Misperceives harmless image as being threatening | Illusions |
| Irrational fears, *i.e.*, leaving his cell, heights, spiders, snakes | Phobias |
| Seems confused about people or surroundings | Disorientation |
| Consistent false beliefs, *i.e.*:<br>- Lawyers out to get him<br>- Guard/another person in love with him<br>- Food being poisoned<br>- Being controlled by outside forces<br>- Others are talking about him | Delusions |

*Figure 1*

## Speech and Language

| Signs | Scientific Names |
|---|---|
| **Nonsensical Speech** | |
| - Speech which is incoherent at times | Word salad: incoherence |
| - Use of new word formance (not slang) | Neologisms |
| Use of "non-words" | |
| - Use of non-sequiturs | Illogicality |
| Conclusions based on faulty premises | |
| **Half Answers** | |
| - Brief, unelaborated answers to questions | Poverty of speech |
| - Monosyllabic answers to questions | Poverty of thought |
| - Language tends to be vague, repetitive, stereotyped | Poverty of content of speech |
| - Answers are lengthy but actual information is little | Poverty of thought |
| - Speech seems like "empty philosophizing" | |
| **Off Track** | |
| - Changes subject in the middle of a sentence in response to another stimulus | Distractible Speech |
| - Answers questions in an oblique or irrelevant way | Tangentially |
| - Pattern of speech seems "disjointed" | Derailment |
| - Ideas slip gradually off-track from one oblique thought to another | |
| - Speech pattern which is circuitous, indirect or delayed in reaching its goal | Circumstantially |
| - Includes many tedious details | |
| - Seems "long-winded" | |
| - Requires that you interrupt in order to finish business | |
| - Starts on one subject, then wanders away and never returns | Loss of goal |
| - Persistent, inappropriate repetition of words, ideas or subjects once the discussion begins | Persaveration |
| **Rapid Speech** | |
| - Talks rapidly and is hard to interrupt | Pressure of speech |
| - Sentences left unfinished because of eagerness to move on | |
| - Continues talking even when interrupted | |
| - Often speaks loudly and emphatically | |
| - Talks too much and interrupts others | |
| **Delayed or Interrupted Speech** | |
| - Speech is very slow | |
| - Excessive wait before answering or responding | Psychomotor Retardation |
| - Difficulty finding right word to use | Verbal Fluency |
| - Stops in the middle of a thought and after some silence cannot remember what he was talking about | Blocking |
| - Serve his "mind went blank" | |
| **Sound-Related Problems** | |
| - Recognizable mispronunciations | Paraphasia |
| - Substitution of inappropriate word | |
| - Slurred speech | Dysarthria |
| - Speaks in a monotone even when discussing emotional material | Aprosody |
| - Talks in excessively formal or stilted way | Stilted speech |
| - Language may appear "quaint or outdated" | |
| **Other Language Problems** | |
| - Writing is very small | Micrographia |
| - Writing is prolific | Hypergraphia |
| - Has trouble reading | Dyslexia |
| Spells poorly | |

*Figure 2*

**Memory and Attention**

| Signs | Scientific Names |
|---|---|
| ♦ Has trouble remembering childhood data | Amnesia: remote memory |
| ♦ Has trouble recalling things that happened in past few months | Amnesia: recent past memory |
| ♦ Has trouble remembering things in last few days | Amnesia: recent memory |
| ♦ Has trouble recalling events surrounding crime or trial | |
| ♦ Has trouble remembering people's names | |
| ♦ Reports "memories" which do not correspond to documentation Seems to "fill in" details of faulty memory | Confabulation |
| ♦ Sometimes appears to be "lying" about events in his life or events surrounding crime | |
| ♦ Has extraordinary ability to recall | Hypoamnesia |
| ♦ Problems concentrating | Distractibility: limited attention span |
| ♦ Attention drawn to irrelevant or unimportant stimuli | |
| ♦ Loses train of thought | |
| ♦ Problems with attention and concentration on emotionally-charged issues | Selective inattention |

*Figure 3*

**Medical Complaints**

| Signs | Scientific Names |
|---|---|
| ♦ Exaggerated concern over health | Hypochondria |
| ♦ Self-wounds or wounds suspicious in origin | Self-Mutilation |
| ♦ "Accidents" | |
| ♦ Difficulty falling asleep | Insomnia |
| ♦ Difficulty staying asleep | |
| ♦ Excessive sleeping | Hypersomnia |
| ♦ Change in eating habits | |
| ♦ Loss or decrease in appetite | Anorexia |
| ♦ Blurred vision | |
| ♦ Need to squint or move closer when reading | |
| ♦ Hearing problems | |
| ♦ Ringing in ears | Tinnitus |
| ♦ Headaches | |
| ♦ Dizziness | Syncope |
| ♦ Nausea | |
| ♦ Excessive tiredness | |

*Figure 4*

**Emotional Tone**

| Signs | Scientific Names |
|---|---|
| ♦ Worry, fear, over concern for present or future | Anxiety |
| ♦ Mistrust, belief others harbor malicious or discriminatory intent | Suspiciousness |
| ♦ Sorrow, sadness, despondency, passimism | Depressive mood |
| ♦ Irritability, belligerence, disdain for others, defiance | Hostility, irritability |
| ♦ Impatience | |
| ♦ Extreme, heightened emotions | Excitement |
| ♦ Flatness in emotional tone, near absence of emotional expression | Blunted effect, flat effect |
| ♦ Sudden changes in mood which are disproportionate to situation | Emotional liability |
| ♦ Inappropriate laughter | |

*Figure 5*

**Personal Insight and Problem Solving**

| Signs | Scientific Names |
|---|---|
| ♦ Low self-esteem | |
| ♦ Exaggerated self-opinion | |
| ♦ Overrates level of ability | |
| ♦ Unrealistic goals: failure to take disabilities into account | |
| ♦ Denial of mental problems | Anosognosia |
| ♦ Difficulty planning ahead | |
| ♦ Poorly organized | |
| ♦ Difficulty thinking as quickly as needed | |
| ♦ Difficulty changing a plan or activity when necessary | |
| ♦ Difficulty in accurately predicting consequences | |
| ♦ Easily frustrated | |
| ♦ Impaired ability to learn from mistakes | |

Figure 6

**Physical Activity**

| Signs | Scientific Names |
|---|---|
| ♦ Restlessness | Agitation |
| Fidgety | |
| Kicks leg often/moves arms around a lot | |
| Overly talkative | |
| ♦ Unusually quick reactions | |
| ♦ Hyper-alert to what is happening in visiting room: constantly looking around, checking behind himself | Hypervigilance |
| ♦ Slow movement, slow speech | Psychomotor retardation |
| ♦ Slow reaction in movements or while answering questions | |
| ♦ Balance problems | |
| ♦ Clumsiness, poor coordination | |
| ♦ Tense posture and/or facial expression | |

*Figure 7*

**Interactions with Others**

| Signs | Scientific Names |
|---|---|
| ♦ Unresponsive family | Social isolation |
| ♦ No regular visitors or letters from others | Feelings of detachment or estrangement |
| ♦ No participation in yard activities | Socially withdrawn |
| ♦ Discontinuation of yard activities | Markedly diminished interest in significant activities |
| ♦ Lack of social greetings to fellow inmates in visiting room | Social isolation<br>Unpopular |
| ♦ Awkward or inappropriate interactions with others in visiting room | Difficulty perceiving social cues |
| ♦ Willingness to "go along with" or cooperate in almost any way | Suggestibility |
| ♦ Deficiency in relating to others: lack of spontaneous interaction | Emotional withdrawal |
| ♦ Socially inappropriate comments and/or actions (including sexual or aggressive) | Disinhibition |
| ♦ Trouble understanding that some of his behavior is inappropriate | |

*Figure 8*

# Chapter 20: Top Ten Tips for Interviewing Emotionally Disturbed Persons

**by Lynn Geurin**

1. PHYSICAL OBSERVATIONS: (MENTAL STATUS EXAM)
   - Affect
   - Body movement
   - Facial structure
   - Physical appearance
   - Mood

2. DON'T BE AFRAID TO ASK:
   - Ask sensitive questions, *i.e.*: abuse, suicide, etc.

3. THOROUGH HISTORY TAKING: (See handout by Robert Walker, LCSW)
   - Familial
   - Past mental health services
   - Substance abuse
   - Victimization

4. IMPORTANCE OF RELATIONSHIPS:
   - Explore personality disorders
   - Categorize as an "order giver, order taker"

5. TIME FRAMES:
   - Differentiate between chronic and acute
   - Genealogy and Timeline

6. DON'T BE FOOLED BY YOUR CLIENT
   - Clients with Mental Illness will minimize
   - Be aware of malingering

7. GATHER INFORMATION ABOUT COLLATERAL SOURCES:
   - Client with MI may not tell an accurate story
   - Mitigating factors
   - Thorough investigation
   - Psychosocial history

8. ALLOW CLIENT TO EXPLAIN EFFECTS OF HIS OWN EMOTIONAL PROBLEM
   - Projection of blame
   - Treatment
   - Distorted thoughts

9. FOLLOW YOUR INSTINCT
   - Consultation with experienced attorney
   - Consulting Experts

10. DON'T IMMEDIATELY ASSUME ANTI-SOCIAL P.D. OR NO MENTAL HEALTH DEFENSE

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# Chapter 21: Book Review: Comprehensive Textbook of Psychiatry VI

Williams & Wilkins Co., Baltimore, 1995
Kaplan, H.I. & Sadock, B.J.

**Reviewed by Douglas D. Ruth**

There's something about a book with a white cover that invites reading, as if the reader expects that, not just the binding, but the content itself will be lighter. The crisp, white covers with red lettering, boasting the color illustration of a SPECT brain image super-imposed upon an MRI scan - the Lexus of neuroanatomic imaging - imply that the *Comprehensive Textbook of Psychiatry*, sixth edition will be entertaining as well as timely. Once the books are opened, the layout further visually encourages reading. Illustrations, tables, graphs, changes in font size, or bold subheadings break up the blocks of text on every page.

Data on functional brain imaging currently make a good index of the recency of published neuro-psychiatric material. Several pages of color plates of PET and SPECT scans start educating the reader before page 1. Close by, a section entitled "Principles of Neuroimaging" in the first chapter, "Neural Sciences," explains the physical principles underlying these diagnostic investigations. In the next chapter, the section "Neuroimaging in Clinical Practice" patiently details the expected findings of CT, MRI, and functional neuroimaging studies such as SPECT scans in stages of psychiatric and neurological disorders. The compulsive researcher who demands even more data or the clinician who skips the basic science chapters and begins reading in the more clinically oriented topics will find even more material. "Schizophrenia: Brain Structure and Functions," a subchapter under Schizophrenia," explains the research and clinical imaging findings in schizophrenia, and illustrates the brains of schizophrenics compared to the brains of their non- afflicted identical twins, for example.

To write for such a disparate audience as psychiatrists must be daunting. The contributors, numbering some 300, plotted two paths in order to satisfy such a variety of interests: providing an encyclopedic text of adequate breadth and depth and discussing the contributions from each subspecialty and school of thought in psychiatry.

The scope of these two volumes is so broad that the psychiatrist, or any mental health professional, can find adequate material to update himself in practically any related subject. A consultation psychiatrist, for example, will find drawings of organ transplantations and will read about the behavioral side effects of immuno-suppressant drugs used in such surgery.

Information is layered in such depth that an academician can prepare entire lectures from the two volumes, saving time he would otherwise spend challenging the maze of the medical center library or driving his modem through the electronic data bases.

In addition to clinical sections devoted to disease entities, chapters and subchapters are dedicated to the interests of subspecialties such as geropsychiatry, child psychiatry, addictionology, and others. Further, devotees to different schools of thought or disciplines, such as psychoanalysis or psychopharmacology, will find chapters addressing their basic theories. Psychoanalysts will be pleased with their own chapter of 55 pages, including no fewer then 7 photographs of Freud.

Then, as each illness is discussed, the theories that each school of thought has contributed to the etiology, pathology, and treatment are presented. Mental health professionals of all disciplines will find this edition a rich resource and will readily make room on their shelves by tossing out several books of more narrow scope, now unneeded.

Forensic psychiatry seems curiously under-weighted in these volumes. Only one chapter of 28 pages is nominally assigned to the subject. Fortunately, it is authored by Thomas Gutheil whose lively and concise writing style and capacity to preserve clinical judgment as focus moves into the courtroom give us great value per line of print in this brief chapter. The brevity forces him to focus on issues that are urgent for most practicing psychiatrists, such as consent, confidentiality, commitment, and malpractice - treatment related matters. The consultative work of the forensic psychiatrist enjoys less attention.

An attorney, especially one experienced in malpractice litigation, might be discouraged to find these scant pages tucked near the back cover as if an afterthought. But a wealth of information that is of value to the forensic assessment is scattered throughout the two volumes. The neuroimaging devices referred to above, for instance, are often used to assess head trauma in personal injury or worker's compensation conflicts and to assess mental illness in addressing criminal responsibility and competence. The phenomenon of behavioral disinhibition from benzodiazepines, presented by the defense as a mitigating factor, is described.

While on the subject of drug abuse, one will be amused to read that the official policy in Singapore is to allow abrupt, or "cold turkey," withdrawal from opiates, since the discomfort is viewed as a deferent to relapse. Photographs of the "skin popper," with countless sores and scars from drug injections, and the heroin addict who is puffing out her cheeks in order to distend the jugular vein to a size that would accommodate a needle, chill the reader.

Descriptions of psychiatric symptoms, psychiatric rating scales, and neuropsychological testing are detailed enough to help the lawyer assess the appropriateness of his expert witness's report. Specific drugs indicated for psychiatric disorders are described, including usual doses, side effects, and even potential drug interactions, providing the attorney with insight into his client's psychiatric treatment.

Annoying proofreading errors seem to be the principal fault of this textbook. An explanation of benzodiazepine intoxication ends abruptly in mid sentence, leaving the puzzled reader flipping pages to see if it might surface later. The word "within" was misprinted as "without," sneaked through the spellchecker in disguise, and tried to reverse the meaning of a sentence. Various authors paraphrased or even repeated comments in consecutive sentences. On occasion a phrase or even half a paragraph was so jumbled as to defy comprehension.

But the reader forgives such flaws in a book with such an attractive cover, enticing layout, and rich content.

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# Chapter 22: Diagnostic and Statistical Manual of Mental Fourth Edition (DSM-IV)

## American Psychiatric Press, Washington, D.C.; May 1994 - $54.00

**by William D. Weitzel**

### DSM-IV: Psychiatry's Course Correction

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* was published for the first time in May of 1994. It will become the contemporary nosological text in January of 1995 after the *International Classification of Diseases-9-Clinical Modification (ICD-9-CM)* has been updated in October of 1994 and subsequently published by the US Department of Health and Human Services. The ICD-9-Manual is a product of the World Health Organization (W.H.O.). The Clinical Modification variation is a product of the U.S. Government. DSM-IV had been planned for release in tandem with ICD-10 which was published by the W.H.O. in 1993. However, for a variety of reasons involving many organizations, including many data collection/keeping entities which must change coding and gear up for automated processing with new codes, it is unlikely that ICD-10 will be used in the United States before the end of this decade.

There has always been a need to organize medical classifications into a diagnostic scheme so that individuals with mental and physical ids-orders can be identified and treated. The first time the W.H.O. presented a Classification of Mental Disorders was in the volume *International Classification of Diseases-6 (ICD-6)* which was published in 1948. The first time the American Psychiatric Association published a *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* was in 1952 and at that time 106 diagnostic categories were identified. ICD-8 was published in 1968 as was DSM-II and at that time there were 182 different diagnostic categories described in this latter American Psychiatric Association publication.

In 1980 ICD-9 and DSM-III were published simultaneously and in a fashion that permitted a "crosswalk" between each of these diagnostic manuals. DSM-III included 265 diagnostic categories and represented a radical shift in how psychiatric diagnoses were conceptualized. The paradigm shift included an emphasis on diagnostic criteria that were meant to be neutral with regard to etiology and usable across the many different theoretical orientations in American psychiatry. The outcome of these explicit diagnostic criteria and the multiaxial diagnostic system introduced at that time improved on the record of poor diagnostic reliability of the previous DSM systems and helped clinical communication and research. The result was that studies were able to show that different psychiatrists using the new DSM classification system in evaluating the same patient agreed on the diagnosis 80% of the time. This is a high level of diagnostic reliability and comparable to that for many other medical illnesses.

DSM-III-R was published by the American Psychiatric Association in 1987. This volume was meant to correct inconsistencies found in the DSM-III and to include new evidence for diagnostic criteria. DSM-III-R expanded the number of different diagnostic categories to 296. DSM-III-R defined diagnoses even more clearly but involved few exclusionary hierarchies - in other words, it was more difficult to render differential diagnoses and to describe an individual with only one or two psychiatric diagnoses. Multiple diagnoses were encouraged for the same individual and the concepts of comorbidity and dual diagnoses were embraced. The trend towards inclusion of less severely ill patients into the diagnostic schema had become manifest and the diagnostic criteria had become more inclusive rather than exclusive.

An American Psychiatric Association Task Force for DSM-IV was appointed in May of 1988 after it had become clear from the early drafts of the W.H.O. ICD-10 scheduled for publication in 1993 that there were real differences from DSM-III-R and the ICD-9 Section on Mental Disorders. Since the United States is bound by a treaty obligation to make it's diagnostic coding and descriptions for the various and many medical disorders coincide with those used in the W.H.O. *International Classification of Diseases Manual*, something had to be done in terms of the dissonance. The solution was DSM-IV.

A 27 member Task Force worked five years to develop the DSM-IV manual in a process that involved more than 1,000 psychiatrists and other mental health professionals. The Task Force on DSM-IV was divided into 13 different work groups involving 5 or 6 members who drew on the expertise of between 50-100 advisors. The development of DSM-IV involved 3 empirical steps:

1) One hundred fifty reviews of the scientific literature were accomplished by the end of 1989 to obtain an empirical data base for decision making;
2) Individuals of each work group then focused on specific issues unanswered by the literature reviews and drew upon the resources of unpublished data sets. The reanalysis of 50 separate sets of data were used to obtain additional information and this was accomplished by mid-1990.
3) The Field Trials took place from 1991 through 1993. This project was carried out at a total of 88 universities and research institutions in the United States and abroad involving more than 7,000 subjects and evaluated the utility of various possible diagnostic criteria sets and dealt with difficult questions associated with differential diagnoses. Each of the Twelve Field Trials focused on criteria related to a single disorder such as Post Traumatic Stress Disorder or Somatization Disorder or else on a group of disorders such as Autism and the Pervasive Developmental Disorders. In each Field Trial information was collected on the perfor-

mance (*i.e.*, reliability, face validity, coverage, goodness of fit) of diagnostic criteria used in DSM-III, DSM-III-R, the research criteria being developed for the 10th Edition of the *International Classification of Diseases* (ICD-10), and the criteria sets proposed for DSM-IV.

The goal involved the creation of a common language for mental health clinicians and researchers to communicate about mental illness. The major methodological innovation of DSM-IV was the effort to move beyond expert consensus (DSM-III) and place greater emphasis on careful and objective accumulation of empirical evidence from available research data through a systematic and explicit process which was constructed and documented.

The 13 topical Work Groups of the DSM-IV Task Force included the subjects of:

1) Anxiety Disorders;
2) Childhood and Adolescent disorders;
3) Eating Disorders;
4) Late Luteal Dysphoric Disorder;
5) Mood Disorders;
6) Multiaxial Issues;
7) Organic Disorders;
8) Personality Disorders;
9) Psychiatric Interface Disorders;
10) Psychotic Disorders;
11) Sexual Disorders;
12) Sleep Disorders;
13) Substance Abuse Disorders.

The 12 Field Trials involved in the third empirical developmental step included:

1) Antisocial Personality Disorder;
2) Autism and Pervasive Developmental Disorders;
3) Disruptive Behavior Disorder;
4) Insomnia Disorder;
5) Major Depression and Dysthymia;
6) Mixed Anxiety-Depression;
7) Obsessive Compulsive Disorder;
8) Panic Disorder;
9) Post Traumatic Stress Disorder;
10) Schizophrenia and related Psychotic Disorders;
11) Somatization Disorder;
12) Substance Abuse Disorders.

DSM-III-R consisted of 567 pages and DSM-IV includes 886 pages. DSM-IV includes 290 diagnostic entities grouped by categories and sub-categories; DSM III-R included 296 categories. There were 13 diagnostic categories that were added, such as Acute Distress Disorder and Bipolar-II Disorder. There were eight diagnostic category deletions including Sadistic Personality Disorder and Passive Aggressive Personality Disorder. Some specific diagnoses were integrated such as Social Phobia disorder which now subsumes DSM-III-R Avoidant Disorder of Childhood. Some disorders previously existed in DSM-III-R but now are made more specific such as Mood Disorder due to a General Medical Condition and Substance Induced Mood Disorder. Both of these replace the terminology "Organic Mood Disorder" which was used in DSM-III-R. Each mental disorder entry contains a specific definition which incorporates a listing of objective signs and symptoms (criteria), possible physical and laboratory findings, epidemiological data, and information about possible links to other medical illnesses. These comprehensive entries enable clinicians to identify patients' illnesses with a high degree of reliability and confidence.

A five volume DSM-IV Source Book is being assembled which will elaborate on the research background for the DSM-IV manual along with commentary by the Work Groups that produced it. This effort will become an archival reference. The research findings specified prevalence, age of onset, and course of illness in far greater detail than earlier efforts. This book will provide a comprehensive resource for recommendations about needed future research.

The terminology "Organic" has been redacted from DSM-IV in an attempt to minimize the usage of an anachronistic concept of a mind-body dichotomy. This term has been eliminated because it incorrectly implied that other psychiatric disorders (not described as organic) did not have biological links.

The criteria for Post Traumatic Stress Disorder have been changed. The new Criterion A requires that an individual "has experienced, witnessed or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others and that the person's response to the stressor must involve intense fear, helplessness, or horror." A new criterion requiring that the symptoms cause clinically significant distress or impairment has been added. The previous criterion A that described the stressor as "outside the range of normal human experience" has been deleted because experience with clinical application proved to be unreliable and inaccurate.

Conservatism was the guiding principal. Many diagnostic categories were simplified while a quest for precision added distinctions and sub-types to many disorders. Separate sections for "Delirium, Dementia, and other Cognitive Disorders," "Substance-Related Disorders," and "Mental Disorders due to a General Medical Condition" have been created. There was an expansion of the Dementia section which added specific types including "Dementia due to HIV Disease." Attention to cultural factors has been emphasized in order to diminish misdiagnoses based on cultural misunderstandings. There is an Appendix on Culture-Specific Syndromes and most individual diagnoses have sections on specific cultures, age, and gender features. Recognition is also given to the finding that mental illness has changing patterns across the life span.

The authors have stressed that rather than being on the cutting edge of research, it was the intention that DSM-IV to be on the trailing edge. In other words, DSM-IV is following research and not initiating it.

Small changes in criteria, nomenclature ("Multiple Personality Disorder" becomes "Dissociative Identity Disorder," for example), sub-types, and organization were many. Examples and explanations are listed in the 20 page Appendix D - the new

"cross-walk" between DSM-III-R and DSM-IV. The most marked expansion was in the treatment of differential diagnoses. Criteria sets were abbreviated and simplified - notably for Somatization Disorder, Generalized Anxiety Disorder, Antisocial Personality Disorder and Schizophrenia (in ways that do not materially influence the number of patients so diagnosed).

Although the boundaries between the psychiatric disorders were left largely unaltered, particular attention was paid to "the boundary with normality." Therefore, descriptions of significant impairment or distress were made more explicit in the criteria sets. The defining presence of a mental disorder requires first of all, the criterion that the disorder cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning." DSM-IV was written for all mental health workers and it does not pontificate about which diagnoses are biomedically based and which are psychosocially based disorders. It is value neutral and descriptive.

The concept of mental disorder, like many other concepts in medical science, lacks a consistent operational definition which covers all situations. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress, (*e.g.*, a painful symptom) or disability (*i.e.*, impairment of one or more areas of functioning) or with a significant increased rate of suffering, death, pain, impairment or an important loss of freedom. In addition, the syndrome or pattern must not be readily anticipated or culturally sanctioned in response to a certain event, *e.g.*, the death of a loved one. Whatever the original stressor, the disorder must currently be considered a manifestation of behavioral, psychological, or biological dysfunction in the individual.

One important change involves the category of Somatoform Disorders. The common feature of the Somatoform Disorders is the presence of physical symptoms which suggest a general medical condition but which are not fully explained by the general medical condition alone, by the direct effects of a substance, or by another mental disorder. The subcategory Psychogenic Pain Disorder has been replaced by the term Pain Disorder. The essential feature of Pain Disorder is characterized by pain as the predominant focus of clinical attention (Criterion A). In addition, psychological facts are judged to have an important role in the onset, severity, exacerbation or maintenance of pain. A specific set of criteria for subtypes and specifiers are described. The three separate subtypes include 1) Pain associated with Psychological Factors; 2) Pain associated with both Psychological Factors and General Medical Condition; 3) and Pain Disorder associated with a General Medical Condition. The latter condition is not considered a mental disorder but is included for discussion in the spirit of completeness.

This attempt to deal in a straight-forward way with pain coincides with the decision by the American Medical Association (A.M.A.) to develop a specific chapter (Chapter 15) in the 1993 A.M.A. *Guides To The Evaluation of Permanent Impairment, (Fourth Edition)*. In the A.M.A. text it is stated that the Secretary of the US Department of Health and Human Services in 1985 formed a Commission on the Evaluation of Pain which concluded that chronic pain is not a psychiatric disorder. Despite that caveat, basic assumptions are elaborated and clinicians are subsequently encouraged to evaluate pain impairment although it is acknowledged in the text to be a difficult task.

Now with the sanction of the American Medical Association as portrayed in the 1993 A.M.A. *Guides* and with the blessing of the American Psychiatric Association (A.P.A.) through the 1994 DSM-IV, psychiatric clinicians will venture forth into what this writer considers a most uncertain area, pain assessment for purposes of determining degree of impairment. This writer anticipates that this subject will require the accumulation of experience and skill on the part of evaluators which will come only with time as both the 1993 A.M.A. *Guides* and the 1994 APA DSM-IV descriptions are applied to this topic. The concepts of reliability and validity will be sorely tested.

A common misconception is that a classification of mental disorders classifies people; whereas, what are actually being classified are disorders that people experience. Over one million copies of DSM-III and DSM-III-R were published. These two texts have been made available in 17 different languages. Now DSM-IV will provide the new clinical reference map with many coordinates that a careful reader will find illuminating, useful, and practical.

**Additional Reading:**


1) Weitzel WD: "DSM-IV: Gestation Report." *The Advocate*, April 1991; pp 43-45.
2) Pincus HA, Frances A, Davis WW, First MB, Whittaker TA: "DSM-IV and New Diagnostic Categories: Holding the Line on Proliferation." *Am.J. Psychiatry* 1992; 149:112-117.
3) First MB, Vettorello N, Frances AJ, Pincus HA: "Changes in Mood, Anxiety, and Personality Disorders." *Hospital and Community Psychiatry* 1993; 44: 1034-1036, 1043.
4) First MB, Allen JF, Pincus HA, Vettorello N, Davis WW: "Changes in Substance-Related, Schizophrenic, and Other Primarily Adult Disorders." *Hospital and Community Psychiatry* 1994; 45:18-20.
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# Chapter 23: DSM-IV Classification Summary

**by Lynn Geurin**

## I. DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE

A. **Mental Retardation:** The disorder is characterized by significantly sub-average intellectual functioning (An IQ of approximately 70 or below) with onset before age 18. Separate codes are provided for Mild, Moderate, Severe, and Profound and for MR severity unspecified.

B. **Learning Disorders:** These disorders are characterized by academic functioning that is substantially below that expected given the persons chronological age, measured intelligence, and age appropriate education. Types: Reading Disorder, Mathematic Disorder, Disorder of Written Expression, and Learning Disorder NOS.**

C. **Motor Skills Disorder:** This disorder is characterized by motor coordination that is substantially below that expected given the person's chronological age and measured intelligence. Type: Developmental Coordination Disorder

D. **Communication Disorders:** These disorders are characterized by difficulties in speech or language. Types: Expressive Language Disorder, Mixed Receptive-Expression Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS

E. **Pervasive Developmental Disorders:** These disorders are characterized by severe deficits and pervasive impairment in social interaction, communication, and presence of stereotyped behavior, interests, and activities. Types: Autistic Disorder, Retts' Disorder, Aspergers Disorder, NOS

**Attention-Deficit and Disruptive Behavior Disorders:** This section includes Attention Deficit/Hyperactivity

Disorder which is characterized by symptoms of hyperactivity, inattention, and impulsivity. Also, included are behavioral disorders, *i.e.*; Conduct Disorder, Oppositional Defiant Disorder, and NOS categories for both.

G. **Feeding and Eating Disorders of Infancy or Early Childhood:** These disorders are characterized by persistent disorders of feeding and eating. Types: Pica, Rumination Disorder, Feeding Disorder.

H. **Tic Disorders:** These disorders are characterized by vocal and/or motor tics. Types: Tourette's Disorder, Chronic Motor or Vocal Tic Disorder, and NOS.

I. **Elimination Disorders:** This category includes; Encopresis - the repeated passage of feces in inappropriate places, and Enuresis - passage of urine in inappropriate places.

J. **Other Disorders of Infancy, Childhood, or Adolescence:**

1. Separation Anxiety Disorder: developmentally inappropriate and excessive nervousness when separated from home or those to whom the child is attached.
2. Selective Mutism: consistent failure to speak in social situation despite speaking in other situations.
3. Reactive Disorder: disturbed and inappropriate social relatedness
4. Stereotypic Movement Disorder: repetitive, seemingly driven, motor behavior.
5. NOS Category

## II. DELIRIUM, DEMENTIA, AND AMNESTIC AND OTHER COGNITIVE DISORDERS

A) **Delirium:** disturbance of consciousness and a change in cognition that occurs over a short period of time. Types:

Delirium due to a general medical condition, Substance Induced Delirium, NOS

B. **Dementia:** multiple cognitive deficits that include memory impairment. Types: Dementia of the Alzheimer Type, Vascular Dementia, Dementia to Medical Condition (e.g.), Parkinson Disease, HIV, Substance Induced Dementia, NOS

C. **Amnestic Disorder:** Memory impairment without significant cognitive impairments. Types: Substance Induced Persisting Amnestic Disorder, NOS

D. **Cognitive Disorder NOS:**

1. Mild neurocognitive disorder
2. Post-concussional disorder

## III. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

**Psychotic defined*

A. **Schizophrenia:** a disturbance of at least 6 months of (2 or more of the following): delusions, hallucinations, disorganized speech, catatonic behavior, negative symptoms. Subtypes: Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual

B. **Schizophreniform Disorder:** Represented by the same symptomology of schizophrenia except for a shorted duration (1 to 6 months).

C. **Schizoaffective Disorder:** A disturbance of schizophrenia symptomology and mood symptoms occur together followed by at least 2 week of delusions or hallucinations without mood symptoms.

E. **Brief Psychotic Disorder:** A psychotic Disturbance that lasts more than 1 day and not more than 1 month.
**(delusions, hallucinations, disorganized speech, catatonic behavior)*

F. **Delusional Disorder:** Nonbizarre delusions of at least 1 month without active schizophrenia symptoms.

G. **Shared Psychotic Disorder:** A person who is influenced by someone with a delusion with similar content.
**delusional*

H. **Psychotic Disorder Due to a General Medical Condition**

I. **Substance Induced Psychotic Disorder**
**delusions or only those hallucinations not accompanied by insight*

**IV. MOOD DISORDERS**

A. **Major Depressive Disorder:** One or more major depressive episodes *i.e.*, depressed mood or loss of interest for at least 2 weeks with at least 4 other symptoms of depression.

B. **Dysthymic Disorder:** characterized by at least 2 years of depressed mood for more days than not.

C. **Bipolar I Disorder:** Episodes of mixed (manic and depressive) symp-tomology

D. **Bipolar II Disorder:** characterized by one or more depressive episodes and at least 1 hypomanic (euphoric or elevated mood lesser than manic) episode.

E. **Cyclothymic:** 2 years of hypomanic symptoms that do not meet the criteria for manic and numerous periods of depressive symptoms that do not meet the criteria for Major Depressive Episode.

F. **Bipolar NOS**

G. **Mood Disorder Due to a General Medical Condition**

H. **Substance Induced Mood Disorder**

I. **Mood Disorder NOS**

**V. ANXIETY DISORDERS**

A. **Panic Attack:** a sudden onset of intense apprehension, fearfulness, or terror with symptoms such as shortness of breath, palpitations, chest pain, choking or smothering sensation and fear of "going crazy."

B. **Agoraphobia:** Nervousness about or avoidance of places or situations from which escape might be difficult, and a tendency to want to stay home or where it is safe for them.

C. **Panic Disorder Without Agoraphobia:** recurrent unexpected panic attacks with persistent concern.

D. **Panic Disorder With Agoraphobia:** recurrent unexpected panic attacks with agoraphobia.

E. **Agoraphobia Without History of Panic Disorder:** the presence of agoraphobia without panic attacks.

F. **Specific Phobia:** extreme anxiety and nervousness provoked by exposure to a specific feared object or situation often leading to avoidant behavior, *e.g.*, fear of snakes.

G. **Social Phobia:** extreme anxiety and nervousness provoked by exposure to social or performance situations often leading to avoidant behavior.

H. **Obsessive-Compulsive Disorder:** Obsessions (persistent ideas, thoughts, impulses, or images that cause marked impairment or distress) and Compulsions (repetitive behaviors, *e.g.*, handwashing, checking or mental acts, *e.g.*, praying, counting).

I. **Posttraumatic Stress Disorder:** reexperiencing of an extremely traumatic event with symptoms of increased arousal and avoidance of stimuli associated with the trauma.

J. **Acute Stress Disorder:** symptoms similar to those experienced in Post-traumatic Stress Disorder that occur immediately after an extremely traumatic event.

K. **Generalized Anxiety Disorder:** characterized by at least 6 months of persistent and excessive anxiety and worry.

L. **Anxiety Due to a General Medi-cal Condition**

M. **Substance Induced Anxiety**

N. **Anxiety Disorder NOS**

## VI. SOMATOFORM DISORDERS

A. **Somatization Disorder:** A symptomatic disorder, beginning before at 30 with a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.

B. **Conversion Disorder:** symptoms affecting voluntary motor or sensory that suggest neurological or medical condition.

C. **Pain Disorder:** Pain is the predominant focus of clinical attention with psychological factors playing an important role.

D. **Hypochondriasis:** Preoccupation with the fear of having, or the idea that one has a serious disease.

E. **Body Dysmorphic Disorder:** preoccupation with an imagined or exaggerated personal appearance defect.

## VII. FACTITIOUS DISORDERS

Physical or psychological symptoms that are intentionally produced in order to assume the sick role.

## VIII. DISSOCIATIVE DISORDERS

A. **Dissociative amnesia:** inability to recall personal information due to a traumatic or stressful situation and too extensive to be explained by ordinary forgetfulness.

B) **Dissociative Fugue:** Confusion about one's past or identity and the assumption of a new identity, with sudden unexpected travel.

C. **Dissociative Identity Disorder** (previously Multiple Personality Disorder): The presence of two or more distance personalities that recurrently take control of a persons behavior, with the inability to recall important personal information.

D. **Depersonalization Disorder:** persistent feelings of being detached from one's body or mental processes.

E. **NOS**

## IX. SEXUAL AND GENDER IDENTITY DISORDERS

A. **Sexual Dysfunctions:** disturbance in sexual desire and cause stress and interpersonal problems.

B. **Paraphillias:** recurrent, intense sexual urges, fantasies, or behaviors, *e.g.*, Exhibitionism, voyeurism, pedophilia.

C. **Gender Identity Disorders:** strong and persistent cross-gender identification, and discomfort with one's own sex.

D. **NOS**

## X. EATING DISORDERS

A. **Anorexia Nervosa:** refusal to maintain a minimum body weigh

B. **Bulimia Nervosa:** repeated episode of excessive eating followed by behavior such as self-induced vomiting

## XI. SLEEP DISORDERS

A. **Primary Sleep Disorders:**

1. Dyssomnias: problems in the amount, quality, or timing of sleep
2. Parasomnias: abnormal behavior occurring while in sleep or sleep stages

C) **Sleep Disorder Related to Another Mental Disorder**

D) **Sleep Disorder Related to a General Medical Condition**

D. **Substance Induced Sleep Disorder**

## XII. IMPULSE CONTROL DISORDERS

A. **Intermittent Explosive Disorder:** discrete episodes of failure to resist aggressive impulses resulting in serious assaults or destruction of property.

B. **Kleptomania:** recurrent failure to resist impulses to steal objects not truly needed

C. **Pyromania:** a pattern of fire setting for pleasure, gratification, or relief of tension

D. **Pathological Gambling:** recurrent and persistent abnormality in gambling behavior

E. **Trichotillomania:** recurrent pulling out of one's hair for pleasure, gratification, or tension relief with noticeable hair loss.

F. **NOS**

## XIII. ADJUSTMENT DISORDERS:

A significant emotional or behavior problem in response to an identified stressor.

A. Adjustment Disorder with Depressed Mood
B. Adjustment Disorder with Anxious Mood
C. Adjustment Disorder with Mixed Anxiety and Depressed Mood
D. Adjustment Disorder with Disturbance of Conduct
E. Adjustment Disorder with Mixed Emotions and Conduct

## XIV. PERSONALITY DISORDERS

A. **Paranoid Personality Disorder:** a pattern of distrust and suspiciousness in interpreting others behaviors as harmful.

B. **Schizoid Personality Disorder:** a detachment from social relationships and a restricted range of expression or feeling.

C. **Schizotypal Personality Dis-order:** A pattern of painful discomfort in close relationships, thoughts, and eccentric behavior.

D. **Antisocial Personality Disorder:** A pattern of the disregard, and violation for the rights of others.

E. **Borderline Personality Disorder:** a pattern of unstable relationships with others, self image, expression, and impulsive behavior.

F. **Histrionic Personality Disorder:** a pattern of excessive emotionalness and attention seeking.

G. **Narcissistic Personality Disorder:** a pattern of grandiosity, need for admiration, and lack of empathy.

H. **Avoidant Personality Disorder:** a pattern of social withdrawal, feelings of being inadequate, and extremely sensitive to negative evaluation.

I. **Dependent Personality Disorder:** a pattern of submissive and clinging behavior with an excessive need to be taken care of.

J. **Obsessive-Compulsive Personality Disorder:** a pattern of preoccupation with orderliness, perfectionism, and control.

K. **NOS**

** Note: For Mental Disorders Due to a General Medical Condition and Substance Related Disorders see DSM-IV.*

*** NOS: Not Otherwise Specified*

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# Chapter 24: Global Assessment of Functioning (GAF) Scale

**by Lynn Geurin**

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code** (*Note*: Use intermediate codes when appropriate, *e.g.*, 45, 68, 72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | | 81 **Absent or minimal symptoms** (*e.g.*, mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (*e.g.*, an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (*e.g.*, difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (*e.g.*, temporarily falling behind in schoolwork).

70 | 61 **Some mild symptoms** (*e.g.*, depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (*e.g.*, occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (*e.g.*, flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (*e.g.*, few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (*e.g.*, suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (*e.g.*, no friends, unable to keep a job).

40 | | 31 **Some impairment in reality testing or communication** (*e.g.*, speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (*e.g.*, depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 | | 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment** (*e.g.*, sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (*e.g.*, stays in bed all day, no job, home, or friends)

20 | | 11 **Some danger of hurting self or others** (*e.g.*, suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (*e.g.*, smears feces) **OR gross impairment in communication** (*e.g.*, largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (*e.g.*, recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

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# Chapter 25: "But Doctor, Isn't That Just Your Opinion?"

## Contributing to the Decision-Making Process of the Forensic Psychologist as Expert Witness©

**by Eric Drogin & Curtis Barrett**

### Taking Charge and Giving Charges

In our last article for *The Advocate*[1], we asserted that:

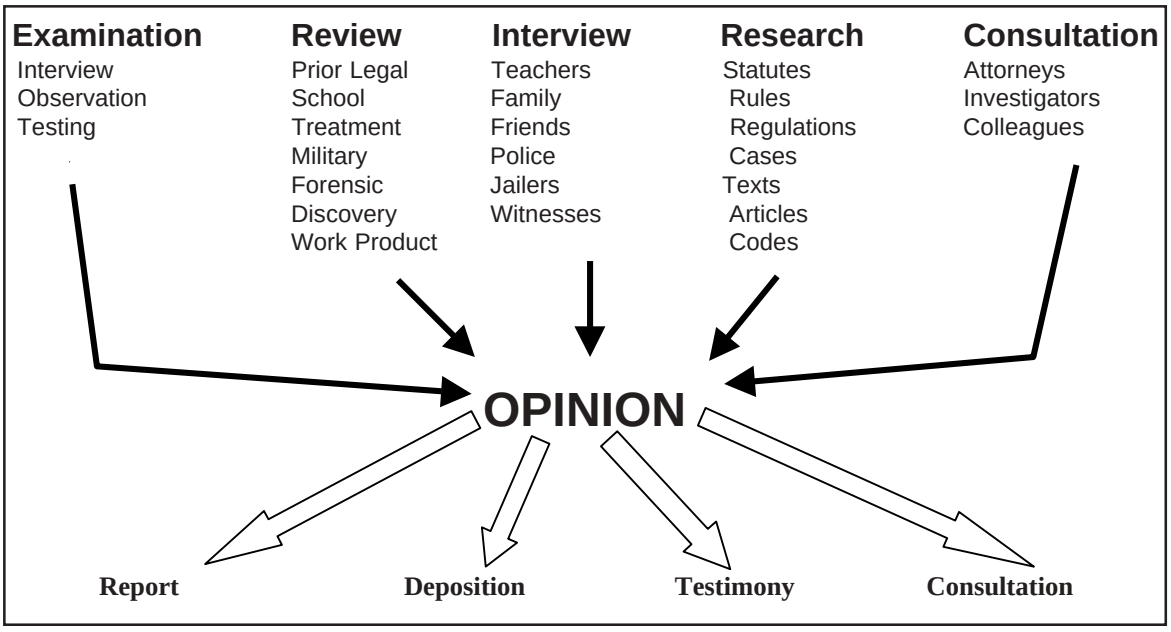
> The difference between the administration of a prescribed series of tests, and the ability to knit results from all sources of data into a responsive, compelling, persuasive, and ultimately convincing whole before the trier of fact, is the difference between the clinical psychologist who performs an *examination* and the forensic psychologist who conducts an *evaluation*.[2]
>
> The *evaluation*, however, is only the first of two steps in fulfilling the role of the forensic psychologist as expert mental health witness. The witness must first perform an evaluation, without bias, resulting in an *opinion*, and then must be prepared to *advocate* that opinion effectively within the overall context of the attorney's case presentation. As noted expert Dr. David Shapiro points out, "one should not consider oneself an advocate for the patient, for the defense, or for the government. One is an advocate only for one's own opinion."[3]

The process that leads to the construction of an expert opinion, and its advocacy in various contexts, can be viewed in the context of a series of "charges." Obviously, the defendant has been presented with "charges," or there would be no defendant. Ultimately, the attorney will be presented an itemized list of "charges" at the conclusion of the case, or quite likely there would be no expert.

What are often ignored are the "charges" with which the expert must be presented by the attorney at the inception of the expert's involvement in the proceedings. All too frequently, experts are merely asked to "perform an evaluation" of a defendant, with little if any additional guidance. Attorneys may focus exclusively on the contents of the forensic psychological report as a test of the adequacy of the expert's performance prior to testimony, without stopping to consider the need to influence the full scope of the expert's role in the construction and presentation of the attorney's overall theory of the case.

### From Evaluation to Opinion to Advocacy

The flow of the expert's transition from forensic evaluation to effective advocacy of an expert opinion can be depicted in the following fashion:



The confluence of data from various sources such as examination, review, interview, research, and consultation (category subheadings provide merely a few examples) informs the scientific basis for an expert opinion. Advised of that opinion, the attorney must then determine if the opinion is sufficiently favorable and/or informative to continue to the advocacy phase, with the expression of that opinion via report, testimony, and/or deposition. Regardless of whether expression of the opinion will be persuasive to the trier of fact, the attorney may benefit from additional consultation by the expert regarding such issues as direct and cross-examination, witness interviewing, *et cetera*.

The scope of the evaluation, and the quality and persuasiveness of the opinion it serves to generate, depends upon the ability of the attorney to provide the expert with the appropriate data in as timely a fashion as possible.

Attorneys often want to know what are the "required" components of the data sources that contribute to the expert opinion. The answer to that question really depends upon the interaction of a variety of factors which may include, among others, the reliability and validity of the data which *have* been obtained, the nature of the forensic issue(s) to be addressed, the current status of the defendant, and the skill, training, and experience of the evaluator.

For example, a recently and severely brain damaged defendant, incapable of coherent speech or any

understanding of verbal or written communication on the part of his attorney or anyone else, may be found incompetent to stand trial on the basis of thorough forensic clinical examinations, with a lesser degree of emphasis upon the contributory opinions of friends, family, and former teachers. Similarly, an opinion on the adequacy of an evaluation performed by another professional in the past may not require the testifying expert to perform an examination of that defendant some years later, as long as the conclusions provided are appropriately limited.

The adequacy and utility of the professional opinion is often most helpfully measured, not in binary terms of "adequate" versus "inadequate," or "competent" versus "incompetent," but rather in incremental terms regarding its potential for persuasiveness, and the degree to which it will withstand the rigors of cross- examination.

## Sources of Guidance

While there is no solitary, bottom-line reference which definitively and comprehensively states the necessary components of a competent forensic psychological evaluation and/or report, there are numerous sources of guidance upon which attorneys and forensic psychologists can draw.

*Ethics Codes and Guidelines* are aspirational state-ments which seek to guide the behavior of pro-fessionals belonging to the associations which promulgate them. Failure to adhere to an ethical code or guideline may lead to expulsion from professional societies, and even to criminal sanctions when compliance is mandated by the psychologist's state licensing statute.

The *Ethical Principles of Psychologists and Code of Conduct*[4] of the American Psychological Association (APA) contains many guidelines related to principles of psychological assessment, and in its most recent incarnation has included standards which pertain specifically to "Forensic Activities":

> **7.01 Professionalism**
> Psychologists who perform forensic functions, such as assessments, interviews, consultations, reports, or expert testimony, must comply with all other provisions of this Ethics Code to the extent that they apply to such activities. In addition, psychologists base their forensic work on appropriate knowledge and competence in the areas underlying such work, including specialized knowledge concerning special populations.
>
> **7.02 Forensic Assessments**
> [a] Psychologists' forensic assessments, recommendations, and reports are based on information and techniques (including personal interviews of the individual, when appropriate) sufficient to provide appropriate substantiation for their findings.
>
> [b] Except as noted in [c] below, psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions.
>
> [c] When, despite reasonable efforts, such an examination is not feasible, psychologists clarify the impact of their limited information on the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions or recommendations.
>
> **7.03 Clarification of Role**
> In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters. When psychologists may be called on to serve in more than one role in a legal proceeding - for example, as consultant or expert for one party or for the court and as a fact witness - they clarify role expectations and the extent of confidentiality in advance to the extent feasible, and thereafter as changes occur, in order to avoid compromising their professional judgment and objectivity and in order to avoid misleading others regarding their role.

**7.04 Truthfulness and Candor**
[a] In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and, consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions.

[b] Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.

**7.05 Prior Relationships**
A prior professional relationship with a party does not preclude psychologists from testifying as fact witnesses or from testifying to their services to the extent permitted by applicable law. Psychologists appropriately take into account ways in which the prior relationship might affect their professional objectivity or opinions and disclose the potential conflict to the relevant parties.

**7.06 Compliance with Law and Rules**
In performing forensic roles, psychologists are reasonably familiar with the rules governing their roles. Psychologists are aware of the occasionally competing demands placed on them by these principles and the requirements of the court system, and attempt to resolve these conflicts by making known their commitment to this Ethics Code and taking steps to resolve the conflict in a responsible manner.

While not adopted by the APA as a whole, the *Specialty Guidelines for Forensic Psychologists*[5] provide additional guidance regarding evaluation and report procedures, including the following:

**VI. Methods and Procedures**

[B] Forensic psychologists have an obligation to document and be prepared to make available, subject to court order or the rules of evidence, all data that form the basis for their evidence or services. The standard to be applied to such documentation or recording *anticipates* that the detail and quality of such documentation will be subject to reasonable judicial scrutiny; this standard is higher than the normative standard for general clinical practice...

[F3] When a forensic psychologist relies upon data or information gathered by others, the origins of those data are clarified in any professional product. In addition, the forensic psychologist bears a special responsibility to ensure that such data, if relied upon, were gathered in a manner standard for the profession...

**VII. Public and Professional Communications**

[E] Forensic psychologists, by virtue of their competence and rules of discovery, actively disclose all sources of information obtained in the course of their professional services; they actively disclose which information from which source was used in formulating a particular written product or oral testimony.

*Learned Treatises*, including texts and journal articles, are a fertile source of guidance for various authors' opinions on necessary elements of various forms of forensic psychological evaluation and/or report. For example, in his influential *The Psychologist as Expert Witness*[6], Dr. Theodore Blau outlined components which he felt must be covered in the psychologist's assessment of criminal responsibility (reproduced here in condensed fashion):

1. Events and Observations Concerning the Crime.

2. The Defendant's Recall.

3. Ancillary Sources.

4. Psychological Evaluation.
   a) A History from the Defendant.
   b) A History from the Family of the Defendant.
   c) Intellectual Evaluation.
   d) Neuropsychological Factors.
   e) Competency Evaluation.
   f) Reading Skills.
   g) Personality.
   h) Measures of Faking or Malingering.

5. The Report of Findings and Opinion.

   a) Retention Process.
   b) Facts of the Case and Sources.
   c) Defendants's Recollection of Events.
   d) Observations of Defendant's Behavior.
   e) Family History and Events of Significance.
   f) Tests and Procedures Used.
   g) Clinical Observations.
   h) Test Results.
   i) Summary of Current Psychological State.
   j) General Concordance of Facts and Results.
   k) Statement of Opinion.[7]

The *ABA Criminal Justice and Mental Health Standards*[8] were the product of several multi-disiciplinary teams, including psychiatrists, psychologists, attorneys, and others, who worked pursuant to a *MacArthur Foundation* grant to in-form the legal process about dealing with the defendants suffering from mental illness or mental retardation. The following is one representative standard, regarding assessment of competency to stand trial:

**Standard 7-4.5 Report of the Evaluator**

[a] The first matter to be addressed in the report should be the assessment of the defendant's competence to stand trial. If it is determined that the defendant is competent to stand trial, issues relating to treatment or habilitation should not be addressed. If it is determined that the defendant is incompetent to stand trial, or that the defendant is competent to stand trial but that continued competence is dependent upon maintenance of treatment or habilitation, the evaluator should then report on the treatment or habilitation necessary for the defendant to attain or maintain competence.

[b] If it is determined that treatment or habilitation is necessary for the defendant to attain or maintain competence, the report should address the following issues:

1) the condition causing the incompetence;

2) the treatment or habilitation required for the defendant to attain or maintain competence and an explanation of ap-propriate treatment alternatives in order of choice;

3) the availability of the various types of acceptable treatment or habilitation in the local geographical area. The evaluator should indicate the agencies or settings in which such treatment or habilitation might be obtained. Whenever the treatment or habilitation would be available in an outpatient setting, the evaluating expert should make such fact clear in the report;

4) the likelihood of the defendant's attaining competence under the treatment or habilitation and the probable duration of the treatment or habilitation.

[c] If the evaluating expert determines that the only appropriate treatment or habilitation would require that the defendant be taken into custody or involuntarily committed, then the report should include the following:

1) an analysis of whether the defendant, because of the condition causing mental incompetence, meets the criteria for in-voluntary civil commitment or placement set forth by law;

2) whether there is a substantial probability that the defendant will attain competence to stand trial within the reasonably foreseeable future;

3) the nature and probable duration of the treatment or habilitation required for the defendant to attain competence;

4) alternatives other than involuntary confinement which were considered by the evaluator and the reasons for the rejection of such alternatives.[9]

These *Standards* also address, in more general fashion, requirements for the overall content of forensic psychological reports:

**Standard 7-3.7**
**Preparation and contents of written reports of mental evaluations**

[b] Contents of the written report.

1) The written evaluation should ordinarily:

A) identify the specific matters referred for evaluation;

B) describe the procedures, tests, and techniques used by the evaluator;

C) state the evaluator's clinical findings and opinions on each matter referred for evaluation and indicate specifically those questions, if any, that could not be answered;

D) identify the sources of information and present the factual basis for the evaluator's clinical findings and opinions; and

E) present the reasoning by which the evaluator utilized the information to reach the clinical findings and opinions. The evaluator should express an opinion on a specific legal criterion or standard only if the opinion is within the scope of the evaluator's specialized knowledge.[10]

*Statutory Guidelines* may be limited in scope, but mandate key requirements that are often ignored by attorneys and not disclosed to expert witnesses. For example, in Kentucky, KRS 504.100 ("*Appointment by court of psychologist or psychiatrist during proceedings*") provides that:

(2) The report of the psychologist or psy-chiatrist shall state whether or not he finds the defendant incompetent to stand trial. If he finds the defendant is incompetent, the report shall state:

a) Whether there is a substantial probability of his attaining competency in the foreseeable future; and

b) What type treatment and what type treatment facility the examiner recommends.

We frequently review reports which provide a bottom-line opinion regarding competency, but fail to adhere to these additional requirements.

Sometimes, the issue is not *what* comprises the evaluation or report, but *who* is to perform or write them. According to KRS 504.016 ("Definitions for Chapter"), pertaining to competency to stand trial and criminal responsibility evaluations:

> (9) "Psychologist" means a person licensed at the doctoral level pursuant to KRS Chapter 319 who has been designated by the Kentucky Board of Examiners of Psychology as competent to perform examinations.

Both KRS 504.100 and KRS 504.070 ("*Evidence by defendant of mental illness or insanity; examination by psychologist or psychiatrist by court appointment; rebuttal by prosecution*") refer to the appointment of a "psychologist" to "examine, treat, and report on the defendant's mental condition." One frequently encounters criminal responsibility and competency to stand trial evaluations where reports are signed by a psychologist at the doctoral level and a psychological associate or certified psychologist at the master's level, and where it transpires that a substantial portion of the evaluation has been performed by the latter professional.

## Conclusions

There are many different routes to a professional opinion. The route taken will determine the credibility, persuasiveness, and generalizability of that opinion, in conjunction with the reputation and skill of the expert witness providing it. A wealth of resources including ethical codes and guidelines, learned treatises, and statutes contributes to the constantly shifting parameters of what are acceptable and/or necessary components of the forensic psychological evaluation and report. Attorneys will greatly enhance the quality of the professional opinions of their experts, to the extent that they provide those experts with the fullest possible range of data, and continue to discuss in a collegial fashion the evolving nature of forensic mental health sciences.

## Footnotes

[1]E. Drogin & C. Barrett, *Forensic Mental Health Assessment: Moving from Examination to Evaluation*, 18 *The Advocate* 129-133, (1996).
[2]*Id.* at 132.
[3]D. Shapiro, *Psychological Evaluation and Expert Testimony*, 77 (1984).
[4]American Psychological Association, *Ethical Principles of Psychology and Code of Conduct*, 47 Am. Psychologist 1597-1611 (1992).
[5]Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 *Law & Human Behavior* 655-65 (1991).
[6]T. Blau, *The Psychologist as Expert Witness* (1984).
[7]*Id.* at 91-93.
[8]American Bar Association Criminal Justice Standards Committee, *ABA Criminal Justice Mental Health Standards* (1989).
[9]*Id.* at 193-94.
[10]*Id.* at 109.

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> Do we admit the existence of opinion?
> Undoubtedly. Then I suppose that opinion appears to you to be darker than knowledge, but lighter than ignorance?
> Both; and in no small degree.
>
> - Plato
> *The Republic*, c.370 B.C.

# Chapter 26: Cross-Examining the Prosecution's Mental Health Expert

By Kelly Gleason & Robert Harp

## I. AVOIDING THE CROSS

Before the issues of cross-examining the prosecutor's mental health expert are addressed, consider the possibility of avoiding the necessity of a cross altogether.

### A. Co-opting the state's expert

Depending upon who the expert is and the facts of your case, you may decide to assist the state's expert by providing information to the expert to insure an accurate, well-informed diagnosis and avoid a finding of competency or sanity. Before making this decision research the expert.

- Talk with attorneys who have dealt with the expert in the past and ask about their experiences and if they have heard anything about other cases. Talk with experts who are familiar with the state's expert.
- Does the expert have a reputation as a hired gun for prosecutors?
- Is the expert open to working with defense attorneys?
- In how many cases has the expert testified? What was the outcome?
- What is the expert's reputation among fellow psychologists or psychiatrists?
- Has the expert ever found anyone incompetent to stand trial or insane at the time of the offense?
- Has the expert worked with your prosecutor in the past?

This approach may be risky, but even if an incompetency or insanity determination does not ultimately result, there may be benefits to the defense. For instance, the state expert may validate information which is crucial to your case before the jury. The expert may be a tremendous help in the sentencing or penalty phase, despite an unfavorable competency/ sanity finding, or even support an extreme emotional disturbance or intoxication defense. Think about the theory of the case before making this decision and about what you can realistically expect from the state's expert, given the information which you have obtained about the expert, the facts of the case, and your client's background and current mental state.

### B. Precluding the state expert's testimony

There may be grounds for a motion to preclude the expert's testimony or part of the expert's testimony for several reasons. Some possible grounds follow:

**1. The expert is attempting to testify to the ultimate issue.** *See, e.g., Kentucky Evidence Law Handbook,* 2nd Ed., Robert Lawson, §§6.15 and 6.20. Kentucky caselaw disallows testimony concerning the specific state of mind of a person at a particular time and place. *Commonwealth v. Rose,* 725 S.W.2d 588 (Ky. 1987); *Pendleton v. Commonwealth,* 685 S.W.2d 549 (Ky. 1985). The Federal Rules of Evidence, Rule 704 prohibits expert testimony on the ultimate issue of sanity in a criminal case. In addition, there is great controversy in general regarding the use of expert mental health testimony in criminal cases and a body of literature which may be helpful for a motion to preclude. *See,* e*.g., Coping with Psychiatric Testimony* by Ziskin.

**2. The expert is attempting to testify regarding a particular matter beyond the scope of his/her expertise.** The "expert" may not possess the academic or clinical background to qualify as an expert. The expert may be qualified to testify to some matters but not to others or may be incapable of reaching a reliable conclusion as to a particular matter. For example, testimony regarding future dangerousness of the accused is recognized as highly unreliable by the profession and even by some courts. *See, e.g., Redmen v. State,* 828 P.2d 395, 400 (Nev. 1992) ("In our view, psychiatric evidence purporting to predict the future dangerousness of a defendant is highly unreliable and, therefore, inadmissible at death penalty sentencing hearings.")

**3. The expert may lack sufficient foundation to testify.** KRE 703. It is not uncommon for experts to perform cursory examinations and some courts have refused to credit testimony based on shabby practices. *State v. Bennett,* 345 So.2d 1129, 1138 (La. 1977) (Evaluation was inadequate and conclusory assertions of competency were entitled to little weight since state clinicians lacked supporting data); *State v. Champagne,* 497 A.2d 1242, 1246 (N.H. 1985) (Competency finding set aside and the appellate court determined that the state expert's testimony was "undermined by his limited contact with the defendant and his failure to probe beyond the surface of the defendant's mental awareness."). Admission of expert testimony without sufficient foundation presumably would violate the accused's due process rights. *See, e.g., Drope v. Missouri,* 95 S.Ct. 896, 904 (1973) ("...the failure to observe procedures adequate to protect a defendant's right not to be tried or convicted while incompetent to stand trial deprives him of his due process right to a fair trial.")

**4. The expert's testimony may be inadmissible due to a violation of the prosecutor's discovery obligations.** RCr 7.24 (including "results or reports of physical or mental examinations" and oral or written incriminating statements). Discovery violations may also violate the accused's rights to due process, a fair trial, confrontation, and effective assistance of counsel.

**5. The expert's evaluation may be inadmissible as the result of a violation of the defendant's Fifth Amendment privilege against self-incrimination and/or the Sixth Amendment right to counsel (and Section 11 of the Ky. Constitution).** *See, e.g., Estelle v. Smith,* 451 U.S. 454 (1981). Kentucky courts have not specifically ruled on whether the state examination is a "critical stage" of the criminal proceeding at which counsel is constitutionally required but at least one other jurisdiction has found this to be so. *Houston v. State,* 602 P.2d 784 (Alaska 1979) (State constitutional guarantee of effective assistance mandates defense counsel presence at court ordered psychiatric evaluation.) There appears to be an implied statutory right to presence of counsel in Kentucky. KRS 504.080 (5) ("A psychologist or psychiatrist retained by the defendant shall be permitted to participate in any examination under this chapter.")

## II. INVESTIGATING THE STATE EXPERT

An effective cross-examination can only be accomplished after investigating the background of the state expert. Remember you practice in a state in which "experts" who have testified in death penalty cases include a fraud, a felon, and a fabricator of credentials. You will not know very important information about the expert unless you investigate.

The following is an outline by Robert Harp, Investigator with the Capital Trial Unit, of the main sources of information for an investigation of a mental health expert.

**********

Background Investigation
Mental Health Expert

I. Personal Information
   A. Obtain as much personal information as possible. This will provide you with other sources of information at a later date.
      1. Full name
      2. Address
      3. Date of Birth
      4. Social Security Number
      5. School{s} attended
      6. Reports, Books or Articles published

II. Professional License
   A. Status
      1. Current or Expired
      2. How Obtained
         a. Test
         b. Agreement from another state
      3. Application information (May not provide this information)
   B. Complaints
      1. Number and type
   C. Disciplinary Actions
   D. License if noted in other states

III. Personal Background Check
   A. NCIC (National Check)
   B. Driving Record
      1. Indication of Alcohol and Drug related offenses
   C. Credit History
   D. U. S. District Court, Bankruptcy Division

IV. City Business License
   A. Location of Practice
      1. Indication of volume of practice

V. County Courthouse Records
   A. Criminal Court Records
      1. Local only, Misdemeanors
   B. Civil Court Records
      1. Civil Suits and Judgements

VI. Professional Associations
   A. American Medical Directory
      1. American Medical Directory, Doctor by States and Cities
      2. Name index of all Doctors (Members)
      3. Year of Birth, Medical School, Year Graduation, Year Licensed, Residence and Office Address
   B. Professional Publications
      1. Papers
      2. Published Articles
      3. Published Book(s)
         a. Name, Date and Subject Matter

VII. Insurance Reporting Service
   A. Type of insurance
      1. Liability
      2. Risk
   B. Claims made against his insurance
      1. Losses

VIII. Foreign Mental Health Professional of Doctor
   A. Immigration and Naturalization Service
      1. Immigration Identification Card

2. Alien Card
3. Aliens must report Address every year
4. Alien Visa File

IX. Military Records

A. Military personnel and Civilian under contract

X. Testimony in Other Cases

A. Civil
B. Criminal

**********

## III. OTHER INVESTIGATION

It may be helpful in planning a motion practice and in preparing for trial or a pretrial hearing to develop a sense of the context in which the expert mental health testimony will be offered and the understanding of the various parties of this testimony.

### A. The prosecutor

What experience has the prosecutor had with mental health experts? A more sophisticated prosecutor will present a different challenge then a less experienced one and may have a repertoire of "dirty tricks" which you must anticipate and diffuse. Has the prosecutor authored any pleadings or other documents which would be useful to the defense? For example, an Assistant Attorney General obtained an additional expert in a Kentucky capital case by alleging that KCPC personnel were incompetent to perform the necessary evaluation. Is there a relationship between the prosecutor and the expert which would suggest bias?

### B. The police/prosecution witnesses

Do the police or other prosecution witnesses have information which will contradict or undermine the testimony of the state expert? They may have helpful observations of the accused around the time of offense or in past contacts with the accused.

### C. The judge

Has the judge had much experience with mental health testimony in criminal cases? Civil cases? As a judge or as an advocate? What is the experience in the local courts with expert mental health testimony in criminal or civil cases?

### D. The jury

The nature of your jury may be very significant to the goals and methods of your cross-examination. Have any jurors been involved in the mental health professions? Have they or their family/friends experienced contact with mental health professionals? How much importance will they attach to mental health expert testimony? Investigate these areas in voir dire.

## IV. DEFINE THE GOALS OF CROSS-EXAMINATION

Do you need to cross-examine this witness? If yes, then define what you hope to accomplish specifically and with the theory of the case in mind. Depending upon the facts of the case and your jury, these goals may vary widely. Some potential goals are discussed below.

**Warning:** In setting the goals for cross-examining the state expert keep in mind what the weaknesses/strengths of the defense expert are (if you have one). For example, you do not want to hammer on the little time spent with the accused by the state expert if your expert did not spend much time with the client either.

### A. Destroy the expert

This is rather ambitious but the situation may lend itself to a scorched earth approach. If there is little or no good information offered by the state's expert in the report or at trial and there is sufficient basis for an attack on the expert's credentials, the quality of the exam, or improper motive/bias, then this may be the way to go.

### B. Elicit positive opinions from the expert

The expert may have reached some conclusions which are helpful to the theory of defense. Bring these points out to the jury and lay the ground-work for an explanation as to why the expert was mistaken as to the harmful conclusions.

### C. Elicit positive facts from the expert

The expert may have no positive opinions to offer for the defense but may be used to validate and reinforce facts which are helpful to the client. For example, the expert can verify that the defendant was diagnosed schizophrenic previously or that the defendant exhibited symptoms of severe depression around the time of the offense. Use the state expert to reinforce the lay and expert witnesses you will call later.

### D. Demonstrate that the expert had insufficient basis, insufficient credentials, and/or insufficient experience to formulate a valid opinion

Unless you decided to attempt to co-opt the state expert, your expert is going to know a lot more about your client, will have spent more time with him/her, and will be more experienced and better-educated (hopefully) than the state expert. You will be able to lay the foundation in cross for an argument that if the state expert had more experience, training, information, and time and had expended the effort to obtain this, then s/he would have reached the same proper conclusion as the defense expert.

## V. AREAS OF CROSS-EXAMINATION

### A. The expert — qualifications and bias

1. Academic credentials
   a. Psychologists — Masters or Ph.D.?

b. Psychiatrists — Specialization?
c. Board Certifications
d. Grades/Class Rank
e. Other

2. Experience
   a. Forensic experience vs. counseling
   b. Numbers of patients/setting
   c. State/private
   d. Previous experience w/ competency and/or insanity evaluation and testimony
   e. Other

3. Compensation
   a. This case
   b. Future cases

4. Professional/philosophical bias
   a. Hired gun for prosecutors
   b. Views on crime and punishment
   c. Treatment or punishment orientation
   d. Publications/speeches/other writings
   e. Work experience
   f. Other

5. Personal bias
   a. Victim of crime
   b. Family/friends victim
   c. Relationship w/ victim
   d. Relationship w/ prosecutor
   e. Race/cultural/gender/class bias
   f. Other

**B. The method**

1. Tests (non-medical)
   a. Objective vs. subjective
   b. How administered
   c. Testing atmosphere/effects
   d. Examiner effects (various factors related to the examiner can effect the outcome, *e.g.*, whether the examiner has a moustache, race, gender, cultural background, bias)
   e. Examinee effects (race, age, gender, occupation, education, economic and marital status, drug or alcohol use — *e.g.*, caffeine can have a substantial impact, depression, etc.)
   f. Inherent bias in tests (race, culture, gender, etc.)
   g. Reliability — the degree to which the testing instrument consistently gives the same results
      1. internal consistency
      2. test-retest consistency
      3. interjudge consistency
   h. Validity — the degree to which the testing instrument measures what it purports to measure
      1. descriptive validity — accuracy of the score, diagnosis, or interpretation as a reflection of current behavior
      2. predictive validity — accurate prediction of future behavior
   i. Research individual tests used (how test was developed, validity/ reliability studies, revisions of the test, critical publications, etc.)
   j. Raw data obtained by testing supports a variety of conclusions
   k. Errors in testing procedure or data
   l. Errors in interpreting the test results
   m. Other

2. Tests (medical)
   a. General physical
   b. Neurological — EEG, CAT scan, PET, MRI, etc.
   c. Lab work (chemical imbalances often are significant in diagnoses)
   d. Expert qualified to interpret test?
   e. Failure to perform indicated medical tests

3. The client interview
   a. Time spent w/ client; number of interviews
   b. Setting (jail, office, etc.)
   c. Others present
   d. Examiner effects (race, gender, cultural background, bias, demeanor, etc.)
   e. Examinee effects (race, age, gender, occupation, education, economic and marital status, drug or alcohol use — *e.g.*, caffeine can have a substantial impact, depression, etc.)
   f. Recording procedure (notes, audiotape, videotape, etc.)
   g. Other

4. The Social History/Records
   a. Client's self-report
   b. Interviews w/ family, friends, employer, etc.
   c. Interviews w/ prior doctors or counselors
   d. Medical records, including birth records, prior psychological/ neurological evaluations, etc.
   e. Criminal records, including juvenile and probation
   f. School records
   g. Military records
   h. Other

5. The crime
   a. Client's report
   b. Interviews w/ police; offense report
   c. Interview w/ crime victim
   d. Interviews w/ witnesses

6. The evaluation team
   a. Staff assistance
   b. Medical assistance
   c. Consulting assistance
   d. The team as a standard of practice (KCPC staffs each patient w/ a psychiatrist, psychologist, social worker, nurses, and a medical physician, and contracts w/ a neuropsychologist and neurologist when that testing is indicated)

e. Discovery of relevant documents and information which are not in the experts "report," *e.g.*, medical evaluations, testing raw data, logs

**C. The conclusion**

1. The written report
   a. Errors of fact
   b. Errors in use of technical terms
   c. Internal inconsistencies
   d. Inconsistencies w/ other documents or testimony
   e. Inconsistencies w/ expert's trial testimony
   f. Other

2. Expert not qualified to reach the conclusion
   a. Ignorance of the history of the profession
   b. Ignorance of substantive principles
   c. Lack of experience on specific topic
   d. Lack of relevant degree, coursework, and/or clinical experience
   e. Other

3. The evaluation process was flawed or incomplete
   a. Better tests were available and not used
   b. Testing was incomplete; further tests required
   c. Errors in testing flawed the process
   d. Interviews were flawed or incomplete
   e. The process did not meet established standards
   f. The process was inferior to that of defense expert
   g. Other

4. Erroneous or incomplete data rendered a flawed conclusion
   a. Failure to verify information
   b. Reliance on hearsay information
   c. Assumptions rather than personal observation
   d. Factual errors
   e. Failure to consider relevant data
   f. Additional information could alter conclusion
   g. Lack of diligence/effort
   h. Other

5. The jury should not agree with the expert's opinion
   a. Inconsistent with common sense
   b. Inconsistent with prosecutor's lay witnesses
   c. Inconsistent with other experts' opinions (the defense expert, previous treating physicians, psychologists, etc.)
   d. Other expert could reach a different opinion based on same data
   e. Interpretive standards are so subjective, especially when the human mind is involved, that the opinion could be wrong — not an exact science
   f. Opinion is a possible, not probable
   g. Controversy within the field of psychology or psychiatry
   h. Expert has made inconsistent statements in the case
   i. Expert has made prior inconsistent statements outside the case (testimony, publications, etc.)
   j. Expert's statements, opinions, process, etc., are inconsistent w/ learned treatises and/or professional standards
   k. Expert has a poor grasp of the facts
   l. Other

## VI. RESOURCES

These are a few helpful sources of information. Your mental health consultant can suggest others. Help is also available through local and national organizations.


- J. Ziskin & D. Faust, *Coping with Psychiatric and Psychological Testimony*, 4th Ed. (Law and Psychology Press, 1988) (3 volumes)
- *The American Psychiatric Press Textbook of Psychiatry* (American Psychiatric Press 1988)
- Diagnostic and Statistical Manual of Mental Disorders (DSM III-R)
- American Psychiatric Association (1987) (The DSM IV will be out this year.)
- H. Kaplan & B. Sadock, *Comprehensive Textbook of Psychiatry* (5th Ed. 1989)
- E. Imwinkelreid, *The Methods of Attacking Scientific Evidence*, (Michie 1982)
- R. Clifford, *Qualifying and Attacking Expert Witnesses* (James Publishing 1988)
- ABA Criminal Justice Mental Health Standards
- C. Roberts & S. Golding, "The Social Construction of Criminal Responsibility and Insanity," Law and Human Behavior, Vol. 15, No. 4 (1991)
- C. Slobogin, "*Estelle v. Smith*: The Constitutional Contours of the Forensic Evaluation," Criminal Law Review," 31 Emory Law Journal 71 (1982)
- American Psychiatric Association, "Report of the Task Force on the Role of Psychiatry in the Sentencing Process," *Issues in Forensic Psychiatry 202* (1984)
- American Psychiatric Association, *Principles of Medical Ethics (Psychiatry)*, (1981)
- American Psychological Association, *Ethical Principles of Psychologists*, 36 American Psychologist 633 (1981)
- 17 ALR 4th 575 — effective assistance and competency
- 3 ALR 4th 910 — right to counsel at psychiatric examination
- 23 ALR Fed 710 — adequacy of psychiatric examination



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# Chapter 27: Some of the Nitty Gritty: Examples of Changes in the *DSM-IV*

**by Kathleen Wayland**

This article discusses examples of some specific changes in the most recent edition of the Diagnostic & Statistical Manual of Mental Disorders, the DSM-IV, the official mental health diagnostic scheme used in the U.S. and their implications for criminal defense team members and their clients.

## Introduction

Published in 1994, the fourth edition of the *DSM* is the American Psychiatric Association's (APA) most current delineation of diagnostic nomenclature and mental health disorders. The *DSM-IV* is the fifth version of the official diagnostic scheme endorsed by the APA and adopted in the U.S. over the past forty years. Its most recent predecessor, the *DSM-III-R*, had been in use since 1987.

Procedural safeguards were instituted by the DSM-IV Task Force and its Work Groups to ensure that proposed changes in the *DSM-IV* have a clear scientific and/or conceptual evidentiary basis. Toward that end, a three-stage empirical process was adopted: (a) comprehensive reviews of the existing empirical and clinical literature on particular disorders; (b) data reanalyses of previously conducted research; and (c) implementation of extensive field trials to address concerns about diagnostic issues in particular disorders.

A secondary but no less important goal of the revision process was to extensively document the empirical and/or conceptual bases of changes. Documentation of the revisions was proposed to minimize concerns about arbitrary and idiosyncratic changes that had plagued earlier versions of the ***DSM***[1] and to maintain historical continuity with the ***DSM-III*** and ***DSM-III-R***.

A major vehicle for documentation of the evidentiary bases for *DSM-IV* text and diagnostic criteria sets is the planned publication of the *DSM-IV Sourcebook*, a five-volume synopsis of the clinical and empirical support for various decisions reached by Work Groups and the Task Force. Volume I has been published and the remaining volumes are expected out over the next few years.

## Basic Structure of the *DSM-IV*

Before identifying some of the major types of changes in the *DSM-IV*, it might be helpful to include basic information about the structure of the *DSM*. Since publication of the *DSM-III* in 1980, the *DSM* has described psychiatric illnesses and mental disorders through a five-dimensional descriptive system, labeled, in *DSM* language, the "multiaxial system." The five "axes" listed in the *DSM* involve five different but intimately related ways of describing psychiatric symptoms. The axes identify a complex range of psychiatric and psychosocial phenomena, including delineation of major mental illness, enduring personality traits and maturational delays, and the description of medical, developmental, psychosocial and environmental phenomena that may exacerbate or mitigate the effects of mental disorders. *See, Table 1, Multiaxial System - DSM-III* and *DSM-III-R*.

### Multiaxial System - *DSM-III* and *DSM-III-R*

**Axis I** - Includes the "clinical syndromes," *i.e.*, the major mental disorders. This axis comprises what most people think of as mental illnesses. It is composed of approximately 15 categories of mental disorders, each comprising a distinct group or class of mental illness (*e.g.*, Mood, anxiety, psychotic, or dissociative disorders). Each group or class (*e.g.*, mood disorders/anxiety disorders) contains distinct disorders (*e.g.*, major depressive disorder, bipolar I and II disorders, etc./panic and anxiety disorders, phobias, PTSD) which make up that group.

**Axis II** - Includes longstanding and en-during personality traits and matura-tional/developmental deficits and delays. Personality traits are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself, "and are exhibited in a wide range of important social and personal contexts. It is only when personality traits are inflexible, maladaptive and cause either significant functional impairment or subjective distress that they constitute an actual disorder. The essence of maturational/developmental delays is a disturbance in the acquisition of "cognitive, language, motor, or social skills." Such disturbances may be pervasive (as with mental retardation), involve delays or deficits in specific skills (reading, arithmetic, language), or involve qualitative distortions in multiple areas of normal development (autism).

**Axis III** - Includes physical disorders and medical conditions that may affect psychological functioning.

**Axis IV** - Includes psychosocial stressors that may influence psychological functioning, they are rated on a five-point scale from "mild" (relationship breakup) to "catastrophic" (death of a child or spouse).

**Axis V** - Includes the delineation of a longitudinal context (known as the Global Assessment of Functioning [GAF]) within which to appraise psychological functioning. Social, psychological and occupational functioning is rated on a 100-point scale of mental illness which includes 90 (absent or minimal symptoms, "good functioning in all areas"), through 50 (serious symptoms, "suicidal ideation, severe obsessional rituals...serious impairment in some functioning") to 20-10 ("persistent danger of severely hurting self or others...persistent inability to maintain minimal personal hygiene [smears feces]...serious suicidal acts with clear expectation of death).

The *DSM* is composed of sixteen major classes of mental illnesses, within which particular disorders are subsumed. For example, the class of mood disorders includes such disorders as major depression, bipolar I and II, and dysthymia; the class of anxiety disorders includes, among others, post-traumatic stress disorder, obsessive-compulsive disorder, and phobic disorders (*e.g.*, simple phobia, social phobia, and agoraphobia).

Individual disorders are placed in a particular class of mental illness on the basis of shared phenomenological features. That is, two disorders within the same class of mental illness may share a predominant emotion or behavioral symptom, may respond similarly to medication, may be genetically linked, and/or may consistently occur together with other disorders. For example, Post-traumatic Stress Disorder (PTSD) and Panic Disorder with Agora-phobia (PDWA) are both in the anxiety disorder class of mental illness, and share similar emotional, behavioral, and physiological symptoms. These disorders have in common a pre-dominant emotion (fear); a similar behavioral pattern (phobic avoidance of feared situations, people or events); and similar physiological responses (increased autonomic arousal when confronted with anxiety-provoking or feared stimuli). Additionally, a similar mode of psychotherapy (behaviorally-based "exposure therapy") has been effective for some patients in reducing distress significantly for both disorders. Finally, evidence suggests a possible biomedical and/or psychophysiological link between PTSD and PDWA, as both disorders occur together with depressive disorders and respond similarly and positively to a certain class of drugs.

The purpose of grouping disorders on the basis of shared features is to facilitate the process of "differential diagnosis," the term used to describe the hierarchical decision-making process required to differentiate a particular disorder from other disorders which have one or more similar presenting features. For example, Attention Deficit Hyperactivity Disorder (a disruptive behavior disorder), Major Depression (a mood disorder) and Post-traumatic Stress Disorder (an anxiety disorder) may all share characteristics of concentration difficulty and agitated behavior. To determine whether these characteristics are symptoms of a particular disorder, and, if so, to identify that disorder, a careful evaluation of present symptoms, as well as a careful history are needed.[2]

The description of particular disorders occurs through clearly specified "criteria sets" which outline such factors as the type, number, duration, and severity of symptoms required to warrant a diagnosis. *See Table 2* for criteria sets for PTSD. A wealth of additional information is provided in the text which accompanies criteria set definitions. One area of further information detailed in the text includes factors predisposing individuals to particular disorders, *e.g.*, family history, exposure to extremely stressful environmental events, and in-utero exposure to trauma and/or toxins. Additional information might also address the nature, subtypes and specific course of particular disorders, *e.g.*, age of onset (early vs. late); mode of

**_DSM-III-R_ Diagnostic Criteria for Post-Traumatic Stress Disorder (309.89)**

A. Person has experienced an event that is outside the range of usual human experience and would be markedly distressing to almost anyone, *e.g.*, serious threat to the life or physical integrity of oneself, one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing a person who has recently been, or is being, seriously injured or killed as a result of an accident or physical violence.

B. The traumatic event is persistently re-experienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (young children may express themes or aspects of the trauma in repetitive play); (2) recurrent distressing dreams of the event; (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes); (4) intense psychological distress at exposure to events that symbolize ore resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, not present be-fore the trauma, indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma; (2) efforts to avoid activities or situations that arouse recollections of the trauma; (3) inability to recall an important aspect of the trauma; (4) markedly diminished interest in significant activities (in young children, loss of recently acquired develop-mental skills); (5) feeling of detachment or estrangement; (6) restricted range of affect or feelings; (7) sense of foreshortened future, *e.g.*, does not expect to have a career, marriage, etc.

D. Persistently increased arousal, not present be-fore the trauma, indicated by at least two of the following:

(1) difficulty falling asleep or staying asleep; (2) irritability or outbursts of anger; (3) difficulty concentrating; (4) hyper-vigilance; (5) exaggerated startle response; (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (*e.g.*, a woman raped in an elevator breaks out in a sweat when entering any elevator).

E. Duration of the disturbance (symptoms in B, C and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma.

onset (abrupt vs. insidious); severity of disorder (mild, moderate or severe); and chronicity and duration of the disorder (episodic vs. continuous, single event vs. recurring episodes, or full vs. partial remission).

### Types of Changes in the *DSM-IV*

Changes to the Axes - *DSM-IV* includes a number of conceptually distinct changes. Revisions were made in the content of two axes within the multiaxial system as the learning, communication and motor skills, and pervasive developmental disorders were moved from Axis II to Axis I. Another change involved the designation of Axis III as relating to "general medical" conditions rather than only "physical" conditions, in order to deemphasize the somewhat inaccurate distinction between "organic" (or biological) and "psychological" factors that was implicit in ***DSM-III-R***. Very minor changes were made in Axes IV and V regarding the specification of psychosocial stressors and general psychological functioning.

Changes to the Criteria Sets and Disorders - With respect to major mental illnesses (Axis I) and enduring personality traits (Axis II), modifications included, among other things:

(1) Changes in the names of major diagnostic classes and disorders. For example, there is no longer a class of disorders known as "organic mental syndrome and disorders." The rationale for this change was that this category, as employed in *DSM-III* and *DSM-III-R* suggested a deceptive distinction between disorders caused by psychiatric (mental, emotional or behavioral) versus organic (physical or bodily) factors.

Of additional interest is the fact that the name of a disorder which has received much public and media attention, Multiple Personality Disorder, has been changed to "Dissociative Identity Disorder." This change was based in part on the recognition that distinct personality entities (*e.g.*, the "Three Faces of Eve") are per se less common than the presence of different and dissociated personality states (*e.g.*, passive, aggressive, gregarious, etc.)

(2) Changes in diagnostic criteria for particular disorders. *See*, discussion of PTSD, *infra*.

(3) The creation of several new diagnoses, such as bipolar II, acute stress disorder, and several new childhood disorders; and

(4) The deletion of some diagnoses, including self-defeating personality disorder.

The current version also lists certain syndromes in an appendix with recommendations for further study, such as post-concussional disorder and mixed anxiety-depressive disorder. Additional axes are also proposed for study, and certain dis-

**Notable Changes in Diagnostic Criteria for Post-Traumatic Stress Disorder (309.81) in *DSM-IV***

A. Person has been exposed to a traumatic event in which both of the following were present:

(1) person experienced, witnessed, or was confronted with an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) response involved intense fear, helplessness, or horror (children may express by dis-organized or agitated behavior).

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1)-(4) Only minor changes; (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma *and* numbing of general responsive-ness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma; (2) efforts to avoid activities, places, or people that arouse recollections of the trauma; (4) markedly diminished interest or participation in significant activities; (3), (5), (6), (7) same as in *DSM-III-R*.

D. Same as in *DSM-III-R*, but with number six (6) deleted.

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
**Acute**: if duration of symptoms is less than 3 months.
**Chronic**: if duration of symptoms is 3 months or more.
**With Delayed Onset**: if on-set of symptoms is at least 6 months after the stressor.

orders are delineated as subsumed by other diagnoses. In addition, developers of the *DSM-IV* placed greater emphasis on the importance of variables such as culture and gender in the development and expression of mental illness (which will be discussed in the next article in this series). Below, a closer look is taken at the types of changes made through a description of the revisions made regarding PTSD.

### An Example of the Concerns Guiding Changes in the *DSM-IV*

PTSD was one of twelve disorders targeted for intensive study through field trials prior to publication of the *DSM-IV*. The following is an overview of two issues discussed among PTSD researchers and clinicians involved in the revision process. This example is offered merely to illustrate the kinds of concerns faced by mental health practitioners making diagnoses, and the conceptual underpinnings of the impetus for reconsideration of existing diagnostic definitions. *See, Table 2* for descriptions of the diagnostic criteria for PTSD in *DSM-III-R* and *DSM-IV*.

### Says Who? - Defining A Traumatic Event (Criterion A)

As can be seen in Table 2, criterion A for a PTSD diagnosis is the experiencing of a traumatic event. The definition of a traumatic event, called the "gatekeeper" to PTSD, is clearly of considerable importance; if an event does not qualify as traumatic, one cannot, by definition, be diagnosed with PTSD. Thus, the definition of criterion A, a traumatic event, has significant implications for assessment of the prevalence of PTSD in both clinical and community samples. If the description of the trauma is overly inclusive, estimates of PTSD would likely increase; if the description is too narrow, estimates of PTSD would likely decrease.

In *DSM-III* and *III-R*, a traumatic stressor was defined as an event "outside the range of usual human experience" that would be "markedly distressing to almost anyone." Several limitations of this definition were noted and investigated, and led to the changes in definition apparent in Table 3. First, epidemiological data about the prevalence of certain traumatic stressors (rape, childhood sexual abuse, assault and batter) consistently indicate that they are a common part of human experience in our society and, thus, cannot be deemed "outside the range of usual human experience." Second, the *DSM-III-R* definition did not recognize the possibility that relatively low magnitude stressors (*e.g.*, a minor car accident), perceived as traumatic by susceptible individuals, could cause the full spectrum of PTSD symptoms.

The *DSM-IV* definition of traumatic event has been both expanded and made more explicit. The definition is more explicit by virtue of the requirement that a stressor involve actual or threatened death or injury, or a threat to physical integrity. The definition is more expansive by virtue of including events that a person has witnessed or "confronted" as qualifying events. Finally, the person's reaction to the event must include "intense fear, helplessness or horror," thus, the traumatic stressor is now in part defined by the subjective emotional response to an event, rather than by the more objective *DSM-III-R* standard of an event that would be "markedly distressing to almost anyone."

### A Square or a Rectangle? - Classifying PTSD as a Disorder

The debate over this issue concerns the appropriate disorder classification of PTSD, or its "nosological home." PTSD was categorized as an anxiety disorder in *DSM-III* and *III-R*. In the development of *DSM-IV*, it was considered for possible placement in two other classes of disorders. First, some researchers and clinicians argued that PTSD more appropriately belongs in the class of dissociative disorders because, while it shares features with other anxiety disorder (*e.g.*, fear, avoidance, hyper-vigilance, poor concentration, etc.), it also shares symptoms with the dissociative disorders (*e.g.*, flashbacks, memory disruption and amnesia). A second proposal was to create a new cause-based class of disorders that share common symptoms arising from exposure to a stress or stressors. Mentioned for possible inclusion in this proposed class, in addition to PTSD, were the adjustment disorders, which by definition involve a maladoptive response to an identifiable psychosocial stressor. Following discussions, it was decided that the most appropriate placement of PTSD in the *DSM-IV* was in the class of anxiety disorders, with which it shares many symptoms.

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**Footnotes:**

[1]It has been argued that earlier versions of the DSM proposed diagnostic criteria sets that were the result of "expert" consensus or "group" opinion, and were therefore necessarily subject to the limitations of group processes.

[2]As noted by Kaplan and Sadock, one of the essential cornerstones of an adequate and reliable mental health evaluation is a thorough review of history and systems. Kaplan, H.I.; Sadock, B.G., *Comprehensive Textbook of Psychiatry*, (Williams and Williams, 5th Ed. 1989). Unfortunately, it is still frequently the case in criminal cases, especially in death penalty litigation that superficial evaluations are conducted based largely on self reports of clients, with no attempt made to obtain and review information about the client and his/her family history. n

# Chapter 28: Working Effectively with Capital Defendants: Identifying and Managing Barriers to Communication

**By Lee Norton, Ph.D., MSW**

**Mitigation Investigations in Capital Cases: Prevention Strategies and Mitigation Training**

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**Introduction.** Inherent in any capital case are a number of variables: the political climate ("we must be tough on crime"), statutory issues (whether mental retardation is considered mitigating, etc.), the judge (his or her knowledge of capital case law, etc.), the prosecutor (issues of over-prosecution, capital case law, etc.), the media (subjectivity to political influence, investigative reporting skills, etc.), lay witnesses (whether they can be found, how impaired they are, etc.), experts (skills matched to the needs of the case, availability, etc.), the client, and his family. Many of these are outside the influence of the defense team. All come into play at one time or another, some more frequently than others. No single variable has greater potential for determining the outcome of the case than the client. The client's perspective, level of understanding and degree of cooperation can translate into a sentence of life in prison or a certain death penalty. And, while issues to do with the client are among the most volatile variables, they are typically those most responsive to actions of the defense team. Hence, it is necessary to pay special attention to the unique attributes of capital defendants and the factors that shape the quality of the relationship between the client and members of the defense team. This entails considering how the professional relationship in a capital case differs from other client-professional relationships.

**The unique relationship between defense teams and capital defendants.** In most client-professional relationships the client approaches the professional with a specific need or aim, and the professional makes a decision as to whether or not she has the skills, experience and resources necessary to assist the client. The professional brings to the task relevant expertise. The client provides the context within which the problem is defined and is involved at nearly every juncture of the process. This is not true of the relationship between capital defendants and defense teams, where the client generally has little say in who represents him and remains essentially powerless throughout the case. This disparity, combined with the potentially lethal sentence, is the source of many of the barriers defense teams routinely confront in death penalty work.

**Knowing the client.** Equally important, the client brings with him unique experiences and limitations that accentuate his powerlessness and increase his anxiety. The intense pressure of the charges against him tax his limited coping mechanisms and cause his mental and emotional problems to become more acute. All other things being equal, establishing a relationship between the client and the defense team would be difficult. Add to this the client's inherent limitations and the effects of extreme stress, and the task becomes formidable. The kinds of problems that emerge between clients and defense teams can be better understood in the context of who the client is and how he sees the world. The following are experiences common to most clients:

***Poverty.*** Defense teams sometimes fail to adequately explore the specific implications of longstanding privation. With rare exception, the client is indigent, having lived his entire life in inescapable poverty. For the child raised in a safe, supportive environment that is otherwise rich and challenging, the effects of poverty are generally inconsequential and transitory, and the child develops skills to better her circumstances later in life. However, in the absence of compensatory factors, severe poverty is devastating and irrevocable, depriving children of basic necessities, including prenatal care and proper medical assessment and treatment. Often these children are born with medical conditions that need ongoing attention and, left untreated, cause progressive problems as the child grows.

The effects of poverty don't stop there. They envelop the child like an endless pall. Lack of resources results in inadequate housing and overcrowding. It is not unusual for clients to recount hideous stories of having had to combat rats and insects in their homes, or even to have been bitten by rats or have seen other children bitten by rats. Overcrowding means the child has no consistent place of his own or for his belongings and is deprived of privacy and a sense of personal boundaries. This increases exponentially the risk of sexual abuse (older children "creeping" the younger ones in their sleep). Constant noise and overstimulation prevent the children from assimilating and accommodating new information, which in turn causes learning problems.

Unabated poverty usually manifests in numerous translocations, often the result of evictions. Almost all clients can recall running from the "rent lady" in the night, and having to make do without electricity. As a result, educational records reflect frequent changes in schools, poor school attendance and diminished performance. Many clients missed

school because they had no clean clothes (some smelled of urine, the result of small children sleeping next to them on pallets having wet the bed at night) or did not have lunch money. When they did attend, they were often hungry, light-headed and unable to concentrate on what the teacher was saying.

Poverty is pervasive, creating a filter that continually shapes the child's world view. It restricts one's focus to physical needs, such as food, shelter, and safety, and prevents the exploration, trial and error learning, and use of imagination that are essential to healthy development. The child raised in extreme poverty has a limited sense of the future and few aspirations beyond the hope for greater material wealth. He does not learn that he can affect his environment or increase his own efficacy. Accordingly, he sees himself as eternally at the mercy of forces beyond his control, unable to alter his destiny in any way. Such hopelessness taints the client-professional relationship and gives rise to one of the greatest barriers to effectiveness.

***Cognitive Deficits.*** Several factors account for the low I.Q.s and myriad learning problems seen in capital defendants. Most variables are attributable to organic or environmental causes or a combination of the two. Many organic problems begin before birth. Clients are often born to poorly nourished, teen mothers or to mothers who have had so many children in such quick succession that they are metabolically depleted, chronically exhausted and suffer compromised immune systems. Many mothers have alcohol and substance abuse problems, the more subtle effects of which frequently go undetected. For example, fetal alcohol effect (as opposed to fetal alcohol syndrome) can be mistaken for other problems or missed altogether, especially when the parents steadfastly deny alcohol use.

Prenatal injuries and birth trauma play a role in some brain deficits. It is not unusual for a client's mother to have made several failed efforts to abort the child (often accompanied by a suicide attempt), or for her to have sustained abdominal trauma during beatings from her parent or guardian, her boyfriend or the child's father. Trauma during labor and delivery, including prematurity, induced labor, anoxia, Rh incompatibility, breech presentation, and other life threatening circumstances account for another proportion of organic problems, and are usually documented in birth records. The social histories of clients reflect a high incident among capital defendants of immune-related illnesses. A history of high fevers, respiratory infections, digestive problems and dehydration are not unusual. Similarly, these clients sustain a high number of injuries (often a result of neglect), including broken bones, ingestion of toxins and poisons, cuts, abrasions, and falls, any of which can cause irreparable brain damage.

A generational pattern of mental retardation, low I.Q. and learning problems is common among clients' families. The source can sometimes be traced to incest or marriage among close relatives. Other times a genetic defect is the cause.

The child's environment is as likely to account for cognitive deficits, as is organic dysfunction. Overwhelmed, depressed caretakers who see themselves as hopeless and helpless are unable to provide the attention and nurturing necessary for healthy cognitive development. Parents overcome by their own insoluble problems tend to withdraw and isolate themselves, shutting out what they cannot face (Garbarino, Dubrow, Kostelny, Pardo, 1992). Lack of stimulation and social interaction interferes with the child's normal learning processes. Without feedback and encouragement from the parent, the child fails to develop curiosity or a desire to explore his environment. This results in an inability to master fundamental mental and social tasks that form the framework for subsequent learning.

Conversely, a chaotic, unpredictable and unstable environment causes persistent anxiety and an inability to attend to information and organize it meaningfully. Overcrowding, inconsistency, and overstimulation overwhelm the child's limited framework for understanding and responding to her experiences. Sameroff (1987) found an inverse relationship between risk factors and I.Q. scores. Children exposed to multiple risk factors were more than 24 times as likely to have I.Q.s below 85 than children raised in low-risk homes (the risk factors included parental mental health, level of education, occupation, ethnic status and level of anxiety; family size, and degree of extended family support.).

Children who are both organically and environmentally predisposed to cognitive limitations absent comprehensive intervention and remediation are hobbled in all spheres of performance. They struggle valiantly to compensate, "catch up", and "act normal," but their marginal abilities and social impoverishment leave them perpetually confused, outside the mainstream of social understanding, and plagued by feelings of alienation and unworthiness.

***Substance abuse.*** The combined factors of self medication and corrupting influences result in a longstanding history of substance addiction in most clients. Abuse, neglect and untreated medical problems lead to self medication. Corrupting influences make various drugs readily available and remove social prohibitions against children using alcohol and illegal drugs. Clients typically begin drinking between the age of eight and thirteen, swallowing the dregs of their parents' glasses and bottles. The progression of addictions appear to vary according to age and location. Older clients who grew up in rural areas describe drinking moonshine -- buck and home brew -- and then moving on to pills and harder drugs. In most instances, their parents and/or other relatives made or sold the moonshine and were also alcoholics. There is usually a family history of arrests for "drunk and disorderly," "public intoxication" and simple assaults associated with being drunk and fighting. Generational medical histories include liver and pancreas disorders, stomach problems, and heart disease.

Younger inner-city clients indicate that their substance abuse began with drinking and smoking marijuana in the mornings on the way to school. "Shake-em Ups" (a concoction made of juice and liquor, such as gin and orange juice) and Wild Irish Rose (cheap wine) are among the more prevalent drinks. Marijuana is used throughout the day; there is usually an area near the school or housing projects -- typically a large tree -- where they stand and smoke. In the afternoon they sip on quart-size bottles of Colt 45 while smoking marijuana. By their early teens, clients begin using cocaine, first snorting it, then lacing (powder cocaine sprinkled on marijuana cigarettes), geeking (rock cocaine sprinkled on marijuana), and finally becoming addicted to crack (rock cocaine). They have usually been introduced to drugs by older relatives -- cousins or aunts and uncles -- who are themselves addicted. In most instances a number of male relatives have served time for drug-related offenses ranging from sale and distribution of cocaine to murder. Many female relatives have a history of arrests for shoplifting, loitering, prostitution and fighting. Some female relatives are "crack whores," who essentially live on the street, have a number of children who are in the custody of HRS (usually because these women have left the infants in the hospital following delivery and failed to return for them and many of the children test positive for cocaine) and ultimately contract any number of sexually transmitted diseases, including hepatitis B, syphilis, gonorrhea, herpes, chlamydia and AIDS. It is not unusual for inner-city clients to have lost several relatives to the AIDS virus.

The unbearable environments in which clients grow up predispose them to self-medication. In the home there is, at minimum, tension, fighting and a climate of competition and hostility. Many homes are managed by a single parent who is responsible for rearing several children in subadequate, overcrowded conditions. The child's needs for affection, holding, and soothing are rarely met. Parents themselves come from socially and emotionally impoverished families that lack positive role models. They lack basic child-raising skills, are overwhelmed and are unable to subordinate their needs to those of their children. They cannot provide the attention and guidance necessary for children to develop self esteem and resilience. In most instances, there is no routine in the home; events occur unpredictably. There are no set times for eating, bathing, doing homework or sleeping. Sleep may be repeatedly interrupted by people coming and going through the night (this is especially true when the parents or other relatives or "friends" are selling drugs). Turmoil and lack of nurturing keep the child in an uncomfortable state of agitation and alarm, anxious, searching for cues as to what to do, and ready for the next "crisis."

The community environment also contributes to the phenomenon of self-medication. Increasingly, clients raised in inner cities exist in virtual war zones (Garbarino, 1992). Rapes, batteries, home invasions, robberies and murders are common. Children use "get-away paths" alternate routes -- while walking home from school to escape being shot in drive-by shootings. Mothers barricade windows with refrigerators, bookcases and other barriers that can absorb the onslaught of bullets during gang wars. Many housing projects have "safe houses"-- apartments designated as demilitarized zones -- where, on a good day, counselors are available to help those on the brink of madness make it through at least another day. However, individuals can find respite for only a few hours and then must leave, inching past bullet-riddled walls and doorways where gang-bangers wait for sundown so that they may resume the same war they fought the night before.

Schools are "one of the most continuous institutions in children's lives, and one of the most important influences on development" (Garbarino, 1992). Yet in urban war zones they provide no escape from tension and conflict. Instead, they resemble concentration camps, with barbed wire coiled along high fences and guards standing vigilant at each entrance. Metal detectors and x-ray machines are required in most inner city schools, yet guns still find their way into hallways and lockers, as do knives, razors and almost any other object that can be fashioned into a weapon. The number of fatalities and wounds clients have witnessed are parallel only to those seen by soldiers on battlefields. The chief differences are that most soldiers (1) are at least 18-years of age and have greater emotional, psychological and intellectual resources to assimilate their experiences and (2) are involved in a conflict directed toward some positive end that they have espoused -- there is some meaning to their actions. Children have no framework within which to understand gratuitous violence. The effects of experiencing and witnessing violence are internalized: their bodies keep the score (van der Kok 1996).

The symptoms caused by persistent danger lead children to find ways to ease their fear and anxiety. Alcohol numbs their awareness and reactions, cocaine makes them feel immune and alive. These drugs are not used recreationally; they are necessary to cope with ongoing tension and highly charged emotions.

Individuals with substance abuse problems who are incarcerated generally undergo some degree of withdrawal, if only psychological. For someone who has not been drug-free in five, ten, or fifteen years, the change is traumatic. Old symptoms reappear, including paranoia, sleep problems, and changes in appetite. The client may feel he is losing his mind. His attention span is often affected; he is nervous and cannot attend to events around him for any sustained period of time. He may develop somatic complaints that plague him: headaches return, old wounds "act up," an ulcer recurs. Some clients can dissociate their symptoms and move forward. Others cannot. It is necessary for the defense team to assess the client's status and use his day-to-day rhythms as a guide to how much and what kind of work can be accomplished.

***Sexual, physical and emotional abuse.*** Almost all clients have been abused in one way or another; most have been abused in a variety of ways. Rarely will a client consider himself to have been mistreated. Rather, he will explain that his father or mother "was strict," or "wasn't affectionate." When asked to describe his childhood or provide examples of instances of "strictness," the client is often at a loss. He will state that he "can't remember" much about his childhood, or has no memories prior to a certain age. It is not unusual for a client to report that he has no memories before the age of thirteen. This may seem unfathomable to defense team members. However, the inability to recall important life events (in the absence of substantial organic impairment) is often an indication of extreme discord, lack of continuity and abuse. At least two factors may account for memory problems associated with abuse. One is that experiences that are overwhelmingly frightening or are beyond a child's ability to comprehend are *dissociated* -- split off -- from consciousness. They are not incorporated into existing cognitive structures and are not available for recall. A second is that traumatic memories are not recorded in the verbal portion of the brain. They exist as images (van der Kolk, 1987). Thus, the client *literally* cannot talk about them.

Another factor that prevents obtaining precise descriptions of childhood experiences has to do with the client's relationship with his caretakers. Abused children are often extremely (if anxiously) attached to their abusive caretakers, always seeking to win approval and unconditional love but never succeeding. The child is caught in a dilemma: he can conclude either that the parent is "bad" or that he is bad. The younger the child was when the abuse began, the more likely it is that he will conclude that he is bad and "deserves" to be punished. The parent must be good. He idealizes the parent, rationalizing and justifying any actions, no matter how egregious. Consequently, interviews with clients who have been abused produce distorted images of the parent as wholly loving, giving, patient and kind. "I was beaten, but only when I deserved it." One client gave adoring descriptions of his mother. Records later revealed numerous reports to children protective services for child abuse. Another client stated that his father "didn't drink much; just beer," and died of a heart attack. The death certificate showed the cause of death as chronic ethanolism. The man -- who was especially cruel and rejecting -- drank himself to death.

Accounts by clients of the lack or presence of abuse should always be corroborated by collateral interviews and records. In most cases, it is unwise to push or harshly confront the client, even when there is documentation of the abuse. This may trigger intrusive traumatic memories or increase the client's defensiveness, forcing him to choose between his own welfare and that of his parent. He will almost always protect his parent. In extreme cases, loyalty to parents is so fierce that a client will "forbid" further investigation and will sabotage his own case to protect his family. He will assert "I am responsible for this, not my parents. I don't want to drag my family into this. I don't want to upset anyone. My mother's health isn't too good; I don't want you talking to her. My father has his own life now; don't bother him."

Most clients suffer some form of physical abuse. However, emotional abuse is more prevalent and in many respects carries more lasting effects. Garbarino (1987) describes the forms of psychological battering that cause the greatest harm.

***Rejection*** - refusal to acknowledge the child's worth and his basic needs; behaviors that communicate abandonment. Includes failing to touch or show affection, or recognize the child's accomplishments, refusing to recognize the child's changing social roles, scapegoating the child, belittling the child, forcing the child outside the family system.

***Isolating*** - preventing the child from engaging in normal social experiences; failing to provide opportunities for appropriate social interaction. Includes leaving the child in his room (or crib) for extended periods of time, punishing the child's efforts *to* make friends, have friends in the home, prohibiting the child from joining sports teams, clubs; keeping the child from social activities by requiring an inordinate amount of household responsibilities (such as cleaning and caring for siblings).

***Terrorizing*** - verbally assaulting the child, and creating a climate of fear and unpredictable threat. Includes threatening the child with extreme or vague punishment; extreme responses to child's behavior; frequent "raging" at child, alternating with periods of superficial warmth; placing child in "double binds," such as forcing child to choose between two arguing parents; changing rules; constant criticizing while failing to acknowledge child's having successfully met expectations.

***Ignoring*** - failing to provide child with essential stimulation. The parent is preoccupied with his or her own goals and interests and is psychologically and emotionally unavailable to the child. Includes not talking to the child, or engaging in conversations limited to instructions and directives but which lack depth and emotion; refusing to engage in conversation at mealtimes; leaving the child without emotionally responsive adult supervision; showing no interest in child's progress in school and teacher's evaluations of child; failing to provide for child's special academic or needs; refusing to discuss the child's problems in a calm, appropriate way; concentrating on other children and other relationships that displace the importance of the child.

***Corrupting*** - missocializing the child, inspiring and teaching antisocial behavior, reinforcing social deviance. Includes reinforcing inappropriate aggression, goading or forcing the child to fight with other children, initiating or encouraging drug use, reinforcing inappropriate sexual behavior, condoning or encouraging other illegal or inappropriate behaviors, such as prostitution, theft, burglary.

(Garbarino, 1987, pp 25-29)

**The adaptive effects of trauma.** The combined effects of these and other factors can result in a cumbersome, frustrating relationship with the client, where progress comes in teaspoons and each task, no matter how small or insignificant, is ponderous and exhausting. Some of the more frequent complaints by members of defense teams include:

* an inability to get a coherent story from the client;

* the client's many different stories, not only of what happened but of his childhood experiences (usually perceived as lying);

* the client's inability (usually perceived as refusal) to identify helpful witnesses (especially for penalty phase);

* the client's inability (usually perceived as *refusal)* to see the gravity of the situation follow a linear train of thought and do *it quickly;*

* the client's inability to refrain from discussing his case with every jailhouse lawyer and snitch with whom he comes in contact:

* the client's inability to recognize the salient issues of his case, instead focusing on irrelevant, minuscule facts, the consideration of which is tantamount to rearranging deck chairs on the Titanic;

* the client's inexplicable changes in mood and affect;

* the client's insistence on pursuing love interests (sometimes obsessions) in place of working on his case;

* the client's sudden discovery of religion and his need to give sermons rather than develop a cogent defense;

* the client's seemingly manipulative behavior, pitting one defense team member against the other, triangluating the defense team against his family, or refusing to allow a full investigation be conducted;

The list only seems to grow, and each case brings a new constellation of threads from which the protective cloak of the defense must be woven. Most problems can be understood, if not resolved, when considered in light of the client's vulnerabilities and limitations. For example, the client's inability to provide a coherent account of the offense, or his pattern of giving different accounts of events, may be attributable to mental retardation, organic impairments that involve perception and memory, mental illness (such as bipolar disorder or schizophrenia), or to the effects of enduring psychological trauma. Each condition can involve distortions of linear thinking, encoding and retrieval of memories, time, and restricted verbal abilities. Individuals who are mentally retarded, have brain deficits or suffer from complex stress disorders are especially susceptible to confabulation, in which they will incorporate facts or details suggested by others into their recollections.[1]

When a client "cannot remember" entire stretches of his childhood, or fails to see the seriousness of his situation (using humor, changing the subject, asserting that "God will take care of me -- something good will happen,") it could be the result of a brain injury. Similarly, changes in mood or obsessions with trivia or (usually imaginary) love interests may be indicative of an affective disorder or other mental illness. However, these signs are also consistent with severe emotional trauma.

Children who are traumatized -- *i.e.*, experience a persistent state of fear, either from domestic or community conflict and violence -- demonstrate chronic physiological hyperarousal. Perry (1995) found increased muscle tone, an increase in basal temperature, sleep irregularities, an inability to modulate affect, impulsivity and an inability to accurately assess social cues [a state van der Kolk (1987) refers to as "frozen watchfulness" (p. 97)]. If the child finds no relief from this fear and generalized anxiety, his stress response mechanisms become maladaptive (Perry, 1995). He develops cognitive distortions (Pynoos 1990) and is unable to assimilate and organize new information (van der Kolk, 1987). The memory traces are affected; the child has difficulty identifying and transferring new concepts into existing cognitive frameworks. More important, traumatized children exhibit very primitive problem-solving skills, have difficulty accommodating previous learning to new situations, and have difficulty learning to self-correct. As a result, they repetitively use old, limited strategies even when these strategies have proven ineffective. These patterns become ingrained, and cognitive development is truncated at a very early age. The child remains in what Piaget termed the *preoperational stage*, which is characterized by an egocentric view of the world, and a unilateral approach to problem solving. He does not move into the stage of *concrete operations*, in which children develop the ability to tolerate ambivalence, and learn how to approach problems more broadly. It is at this stage that the child begins to internalize the values of right and wrong and experience genuine guilt (van der Kolk, 1987). Failure to move fully out of preoperations leaves the child stuck, with a severely impoverished repertoire with which to find a way out.

In a very real sense, there *is* no way out, because children raised in an abusive environment are powerless. They have nowhere to go and lack the social, emotional, and cognitive tools to extricate themselves. Besides the physiological hyperarousal that impairs learning, memory, and response to stressors, there are other characteristic signs of prolonged psychological trauma that are critical to death penalty work because they provide hypotheses for understanding our clients' behavior and actions. Traumatized people: (1) often "compulsively expose themselves to situations reminiscent of the trauma;" (2) suffer from problems with attention, distractibility and stimulus discrimination; (3) experience a numbing of responsiveness or constriction; and (4) demonstrate alterations of personality and defense mechanisms (van der Kolk, et al, 1996).

Compulsive exposure to situations similar to the original trauma -- "reenactment" - explains the client's self-defeating behavior, inability to decide who will hurt and help him, and the uncanny ability to *elicit* disapproval, rejection and even punishment. The client often unconsciously recreates with his defense team the kind of exploitative, abusive relationships he experienced throughout his life. Seen in this light, his seeming manipulative behavior, penchant for disclosing sensitive information to jailhouse lawyers and snitches who will ultimately testify against him (guaranteed to infuriate defense team members), and hyper focusing on minutia is understandable as a manifestation of traumatic reenactment.

Pronounced changes in mood may be attributable to psychic numbing and constriction, which alternate with hyperarousal and impulsivity. Constriction insulates the individual from cognitive and emotional intrusions; its ultimate function is to protect against blinding pain. The cost of dissociation is a limited awareness of one's environment and an inability to recognize and act on important cues and information. The individual appears uninterested, distant, even cocky or overly confident, with an "I don't care" attitude. In reality, his mind is overloaded and he simply cannot perceive and digest what is being conveyed, at least not at a given point in time.

**The importance of insight.** An understanding of the pervasive effects of psychological trauma sheds light on the diagnoses given to clients by mental health professionals. More often than not, capital defendants have been evaluated and diagnosed in a variety of settings, beginning in childhood and adolescence. School records show referrals for psychological and intelligence testing. Cognitive deficits are often identified. Sometimes the child is placed in special education classes, though in most poverty-stricken areas these resources are unavailable. The records are replete with references to emotional and behavioral problems, noting unexplained aggression and irrational acting out. Teachers are often at a loss as to what to do. As the child grows, his problems become more unmanageable: He cannot keep up in school and does not understand the intense physiological changes he experiences without warning. His attendance falls; most clients, frustrated and humiliated, drop out by the tenth grade. With virtually no skills, guidance or support, the client eventually finds himself either in the mental health or criminal justice systems or both. A host of diagnoses follow, most on Axis II: conduct disorder, antisocial, borderline and narcissistic are the most frequently seen personality disorders. Other diagnoses include polysubstance abuse, depression and borderline intelligence (in more recent times attention deficit and attention deficit/hyperactivity disorders are seen). Treatment recommendations often consist of anger management and social skills classes, sometimes antidepressants. In short, clients fall through the chasms of the educational, social services, criminal and mental health systems. Inevitably, they become caught in the revolving doors of jails and prisons, where they are dismissed as morally inferior and are quickly forgotten.

Gelinas (1983) discusses this "disguised presentation" of survivors of childhood abuse, whose many, complex symptoms lack a distinguishable pattern or discernable etiology. Their relationships are almost always intense, short-lived and destructive. They exhibit a startling propensity for revictimization, which is so great that even their relationships with mental health and criminal justice systems take on the dynamics of the abusive family (Herman, 1992). Herman (1992) suggests that many trauma victims are misdiagnosed, stigmatized with diagnoses of untreatable personality disorders. The most common response is to "refer them" (Lazarus, 1990) and/or blame the clients for their problems. It is Herman's position that continued research into the causes and effects of trauma will result in new conceptualizations of post-traumatic stress disorder and personality disorders. She proposes the diagnosis "complex post-traumatic stress disorder" to describe the effects of prolonged trauma (Herman, 1992).

Herman's diagnosis has not yet been fully adopted. However, the committee responsible for refining the definition of post-traumatic stress disorder (American Psychiatric Association, 1994) considered the work of Herman and others, and, based on this evolving understanding of trauma recommended a new diagnosis of "disorders of extreme stress not otherwise specified" (DESNOS). Criteria for the diagnosis include, among other traits, lasting characterological changes following chronic trauma, and address the impact of trauma at different stages of development. Thus, it is becoming evident that characterological disorders are in many instances part of the expected sequelae of trauma.

Understanding trauma helps defense teams establish and maintain positive relationships with clients. Bowlby (in van der Kolk, 1987, p.32) has found that "the most powerful influence in overcoming the impact of psychological trauma seems to be the availability of a caregiver who can be blindly trusted when one's own resources are inadequate." The client's relationship with the defense team is likely his first encounter with individuals who possess greater insight, judgment and skills, and who can therefore be trusted to act in his best interest, protect him from a death sentence and help him make sense of his unimaginably confusing life. This takes time, and results are achieved as the relationship grows and develops. Trust is earned, not given. The client may test the defense a hundred times. There may be forward movement only to be followed by disappointing regression. The relationship is the vehicle for the work and must maintain a position of prominence. Above all, it should be remembered that in most cases, the client -- no matter how competent and integrated he may sometimes appear -- suffers from a number of intellectual, social and emotional impairments that can take a hundred different forms and have culminated in the charges the client faces.

When defense teams can view clients as effectively mute -- with no voice to describe the atrocities they have suffered -- and see clients' perplexing behaviors as diagnostic of the

wounds they carry, team members can maintain the perspective necessary to circumvent many of the barriers that inevitably arise during capital cases. To achieve this perspective, defense team members must see themselves as scientists -- trained observers who record and analyze the thoughts and actions of the client in order to uncover how the client's personality developed. Defense team members must also observed their own actions and reactions and see these responses as potentially diagnostic of the client's problems and of the kind of dynamic that is forming between the client and the team. The team should examine extreme negative emotions, including anger, disgust, or a desire to quit working on the case; these are important flags and should be examined by the team. Conversely, benevolent emotions such as extreme empathy and pity, or an intense need to befriend the client, may be a sign that team members have identified with the client in an unhealthy way. One of the strongest indicators of problems is discord within the defense team. If members find themselves taking positions about the client and arguing over who is right, morally correct, etc., it may be a sign that the team has lost its objectivity and recreated a triangular dynamic of victim, perpetrator and rescuer, in which team members take on different roles at different times. This dynamic can be devastating, keeping the team mired in unchecked emotions and unproductive behaviors. In extreme cases, the result is an hysterical frenzy that resembles the dynamics of the client's family and severely compromises the team's effectiveness. The best medicine is prevention. Dialogue among team members is essential. There should be routine debriefings of all interactions with the client and lay witnesses, which involve describing the content of the conversations as well as impressions and reactions.

Maintaining a balanced perspective requires the ability to simultaneously attend to *process* and *product*, see the *forest* and the trees, observe the *client* and *oneself*. For most people, achieving this delicate balance is an acquired skill, the fruit of patience, determination and practice. However, the benefits to the client and the case can be immeasurable, for insight is the defense team's most valuable tool.

**Summary**

Capital cases are complex. Many variables determine the outcome of the case, most of which are outside the control of the defense. The factor with the greatest potential for determining the outcome of the case is the client. Problems that undermine the effectiveness of the defense team are usually associated with the client's impairments or to the dynamics between the client and the defense team.

The client comes into the case with numerous handicaps and generally has little insight about his limitations. He is powerless, having been, thrust into the hands of people he does not know and does not trust. He has no templates for trusting relationships. He has been exploited and abused; he suffers the invisible scars of this abuse. His intellectual, social and emotional impairments manifest in behaviors that thwart the efforts of the defense team: He can't give a consistent, coherent account of the offense, adequately understand the charges or the state's case against him, identify lay witnesses, or work with expert witnesses. His moods change inexplicably, and he appears manipulative, often refusing to assist with investigation into essential aspects of the case (most notably, mitigation).

The client's behaviors are directly related to the nature of his neglect and abuse. Left unchecked, the effects of the abuse will take control of the case, perpetuating a pattern of selfdestructiveness. This will bleed onto the defense team, infecting members and causing internal conflict. The relationship between the client and the defense team is the primary vehicle for reshaping the client's thinking and behavior. This requires objectivity and insight. The team must work systematically to accomplish important instrumental tasks, while monitoring the dynamics between the client and the team. Generally, a stable, dependable relationship with the client enables him to disclose his "story" and ameliorates his self-defeating tendencies. This in turn allows team members to develop a compelling theory of defense.

Achieving a stable relationship between the client and the defense team is an ongoing process with many ups and downs. The key is perseverance and a mechanism for processing day-to-day events in light of overall goals. Conversation and interaction is essential. The left hand must know what the right is doing. All teams members need to be heard, all significant concerns discussed. This helps identify important, unknown issues, as well as discharge the toxic effects inherent in sharing the burden of pain.

Sometimes barriers seem insurmountable, problems insoluble. Rarely is this true. Rather, the wisdom of the group is vast, its resources great. When in doubt, simply show up and be present. Trust the process. Take what you get and see what happens; one never knows how today's efforts will shape events ten years hence. Learn from each day's mistakes; forgive others their shortcomings and failures and move on. Above all, be patient with yourself and never give up.

**Endnotes**

1. This typically occurs during confessions, where authorities provide the client information about what he did, how he did it, in what order, etc. These suggestions are usually offered affably, in the spirit of "cooperation" and an interest in "getting at the truth." The client's neediness and inability to fully understand social and professional roles causes him to want to please and gain approval agrees with suggestions, even when he is confused.

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# Chapter 29: Understanding Severe Traumatization

**by Lizabeth Roemer & Leslie Lebowitz**

Emotional, physical or psychological traumatic experiences, particularly chronic and/or severe, early traumas, often leave long lasting psychological consequences in their wake. This traumatic legacy takes many forms: Trauma survivors can react dramatically to undetectable or slight provocation, or respond to recollected images of horror in their heads that others can't see, rather than their external environment. Some survivors of trauma may appear emotionally callous, detached, and distrustful of others, or express rage and apparently undue aggression, but show little or no remorse. People who have been traumatized may also display extreme, fluctuating emotions, and may alternate between extreme dependency and marked disconnection in their relationships with others. They may display little regard for their own or others' safety and well-being. When these behaviors are not interpreted in the context of the person's past trauma, they appear disagreeable or odd at best, and reprehensible at worst. The shame and secrecy surrounding traumatic experience compounds this predicament, with individuals rarely disclosing the histories which would provide meaning and context for their actions. A traumatic experience may so profoundly alter an individual's feelings, thoughts and reactions, forming and shaping the person's personality and way of relating to the world, that even a distant past event can dramatically influence present day experience and behavior.

Traumatic experiences, particularly when they are prolonged, severe and happen during childhood, disrupt basic human emotional, cognitive, and physiological processes, resulting in pervasive, far-reaching consequences. However, in spite of the broad reach of traumatic injury, it is often difficult to identify and understand the traumatic origins of the problems many victims have. In this article, we aim to provide a context in which to understand those individuals for whom the wake of trauma has led to destructive, debilitating actions and reactions. We first provide an overview of the definition of a potentially traumatizing event and its effects, then we discuss the particular risks of chronic childhood trauma which are pertinent to this discussion. The bulk of the paper is devoted to describing how traumatic experience can disrupt the optimal functioning of our cognitive, physiological and emotional systems. We conclude with a brief overview of some of the potential long-term effects of traumatic experiences most relevant to our understanding of destructive behavior, focusing particularly on hypersensitivity and reactivity, and conscious and unconscious efforts to avoid traumatic memories and feelings. Placing a client in the context outlined here may help seemingly inexplicable actions become understandable.

### What is a traumatic experience?

According to the Diagnostic and Statistical Manual for Psychiatric Disorders criteria for Post-Traumatic Stress Disorder, a potentially traumatizing event is one in which an "individual experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (see DSM-IV, APA, 1994). The DSM criteria also specify a subjective response that is characterized by fear, helplessness, and/or horror. Research and clinical observation indicate that the range of events falling under this classification (*e.g.*, physical or sexual assault/abuse; witnessing violence to others; sudden, unexpected death of a loved one; severe physical and emotional neglect) evoke several characteristic responses from the individual: a) the experience of extreme, overwhelming emotions (*e.g.*, terror, helplessness, horror, rage, shame); b) heightened, sustained physiological arousal; and c) the shattering and/or distortion of basic beliefs and assumptions that are necessary for us to function optimally in the world (*e.g.*, that there is some safety and predictability in the world, that the self has some power and worth, that some people are good and trustworthy).

To be traumatized is, by definition, to have the untenable happen; a victim is left with the almost insurmountable task of making sense of and coping with something that is overwhelming, beyond comprehension, inherently unacceptable. For example, a boy who watched his mother being beaten and raped experiences debilitating fear, along with incapacitating shame and guilt at not having rescued her (even in the case where any effort on his part would have been futile). He may be left with a profound sense of danger and lack of meaning in the world, along with a malignant sense of self, that may preclude his ability to form mutually satisfying relationships, find meaningful work. The potentially devastating impact of trauma cannot be overemphasized.

The nature and course of post-trauma response is of course varied and complex, shaped by a host of factors (*e.g.*, severity and frequency of traumatic exposure, age of victimization, level and nature of pre-trauma functioning, and characteristics of the recovery environment [Green, Wilson, & Lindy, 1985). Certainly many victims are fortunate enough to have the internal and external resources (*e.g.*, emotional support, effective coping skills, a history of positive relationships) necessary to cope with horrible events in such a way that their adjustment is relatively smooth, resulting in few, if any, long-term negative effects. Others, however, are not so lucky due to characteristics of the events themselves, their developmental history, or the environment in which they struggle to cope with these experiences. Often traumatic histories are compounded by additional stressors (*e.g.*, poverty, oppression) and the occurrence of additional traumatizing events, significantly reducing the possibility of successful recovery.

We will focus here on the kinds of lingering, debilitating difficulties some victims experience in order to provide a context for understanding and empathizing with people whose

traumatic histories have shaped and altered their lives in destructive ways. (see Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 1996, for more extensive discussions of the range of post- traumatic sequelae and factors of risk and resiliency). Although we include in our discussion those characteristics which fall under the diagnostic category of post-traumatic stress disorder (PTSD), we describe here a broader array of damage and dysfunction that is often associated with severe traumatization and is not adequately described by the diagnostic category of PTSD.

**When the victim is a child.** Although detailed discussion of the range of factors that impact traumatic recovery is beyond the scope of this paper, we highlight one of particular relevance: the age at which victimization occurs. Trauma that occurs during adulthood burdens an already formed personality. However, trauma that occurs during childhood often alters the very course of personality development (Herman, 1997). During childhood, we are just beginning to develop the capacities that help us function and thrive in the world: we are learning how to understand, manage, and regulate our emotional experience; we are developing our views of the world and ourselves; we are forming attachments and blueprints of relationships that will be the basis for all our future interpersonal relationships and the neural pathways and biochemical patterns of our brains are being established. Prolonged victimization and/or recurrent exposure to horrible, overwhelming events shape these emerging abilities in ways that profoundly impact the course of our future development. Such experiences may preclude the development of healthy ways of coping with our emotions, or functional views of the world, ourselves, and relationships, all deficits which will significantly affect every subsequent reaction and interaction we have. Researchers have even demonstrated that our brains will not adequately acquire capabilities we take for granted (*e.g.*, being able to talk about our feelings, think before we act, regulate our impulses) if we do not receive the appropriate stimulation (warmth, attention, control over our environments) at certain critical periods of development (Perry, 1997).

Children are also more vulnerable to the negative effects of trauma because they have less power than adults and they are less able to find means of escaping, or even comprehending, a traumatic situation, leaving them more susceptible to feelings of helplessness, arguably the core traumatic emotion. Children who are abused within the family are placed in a particularly untenable position: the adults they must rely on to meet their basic physical and emotional needs have betrayed them. They are faced with dramatically conflicting imperatives: the powerful human drive to attach to a caregiver, to rely on someone, to bond, and the need to protect oneself from abuse and make sense of a situation which defies comprehension. How can this person I rely on, trust and love do such horrible things? How can someone who is supposed to love me treat me this way? The absence of satisfactory answers to these questions and/or their probable answers in the direction of self-blame profoundly shapes a child's sense of the world, relationships, and, perhaps most tragically, his/her own self-worth.

A naive observer might expect childhood events to be more easily forgotten, "put in the past," so the victim can "move on." However, there is evidence that, for many individuals, traumatic memories do not fade with the passage of time. For some they will become "integrated" and modified by subsequent experience and learning, thereby lessening their emotional intensity and functional impact. But, in the absence of these reparative and transformative processes, they will remain as emotionally vivid as the day they were experienced. Thus, managing a traumatic event involves coping not only with the event itself, but also with the endurance of that event inside oneself — the intense feelings, graphic images, and life-altering thoughts that persist long after the event itself has passed. Because we are accustomed to the way non-traumatic memories gradually decrease in intensity and salience, we might minimize or underestimate the impact of a horror that does not dissipate over time. To understand the experience of a trauma survivor, we must imagine what it would feel like to continue to relive an unbearable event, with all of its concomitant horror, fear, and helplessness without our volition even years after the event is past.

**The impact of traumatic experience on the individual.** Researchers and clinicians recognize that the psychological consequences of trauma affect multiple domains of functioning: emotional, cognitive, physiological. In each area, traumatic experience disrupts and dysregulates the delicate balance that allows each system to respond optimally to incoming information. These disruptions in intrapersonal processes reciprocally interact with the interpersonal ruptures that accompany traumatic experience (*e.g.*, loss of trust in significant others, shame-induced isolation from others) with each deficit potentially exacerbating the others in an escalating cycle. Within this traumagenic internal and interpersonal context, some victims come to behave in ways that are self-destructive and/or destructive to others. We describe below how traumatic experience alters our thoughts and perceptions, our physiology, and our emotionality. We then discuss some of the long-term consequences of these experiences which helps explain the men and women whose lives have been negatively effected by traumatic experience.

### Effects on Thoughts and Schemas

How we construct and organize our experience.

What each of us perceives as "real" in the world is actually a composite that is a product of our selective attention to information and our subjective interpretation of that information. In other words, we construct our reality - through the development of "schemas." Schemas are the enduring mental structures - mental maps - that help us make sense of the immense amount of information that continually confronts us. We develop these schemas at both conscious and unconscious, micro and macro, levels. Schemas guide us in areas that range from trivial and concrete tasks to the most meaningful questions about our sense of self and the world. For instance, when

we encounter a new baby, our actions are guided by our schemas: If we have had extensive prior experience with babies who enjoy being tickled, we are likely to tickle this new baby; if the babies we know prefer gentler play, we may rock this baby and sing to it. Our reaction is more heavily based on our prior experience than on new information about this particular baby. Ideally, however, if this baby responds counter to our expectations, we will search out alternative strategies, and alter our schema. In this way, our expectations and knowledge base (our schemas) are molded by our experience, and our behavior is in turn guided by these schemas. These schemas guide our interpretation of (and reaction to) events in our environment, reducing the mental work involved in making assessments and decisions. However, this expediency brings with it the risk of misperception or distortion: if we expect the baby to like being tickled, we are considerably more likely to notice indications that s/he is enjoying this activity than we are to note any contradictory information, and we might never try out her favorite games if they are not represented in our schema. Our method of cognitive processing contains a danger within it: The most efficient, definitive way to process information is through rigid adherence to schemas. However, rigid, extreme schemas lead to rigid (and often maladaptive) ways of behaving. Rigid schemas are often inaccurate, distorted, or negative, all of which lead to problematic actions. For instance, a caretaker's schema that babies don't need to be played with at all would have profoundly detrimental consequences for the baby of that caretaker. On the other hand, overly flexible schemas wouldn't provide sufficiently clear and automatic guidelines for functioning.

In addition to these types of specific schemas regarding various situations and events, we develop more central schemas which encompass our perceptions and expectations of ourselves, the world, and other people. It is generally accepted that certain basic schemas allow us to function optimally in the world (Epstein, 1994; Janoff-Bullman, 1985; McCann & Pearlmann, 1990). In general, people need to have some sense of safety in the world and to feel they can rely on themselves and others to ensure that safety. Also, people need to have a sense of self-worth and to feel valued by those people they trust. Further, people need to believe in some type of order, meaning and fairness in the world, that things happen for a reason, that life is not totally capricious. These basic assumptions are what enable us to interact proactively, planfully, and positively in the world, develop relationships, care for ourselves and others, explore new places, and treat others fairly. For instance, because we believe that we can trust some people, we act in trusting ways with them, which increases the chances they will be deserving of this trust. In this way schemas are self-fulfilling prophecies.

**How we process information that is inconsistent with our schemas.** We are often confronted with information that is inconsistent with our existing schemas, both our central, basic, schemas and our more specific, concrete schemas. When this occurs, one of two things must happen. Either we must alter the incoming information so it remains consistent with the schema, in which case our schema remains unchanged (referred to as assimilation), or we must modify our schema so that it encompasses the information at hand (accommodation). Referring back to our prior example of the baby: assimilation would be occurring if we interpret the babies' cries as squeals of glee so this event is consistent with our "babies like to be tickled" schema. Or, we might (more appropriately) accommodate the information that this baby is different by altering our schema to "some babies like to be tickled and this one does not." Our psychological equilibrium is in part maintained by our ability to balance these two processes of assimilation and accommodation so that our schemas grow and positively reflect reality but we also maintain a relatively consistent view of the world. In other words, we do best when we are able to establish and maintain flexible, positive schemas.

Clearly, our process of maintaining cognitive homeostasis is quite complex and multifaceted. We need to make meaning of our world, to understand it, to develop expectations and beliefs that will guide us and help us efficiently organize incoming information. However, if our beliefs are too rigid, definitive, negative, absolute, they will lead to distortions. We must interpret information in light of our schemas, yet at times we need to reassess our schemas in light of our experience. And we must generally maintain some faith in ourselves, the world, and others. However, if this faith is extreme, or overstated, it may lead to dangerous behaviors, or may be easily shattered. Traumatic experiences rupture this homeostasis at nearly every level.

**How traumatic experience disrupts our cognitive equilibrium.** Our need to understand, comprehend, and make sense of experiences is dramatically heightened when events are emotional, overwhelming, unpredictable, and challenge our central, basic schemas. A trauma victim is confronted with experiences that cry out for comprehension, for schemas which will structure and order them, for some sense of meaning and purpose. Yet the overwhelmingly negative nature of traumatic events make them difficult to reconcile with positive, coherent, agentive views of self and others. Often, profound contradictions exist even within the event itself: a father is affectionate and loving, yet violates a child claiming it is her fault, then apologizes profusely and says how much he loves her. There is no simple construction of this event that can maintain positive core assumptions and adequately explain the entirety of the victim's experience.

Nonetheless, human beings need to maintain a coherent understanding of reality. The lack of clear positive answers in a traumatic situation drives the victim to develop or alter his/her schema to explain what is happening. It is important to note that this process is happening instantaneously, outside of awareness, while the victim is in a state of hyperarousal that interferes with any form of reasoned, analytic thought (as described below). In this state, the victim is vulnerable to embracing definitive, extreme, negative schemas which are con-

sistent with what is happening (*e.g.*, they are helpless, they are to blame, the world is unfair). Often a victim will embrace one negative belief, which will serve to protect several other positive beliefs. For instance, blaming yourself for what your father has done to you preserves your trust and faith in him. Once these beliefs have been adopted in a state of extreme emotion, they exert a powerful influence on subsequent behavior and adaptation. The rigid, extreme nature of these negative schemas interferes with the incorporation of new information, contributing to their maintenance.

In cases of chronic developmental trauma, more positive fundamental schemas (*e.g.*, the world is safe, has meaning, people can be trusted) never even have the chance to develop. Instead the child, based on her/his experiences, may form primary beliefs that the world is unsafe, that people cannot be trusted, that fairness should not be expected, and that there is something fundamentally wrong with her/him, and that s/he has no future. How can this child form a meaningful, positive connection with another person when this is what s/he expects to find? How will s/he learn to follow the rules of society, when these rules apparently contain no justice or even predictability for her/him and when s/he can not imagine a future? These negative assumptions will color every future interaction, both in terms of what the survivor perceives (*e.g.*, misconstruing helpful behavior as malevolently motivated), and how the survivor acts (*e.g.*, hurting others before they can hurt him/her).

However, human needs are remarkably robust, and the basic human need to relate to others, to venture out into the world, even to value oneself, does not completely deteriorate in the context of these negative schemas. Unfortunately, this may only lead to further difficulties for a trauma survivor. The survivor is motivated to act in ways that are inconsistent with her/his negative schemas, and is therefore acting without the guidance of adaptive schemas. S/he is at risk then of forming a relationship with someone who is untrustworthy, because s/he hasn't formed a series of guidelines for determining whether someone should be trusted. Without this type of schema, signals of danger may easily be overlooked, increasing the risk of revictimization, further confirming negative schemas. Similarly, a survivor might find him/herself in a dangerous situation because his/her extreme view that every situation is fraught with danger precludes the ability to adequately assess and ensure relative levels of safety and self-protection. The survivor often oscillates between extremes in relation to his/her environment - at times acting like a daredevil, at other times being cautious and overly careful; at times indiscriminately seeking connection, at other times being isolative. The rigidity with which these schemas have developed, coupled with the physiological and emotional constraints discussed below, greatly interferes with the survivor's ability to find any middle ground in his/her cognitive construction of the world - each extreme drives the opposing extreme in an endless, self-perpetuating cycle. (*e.g.*, the inevitable negative outcome when a survivor acts without consideration of safety confirms beliefs that the world is unsafe, further restricting subsequent behavior, increasing the need to finally break out of that constraint, etc.)

### Effects on the Brain

**How we maintain biological equilibrium.** Our brains involve multiple, intricate, interconnected systems designed to detect internal and external stimuli, identify and interpret them, integrate complex information coming from multiple sources, and motivate appropriate action. Contrary to common belief, the human brain is not a fixed, unchanging organ but rather develops and is shaped in an ongoing fashion by the environment. Each environmentally triggered physiological reaction causes a chain of events in the brain (*e.g.*, release of neurotransmitters) as information is passed from one system to another (stimulating the release of other neurotransmitters). Elaborate checks and balances regulate these events in an effort to maintain homeostasis in the brain's chemistry; in this way the brain remains prepared to detect future new information and process it accordingly. For instance, upon detection of threatening information, catecholemines are immediately released, preparing the organism for quick unreflective responses of fighting or fleeing. Simultaneously, other regulatory neurotransmitters are released, in order to return the organism to baseline where it is prepared to carefully assess further incoming information. Higher cortical activity (thinking and reasoning) further helps to modulate and regulate the more primal fight or flight response. In this way we are able to quickly jump out of the way of a moving bus without first deliberating, yet shortly afterward are able to carefully look both ways, calculate the relative speed of oncoming traffic and therefore safely venture across the street. Once on the other side, we are able to reflect on this experience, learn from it, and therefore potentially avoid future dangers. The initial fight or flight response enables us to establish immediate safety; deliberation at that point would be fatal. However, the subsequent regulatory mechanisms are what enable us to continue functioning in the world, and to learn from our experience.

**How traumatic experience disrupts our biological equilibrium.** Just as trauma overwhelms our natural cognitive regulatory systems, it can also short-circuit our biological regulation. Traumatic experience produces such a strong and overwhelming fight or flight response, that it compromises our brain's regulatory functions, with negative long-term consequences. Evolutionarily, it has been essential that the brain's responses to threats of harm are immediate and extreme. If a saber-tooth tiger approaches you, unless you immediately perceive the danger and are activated to run or fight, you will die. Dangerous events thus evoke powerful responses from our brain, sending massive amounts of neurotransmitters coursing through the structures of our brain, resulting in a cascade of hormones and resultant bodily sensations (rapid heart beat, sweating, increased blood pressure), attentional consequences (narrowing of attention, heightened awareness of threat cues, lack of attention to unrelated cues), and motoric responses (*e.g.*, heightened ability to run or fight). For discrete dangers,

this is quite functional, the individual is able to attend to the necessary information at hand, enact the appropriate behaviors to ensure survival and then return to baseline functioning.

However, chronic danger produces chronic activation of what was likely intended as a rapid response systems and the long-term consequences of these reactions can be damaging. Research has shown that chronic exposure to traumatic stress - to the hormones and neurochemicals that are released within us in reaction to it - impacts the brain's chemistry and physiology. Individuals with a history of chronic traumatic experiences exhibit increased levels of baseline arousal, heightened physiological reactivity to both trauma-relevant and neutral information, increased levels of catecholomines (*e.g.*, adrenaline), dysregulation of regulatory neurotransmitters, and increased levels of neurochemicals (endogenous opioids) which may be associated with emotional numbing. These effects may even have a structural impact on the organs of the brain. For example, stress hormones may cause actual cell death in the hippocampus, an area of the brain that plays an important role in evaluation and consolidation of new information to be stored in memory (see van der Kolk, 1996, for a review of the biological effects of trauma).

So, after chronic exposure to overwhelming, terrifying experiences, an individual's physiology may be altered so that they remain in a state of readiness to perceive threat and act immediately. These alterations may interfere with the brain's ability to process information completely by short-circuiting the balanced relationship between primal immediate responding and higher cortical reasoning and analyzing. Usually, information travels through an intricate network of brain cells (neurons) that begins by registering sensory information in the most "primitive" parts of the brain. It then continues through other parts of the brain — such as the amygdala — that assign an emotional tone to the information, and then threads its way into the most evolutionarily advanced part of the brain, the neocortex, where the information can be integrated with the brain's most complex forms of functioning such as the ability to reason and the ability to transform experience into language. In a state of arousal, this system is short-circuited in order to facilitate rapid response. Thus, in a crisis, sensory stimuli (such as hearing an angry tone of voice or seeing a hostile facial expression) immediately signal bodily responses that prepare for action, with little or no cortical mediation. This may compromise an individual's ability to control their reactions; it is through cortical activity that we reason, weigh options, and deliberate. When we remain in a constant physiological state of readiness, we are always ready to jump out of the way of the bus (even when it wasn't really going to hit us), but far less able to assess relative danger and determine a safe opportunity to make our way across the street. This over-reaction to threat can be easily triggered by reminders of a previous traumatic experience.

This reduction in cortical mediation yields pervasive psychological consequences. As described above, being confronted with a traumatic event provides an immense challenge to our meaning-making structures, our schemas. However, the depletion of cortical involvement significantly impedes our ability to negotiate such a challenge. Not surprising, then, that a trauma survivor has difficulty developing or maintaining the type of complex schematic structures that might provide meaning for the experience while still maintaining necessary positive assumptions. Lack of cortical mediation similarly interferes with the survivor's ability to regulate his/her emotional experience, as described below.

### Effects on our Emotions

**The function of emotions and emotional regulation.** Our emotional responses provide us with essential information about our environment that motivates our actions and helps us to function effectively in the world. Each emotion brings with it specific information and physiological reactions which guide our actions. Just as cognitive and physiological balance and flexibility is important for our well-being, so is emotional regulation. We need to be able to recognize our emotional responses, understand them, and modulate them. We want to be aware of our feelings, but not be compelled to action solely based on these feelings. The balance between amygdala responses and higher cortical reasoning described above is one of the ways that we achieve this regulation. Ideally, we experience our emotions, but analyze and interpret them before acting. Traumatic experiences typically evoke powerful, overwhelming feelings of fear, rage, helplessness, grief, guilt, shame and alienation (which can cause uncontrollable behavior). Moderate levels of these emotions occur in everyday life, and individuals are usually able to cope with them through a variety of processes which involve some combination of experiencing (enduring) them, expressing and/or sharing them, and understanding them until they gradually lessen and abate. The key here is balance. Denial and suppression of emotion is no more healthy than is complete abandonment to one's emotional state. In general, most people are able to maintain a state of emotional equilibrium in which they are responsive to events, but not overcome by them.

**How traumatic experience disrupts our emotional regulation.** During a traumatic experience, emotions are so unbearably intense, intolerable, and overwhelming that they either deactivate or defy our normal coping strategies. For example, horror, fear, helplessness, shame, and despair that accompanies being raped by your favorite uncle outstrips normal regulatory responses. However, human beings don't just cease trying to respond effectively to their environment. Dramatic forms of emotional experiences instead invoke equally dramatic forms of emotional regulation, often outside of awareness. Rather than the typical vacillation between some degree of emotionality and some degree of regulation, resulting in an optimal balance between the two; traumatic affects usually result in extreme, absolute regulation and constriction, prompting an extreme vacillation between all-consuming emotionality, and disrupted, apparently absent emotion. Under ideal circumstances (*i.e.*, normal bereavement) social mechanisms and support provide a way to move back and forth between these

extremes, gradually processing the feelings and meanings of the event until they lessen in intensity and equilibrium is re-established. Trauma, however, is more extreme than a normal stressor and we have no established social processes to deal with it. Hence, more extreme strategies are often used and, more importantly, in the absence of meaningful social assistance, often maintained. The most serious consequences of traumatic experience come from the endurance of what are "intended" to be brief responses. Dissociation provides an excellent example of this.

**Dissociation and emotional numbing.** During traumatic experiences, victims often report experiencing themselves as separate from their bodies, sometimes watching from above or from the corner of the room. In these descriptions, the victim becomes an observer and is no longer experiencing the emotions of the person who is in the process of being victimized. S/he can see everything that is happening, and may even know how the victim is feeling, but the act of dissociation protects him/her from actually experiencing the overwhelming emotion. This is a highly effective form of responding to unbearable feeling in the moment as it greatly reduces the intensity of emotion. However, recent studies indicate that these responses may have detrimental long-term psychological consequences and are an important predictor of subsequent post-traumatic symptomatology (see van der Kolk, van der Hart, & Marmar, 1996, for a review).

Another extreme emotional adaptation used by trauma victims is emotional "numbing." Victims commonly report feeling shocked or "numb" during victimization, particularly when it is chronic and prolonged. Some researchers have suggested that secretion of endogenous opioids may be associated with this response (van der Kolk, 1996). It is unclear whether reports of numbing indicate actual deficits in emotionality or if they instead indicate an overwhelming, undifferentiated response that the victim cannot identify or acknowledge, and so construes as numbing. Again, this numbing is an effective means of managing the initial traumatic impact since it lessens (although doesn't eliminate) emotional intensity. However, again numbing does not seem to lead to long-lasting relief and it can lead to long-term impairment.

Both numbing and dissociation may first emerge during a traumatic experience, but they often remain as common emotional regulation strategies in the wake of trauma, interfering with survivors' recovery. Although both strategies originate in response to extreme emotions, they become habitual and are then elicited by a range of emotional experiences. A rape survivor may find that during a stressful conversation with his mother, he has "checked out" and is experiencing himself as across the room, not following much of the conversation. These responses leave the survivor unaware of his surroundings, unable to respond optimally to his environment (regulate his reactions), and ironically even more vulnerable to threat. Dissociation has been implicated in the prevalence of revictimization among rape survivors (Cloitre, Scarvalone, & Difede, 1997). Ironically, one lives through a horrible event in part by separating oneself from it, and, as a result, comes to easily dissociate from reality, increasing risk for more pain and suffering. These ways of responding also exacerbate one's sense of confusion and inability to make sense of events.

Habitual numbing and emotional constriction bring with them their own unique disruptions of recovery and adaptation. Particularly for male survivors, who are socialized to control and constrict virtually all emotional experiences except anger (Lisak, Hopper, & Song, 1996), overwhelming, dysregulated affect elicits repeated, constant efforts at constriction and concealment. Through a variety of processes that we are just beginning to explore (*e.g.*, opioid mediation, chronic overarousal resulting in the depletion of emotional resources, detachment, isolation and alienation from others motivated by shame and fear [see Litz, 1992, for an extensive discussion]), trauma survivors often appear numb, remote, distant, or emotionally callous. While at a funeral of someone they know they loved, survivors will describe feeling empty, vacant, "knowing" they should feel sad but having no experience of that emotion. This disruption in natural emotional reactions alienates the survivor from his/her own feelings as well as from other people. Often other people will interpret these reactions as indicative of disinterest and callousness. A lifetime of trying to quell overwhelming emotions and maintain safety in a world perceived as dangerous may evoke an external presentation of callousness, but, underneath this exterior, a cauldron of intense, unmodulated, overwhelming feelings resides. This may explain why some defendants display no emotional response when they hear a jury sentence them to death; they have spent years practicing this form of emotional protection and can not help using it at this moment of profound stress and despair.

**Disruptions in describing an emotional event.** One of our most effective ways of regulating an emotional experience is through language. As we describe an event, recall the emotions we felt at the time, and discuss the thoughts we were having, we are integrating this experience more fully, making meaning of it. We are also engaging those structures in the brain associated with regulation of emotion and behavior, enhancing the connections between the emotional memory and higher cortical processes. As we verbally examine our emotions, the feelings are simultaneously accorded a place in our conscious mental structure and tempered by the words we assign them. Describing our feelings also allows others to understand and validate our emotional experience, reducing the isolation that otherwise may exacerbate our emotional distress.

Unfortunately, traumatic events are not easily described for a variety of reasons. Description of these experiences is likely to evoke intolerably painful emotions and memories that the survivor has been trying desperately (both consciously and unconsciously) to avoid. Also, traumatic events often engender shame, due to the degradation and utter helplessness the individual was subject to during victimization as well as the social stigma of victimization. Shame interferes with interpersonal communication. Also, as discussed below, often the

survivor will literally not have access to many elements of the experience, due to dissociation, biological factors (*e.g.*, decreased cortical involvement, hippocampal cell death), and other trauma-related phenomena that interfere with the integration of memory. For men, whose gender socialization demands masculine virtues like emotional stoicism, power, and control, disclosures of traumatic experiences (and the inevitably associated emotionality) threaten their very gender identity, greatly reducing the likelihood of disclosure. Finally, trauma victims often accurately perceive that others do not want to hear about the horrible things they have lived through. They fear rejection, incredulity, and invalidation.

**Disruptions in our storage of emotional experience.** The intense emotions of traumatic experience also influence the storage of traumatic memories. When we experience an emotional event, we store a variety of information about this event in our minds. The sights, sounds, smells, tastes, feelings, sensations, meanings and interpretations of the event are all associated with each other and we are able to access each component when we are reminded of an event. However, traumatic experience overwhelms this process, disrupting attentional and organizational abilities, so that components are not efficiently integrated and stored in memory. Parts of the memory may be fragmented or separated so that the emotions are separate from the thoughts, the pictures separate from the words, parts of the event separate from each other, and the meaning of the event may be distorted or nonexistent. This process of fragmentation may serve to reduce the overwhelming nature of the event at the moment of storage. However, it interferes with our ability to make sense of and understand the event later, further interfering with the development of flexible, adaptive schemas. When something in the environment reminds the survivor of the experience (*e.g.*, a smell, a voice), only a fragment of the experience may be recalled (*e.g.*, the image of a face, a feeling of dread). The connections which would help understand these responses may be absent, leaving the survivor bewildered, frightened or angry, motivated by impulses s/he cannot understand. For example, a victim hears a male voice and experiences an overwhelming desire to strike out, with little awareness that this impulse is not being motivated by current experience, but is instead activated by unintegrated memories of the past. For instance, the voice might sound like his older brother's, who anally raped him repeatedly during childhood. However, his conscious experience might consist only of this impulse to harm, out of fear or self-protection. In the absence of the modulating effect of understanding the context of this impulse, *i.e.* accessing more elements of the memory in order to help identify the impulse as historical rather than current, he may act on his impulses (particularly given that his inhibitory abilities may not be fully developed due to development trauma) without any externally adequate cause.

**The long-term impact of traumatic experiences.** Traumatic experiences disrupt the basic human processes of emotion, cognition and physiology. When these disruptions are not counteracted by equally powerful positive experiences (*e.g.*, exceptionally loving and supportive long-term relationships), the consequences are often extensive, and devastating. Reactive, extreme, dysregulated functioning interferes with the establishment of mutually satisfying relationships. Conversely, our ability to regulate our feelings and maintain adaptive schemas is predicated on a minimal level of positive interpersonal relationships. Interpersonal violence (particularly when it originates from primary attachment figures) disrupts both intrapersonal and interpersonal functioning, creating a debilitating cycle of biological, emotional, cognitive and relational effects. Our interpersonal relationships are the foundation for our membership in society. We comply with the guidelines of society because we can, and because of our sense of connection to the whole, our identity within the group. The disruption of basic regulatory abilities and the psychological foundations for this sense of belonging pose a two-pronged threat to our ability to conform to society's rules.

The traumatic legacy of pervasive dysregulation, alienation, despair, terror, rage, and self-hatred results in a host of devastating sequelae. Traumatic sequelae are far from static: efforts to minimize one set of difficulties elicit a host of new problems resulting in a constantly changing picture, reflecting the struggle to adapt. Trauma survivors commonly alternate between phases of over- and under-control, sometimes cycling within an hour, sometimes over a decade or a lifetime, reflecting the different demands of trauma (to avoid versus to make sense) Many aspects of survivors' actions are contradictory, further compounding their difficulty understanding themselves, and our difficulty understanding them. We highlight below two components of possible long-term reactions to trauma that may particularly account for participation in apparently inexplicable, destructive actions. They represent the two poles of the dialectic of the traumatic legacy: intrusive recollections and extreme, reactive emotionality versus endless, futile efforts to avoid and banish chronic, intolerable distress.

**Reactivity and hypersensitivity to danger.** A survivor of severe trauma whose recovery has been thwarted lives in a state of constant readiness. High levels of arousal and hypervigilance, and schemas regarding the lack of safety in the world, combine to create a style of processing information that is exquisitely sensitive to the slightest indication of threat and often overlooks evidence of safety. Individuals may respond to benign cues with hostility, preparing to fight and protect themselves, and thus elicit hostile responses from others, exacerbating the situation. Heightened reactivity to trauma-related cues compounds the risks associated with this style of responding. A trauma survivor may be triggered and find him/herself in a state of alarm and readiness without understanding why, and may react impulsively, uncontrollably, at times violently and aggressively, because his/her reasoning ability is temporarily diminished and short-circuited. Violent actions are particularly likely, both because they are a natural response to feeling threatened, and because survivors are often raised in extremely violent environments, learning that such actions

are appropriate ways of responding to conflict or danger. Traumatized men may be particularly at risk for violent, aggressive actions because anger is one of the few emotional outlets permitted by their gender socialization. Violent actions are also self-perpetuating, both because they elicit violent responses from others, confirming the perception of danger and need for self-protection, and because they temporarily alleviate the sense of helplessness and powerlessness that is so devastating for trauma survivors. The factors that typically inhibit violent behavior (ability to reason and weigh options, compassion for self and others, belief in a sense of justice and meaning in the world) are often disrupted among these survivors, so that a pattern of violence can easily be established and maintained.

**Avoidance efforts which may mask traumatic symptoms.** One of the challenges to recognizing trauma-related difficulties is the fluctuating nature of symptoms and responses, and the range of behaviors that serve to mask the traumatic etiology of distress. The overwhelming, intense, horrible nature of trauma-related thoughts, feelings, and images motivates elaborate, complex efforts of avoidance (usually without conscious awareness of this goal). These effects are ultimately ineffective, except in masking the initial source of suffering. Even when survivors display what we have come to accept as the classic post-traumatic response — being bombarded with intrusive recollections, avoiding any situation reminiscent of the trauma, chronically hyperaroused and irritable, detached and numb — they experience periods of numbing and avoidance in which the traumatic source may not be evident and the survivor may appear to be depressed without any obvious cause.

**Concealment of a traumatic history.** The most obvious example of efforts to quell the pain of the trauma is the avoidance or denial of a traumatic history. Discussing abusive experiences tends to activate the associated emotions, often at the same level of intensity with which they were first experienced. (Symptoms and distress commonly intensify initially upon disclosure, extensive resources are needed to facilitate this process [see Herman, 1997; Roth & Batson, 1997, for thorough discussion of the process of disclosure]). Often then, survivors don't disclose events and even deny them when asked directly. Sometimes this lack of disclosure is deliberate, mediated by shame and lack of trust. At other times, the survivor may not have sufficient conscious access to their trauma history to disclose, even if they might want to.

**Alcohol and substance abuse.** Other efforts to modulate distress are less straightforward. Drugs or alcohol are often used as a form of self-medication in order to block post-traumatic symptoms. Even survivors who have maintained sobriety for decades now will confirm that the most effective, immediate way of diminishing traumatic feelings is through substance use. Given that dissociation and numbing are not completely effective, survivors often turn to these more efficient means of regulating their emotions and distracting themselves from their memories. Unfortunately, the benefits are temporary, and chronic substance use brings with it a host of other complicating difficulties, including decreased attention to safety and increases in mistaking behavior, again increasing the chances of further victimization. Social isolation, particularly from nonsubstance using family and friends, compounds feelings of alienation and self-loathing. The financial strain of drug use, coupled with inability to work (due to the entire post-traumatic constellation of responses) increases the likelihood of criminal behaviors.

**Social isolation and disruptions in interpersonal relationships.** Many of the effects and long-term sequelae of traumatic experience we have discussed here disrupt the survivor's interpersonal relationships. Just as substance use initially diminishes distress but has a host of subsequent complications, isolation and interpersonal distance can be momentarily comforting for a trauma survivor. Victims have experienced horrendous degradation and pain at the hands of another person, they are strongly motivated to avoid interpersonal vulnerability and doing so somewhat enhances their sense of safety and protection. Feeling love or a sense of connection to someone else often serves as a traumatic reminder, evoking a host of conflicting, intolerable emotions. Isolation and/or rage protects them from this agony. However, the isolation and alienation further erodes their sense of self-worth, and they cannot banish the natural human need for connection and compassion. These conflicting needs and desires result in inconsistency in their relationships. Survivors may fluctuate between extreme, defiant independence, and equally profound dependence and reliance on others. Or they may insist that they have no need for anyone and consistently act in hostile ways that ensure others will keep their distance, yet unconsciously hope that someone will remain, withstand their constant testing, and show that they are in fact worthy of love. Working with survivors of extreme trauma requires immense patience and endurance. We need to accept that they cannot trust us and believe we are on their side, to do so would be to ignore the extensive experience predicting otherwise, and would make them intolerably vulnerable. However, tentative trust can be developed overtime, as long as we are consistent and forthright and show ourselves to be deserving of that trust.

**Self-destructive, suicidal and homicidal impulses.** The most dramatic efforts to expel, diminish or expunge traumatic memories and feelings come in the form of self-destructive actions like burning or cutting oneself, and, even more dramatically, serious suicidal attempts. Acts of self-harm are often clinically understood as attempts to distract from psychological suffering, or to reconnect, through pain, with one's body after chronic, pervasive dissociation. The depth of suffering and dearth of self-regard necessary for self-inflicted pain to be experienced as a relief is monumental, and hard to understand for those fortunate enough never to have experienced it. Often this despair takes the form of an overwhelming desire to end the pain, and simply cease to exist. Sometimes, the rage toward those who have victimized becomes intertwined with profound self-loathing, so that homicidal and suicidal impulses become entangled, with the survivor feeling driven to do anything to stop the pain and suffering they

experience, to quell their endless rage. Even homicide can sometimes be in part a self-destructive act. Often there is little regard for one's own well-being or concern that incarceration may follow. Also, sometimes homicidal impulses are motivated by a desire to kill what the survivor perceives as a part of him/herself represented in another person. Also, injuring or killing a loved one ultimately causes the survivor pain as well.

## Conclusion

Clearly, we can only provide a snapshot here of how a devastating, severe traumatic history might effect an individual and lead them to behave in destructive, dangerous, criminal ways. Because traumatic events push us to the extremes, leading to profound contradictions in our views of ourselves and others, the legacy of trauma is a fluctuating, often inconsistent, extreme way of responding to the world. Fortunately, many survivors find people and inner strengths along the way that help them develop more positive forms of adaptation, never losing or gradually regaining the ability to regulate their responses, flexibly process information, and adaptively respond to their environments. For those who do not, the patterns described here can be self-perpetuating, with each iteration further diminishing the likelihood that alternative perspectives will be adopted, that more effective forms of regulating emotions will be established, that (perhaps most crucially) positive relationships will be established. The apparent incomprehensibility of many trauma survivors' reactions, coupled with the ways their reactions mask the source of their distress, interferes with our ability (along with their own) to understand their reactions and respond compassionately. By viewing their seemingly inexplicable actions in the context of post-traumatic adaptation, responses become understandable and meaningful, profoundly altering our perceptions of these individuals.

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# Chapter 30: Breaking Through: *Communicating And Collaborating with the Mentally Ill Defendant*

**by Eric Drogin**

*The more elaborate our means of communication, the less we communicate.*
— Joseph Priestley (1733-1804)

## INTRODUCTION

Functioning within a system inured to spending hundreds of dollars an hour on specialized mental health expertise, many criminal defense attorneys adopt a deferential, even disingenuous manner when compelled to comment on the behavior of their own clients: "What do I know? I'm not a psychologist!"

For expert witnesses to wish they had a dollar for every time they heard this would be to ignore the fact that, of course, they already do. Many dollars.

As personally and financially gratifying as this approach may be for the forensic psychological community, one inescapable fact makes it less than ideal for attorneys and the persons they attempt to defend:

No matter what firm you join (to say nothing of working in indigent defense systems), there will *never* be enough money to run every mental health aspect of each case by a mental health expert or consultant.

This may never be more evident than during the initial phases of representation in cases where competency and sanity issues are off the table (and therefore, no funded mental health expertise is forthcoming), important deadlines are looming, and quite simply, you and your client are incapable of working together.

What is frequently overlooked in such cases is that the defense team already has considerable expertise at its disposal. Attorneys, investigators, and other staff persons have their own varied life experiences upon which to draw. In addition, in a somewhat different way from their mental health colleagues, they are themselves students (and, in the courtroom, teachers) of human nature, whose stock in trade already consists of identifying, explaining, and normalizing the behavior of persons from every walk of life.

The purpose of this article is not to turn defense team members into diagnosticians or psychotherapists, but rather to enhance their ability to communicate and collaborate with certain types of mentally ill criminal defendants. Common traits and recommended modes of interaction are identified where clients may be affected by symptoms of depression, mental retardation, paranoid personality disorder, bipolar disorder, Schizophrenia, and substance dependence.

Readers will find frequent references to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. **[1]** While some (but not all) of the diagnostic criteria are identified for each of the disorders listed *supra* (in considerably abbreviated form), these are not intended for use in "ruling in" or "ruling out" the presence of a specific mental illness. Rather, they provide some very general examples of the sorts of actions, thoughts, or feelings defense team members *may* encounter when dealing with mentally ill clients.

## DEPRESSION

According to the *DSM-IV*, persons suffering from a Major Depressive Episode may display:
(1) depressed mood;
(2) diminished interest or pleasure
(3) weight loss;
(4) sleep disturbance;
(5) agitated or slowed movements;
(6) fatigue or loss of energy;
(7) feelings of worthlessness or guilt;
(8) concentration problems or indecisiveness; and
(9) thoughts of death or suicide. **[2]**

During a client interview, depressed defendants may be listless, apathetic, and seemingly disinterested in the details of their representation. Despite the fact that important decisions must be made as soon as possible, they can adopt a frustratingly indifferent attitude about counsel's need for information and advice in the face of rapidly approaching deadlines. Often, the depressed defendant may dissolve into tears, seemingly incapable of taking an active role in his or her own defense.

For these and other reasons, the defense team may wonder whether such persons are actually competent to stand trial. Attorneys sometimes conclude – erroneously – that a client must exhibit psychosis or mental retardation in order to be incompetent. In fact, some severe forms of clinical depression can, in particular, render criminal defendants incapable of participating rationally in their own defense. **[3]**

Once the issue of trial competency has been resolved, the defense team may still be left with a client whose collaborative abilities are minimal at best. Key to establishing a working relationship with such persons is understanding what cognitive behavioral therapists have termed the *cognitive triad*: **[4]**

*The cognitive triad consists of three major cognitive patterns that induce the patient to regard himself, his future, and his experiences in an idiosyncratic manner …*

*The first component of the triad revolves around the patient's negative view of himself. He sees himself as defective, inadequate, diseased, or deprived. He tends to attribute his unpleasant experiences to psychological, moral, or physical defect in himself. In his view, the patient believes that* because *of his presumed defects he is undesirable and worthless. He tends to underestimate or criticize himself because of them. Finally, he believes he lacks the attributes he considers essential to attain happiness and contentment.*

*The second component of the cognitive triad consists of the depressed person's tendency to interpret his ongoing experiences in a negative way. He sees the world as making exorbitant demands on him and/or presenting insuperable obstacles to reaching his life goals. He misinterprets his interactions with his animate or inanimate environment as representing defeat or deprivation. These negative misinterpretations are evident when one observes how the patient negatively construes situations when more plausible, alternative interpretations are available. The depressed person may realize that his initial negative interpretations are biased if he is persuaded to reflect on these less negative alternative explanations. In this way, he can come to realize that he has tailored the facts to fit his preformed negative conclusions.*

*The third component of the cognitive triad consists of a negative view of the future. As the depressed person makes long-range projections, he anticipates that current difficulties or suffering will continue indefinitely. He expects unremitting hardship, frustration, and deprivation. When he considers undertaking a specific task in the immediate future, he expects to fail.* **[5]**

In other words, the depressed criminal defendant is not merely so "sad," "miserable," or "unhappy" that a preoccupation with these emotions is crowding out the desire to assist counsel in developing a viable defense to his or her current charges. Rather, clinical depression is inseparable from an entrenched negative of one's self, situation, and prospects that interferes *logically* with the desire and/or ability to interact effectively.

Cognitive therapists have developed a series of labels to describe these "Common Patterns of Irrational Thinking":

(1) *Emotional reasoning.* A conclusion or inference is based on an emotional state, *i.e.*, "I *feel* this way; therefore, I *am* this way."
(2) *Overgeneralization*. Evidence is drawn from one experience or a small set of experiences to reach an unwarranted conclusion with far-reaching implications.
(3) *Catastrophic thinking*. An extreme example of overgeneralization, in which the impact of a clearly negative event or experience is amplified to extreme proportions, *e.g.*, "If I have a panic attack I will lose *all* control and go crazy (or die)."
(4) *All-or-none (black-or-white; absolutistic) thinking*. An unnecessary division of complex or continuous outcomes into polarized extremes, *e.g.*, "Either I am a success at this, or I'm a total failure."
(5) *Shoulds and musts*. Imperative statements about self that dictate rigid standards or reflect an unrealistic degree of presumed control over external events.
(6) *Negative predictions*. Use of pessimism or earlier experiences of failure to prematurely or inappropriately predict failure in a new situation. Also known as "fortune telling."
(7) *Mind reading*. Negatively toned inferences about the thoughts, intentions, or motives of another person.
(8) *Labeling*. An undesirable characterization of a person or event, *e.g.*, "Because I failed to be selected for ballet, I am a *failure*."
(9) *Personalization*. Interpretation of an event, situation, or behavior as salient or personally indicative of a negative aspect of self.
(10) *Selective negative focus (selective abstraction)*. Undesirable or negative events, memories, or implications are focused on at the expense of recalling or identifying other, more neutral or positive information. In fact, positive information may be ignored or disqualified as irrelevant, atypical, or trivial.
(11) *Cognitive avoidance*. Unpleasant thoughts, feelings, or events are misperceived as overwhelming and/or insurmountable and are actively suppressed or avoided.
(12) *Somatic (mis)focus*. The predisposition to interpret internal stimuli (*e.g.*, heart rate, palpitations, shortness of breath, dizziness, or tingling) as *definite* indications of impending catastrophic events (*i.e.*, heart attack, suffocation, collapse, *etc.*). **[6]**

Realizing the source and nature of these irrational patterns of thinking will help the defense team in determining the best ways to impart and obtain critical information in anticipation of pending hearings and motions.

*These clients should never be told that they are not feeling what they claim to feel*; nor should it simply be asserted that they are "wrong" about their perceptions and predictions concerning the case at hand.

Instead, counsel may elect to:

(1) Acknowledge the client's current feelings.
(2) Point out that counsel has worked with many persons in similar situations, with similar feelings, while owning that this is not, in and of itself, expected to make the client feel better.
(3) Observe that counsel has managed not only to work with, but to help other persons who have felt the same way.
(4) Indicate that counsel sees many aspects of the case a certain way, and understands how and why the client may currently see some aspects differently.
(5) Patiently review some of the issues, not arguing with the client, but gently noting differences of opinion as

they arise, suggesting that the client may come to view some perspectives differently upon later reflection.

(6) Reassure the client that counsel will revisit these issues with the client when there has been some time for both parties to consider them at length.

While detailed consideration of additional measures is beyond the scope of this article, it is assumed that counsel will attend to such usual issues as monitoring for suicidality, obtaining clinical assistance where indicated, and documenting prolonged difficulties in communication and collaboration which may indicate that competency concerns have resurfaced.

## MENTAL RETARDATION

Persons who have received a diagnosis of mental retardation will typically exhibit:

(1) significantly low intellectual functioning; and
(2) impairments in adaptive behavior. **[7]**

These difficulties must begin before the person reaches the age of 18. The Intelligence Quotient ("I.Q.") range associated with this condition is typically 70 or below, although certain test-specific and other considerations may result in such persons having I.Q. scores that are several points higher. **[8]**

Once the presence of mental retardation has been determined, interviewing these criminal defendants takes on a singularly diagnosis-specific aspect. Mitigation experts have maintained that:

People with mental retardation tend to think in concrete and liberal terms. As a result, they may not understand the meaning of such concepts as plea bargain and waiver of rights. One of the safest ways of communicating with people with mental retardation is to use simple words in open-ended questions. Always ask questions that require them to explain their reasoning. If possible, have present a social worker or an individual who is close to the defendant to assist him or her in interpreting what is being said and asked and to ensure that the defendant understands the process. ***[9]***

*This perspective has been echoed in recommendations offered by clinicians, as well:*

Informal clinical interviews with the client (when possible) and informants who know the client well, such as parents, teachers, and day program supervisors, typically initiate the diagnostic process and precede structured assessment procedures. ***[10]***

Although counsel will attempt to converse at a level most likely to be understood by the defendant with Mental retardation, this should not be taken as advice to speak with such persons as if they are children. According to core training resources in the field of psychiatry:

*[T]he interviewer should not be guided by the patient's mental age, which cannot fully characterize the person. A mildly retarded adult with a mental age of 10 is not a 10-year-old child. When addressed as if they were children, some retarded people become justifiably insulted, angry, and uncooperative. Passive and dependent people, alternatively, may assume the child's role that they think is expected of them. In both cases, no valid [information] can be obtained.* **[11]**

The defense team should also remain aware that they are not the only persons interested in obtaining information from the client with mental retardation:

*Keep in mind that the defendant may be unfamiliar with the jail setting and will find themselves wanting to talk to anyone. If possible, counsel should obtain a court order to prevent the prosecution from contacting the defendant.*

*Many prosecutors send police personnel, investigators, or psychologists into the jail to interview the defendant. In most cases, a defendant with mental retardation will talk to these people, and may make false statements and admissions …*

*People with mild mental retardation often have significant difficulty coping and adapting. Skills such as communication, socialization, and functional academic abilities usually are quite limited. These skill deficits limit their ability to interact with their lawyer and to fully understand the significance of their Miranda rights.*

*This is especially problematic because defendants with mental retardation may waive their rights to remain silent or to speak with a lawyer, in favor of talking with interrogators to please them. Given this tendency, characteristics such as acquiescing to those in authority may hinder efforts to learn the truth.* **[12]**

*Because of the likely presence of suggestibility, counsel must be careful not to "lead" criminal defendants into misleading statements about past or present behaviors, feelings, and attitudes. The same dynamics that defense attorneys are concerned will impair a client's Miranda protections may also burden the defense team with bogus information that will frustrate attempts at competent representation.* ***[13]***

## PARANOID PERSONALITY DISORDER

A primary concern in working clients with a paranoid personality disorder is that they not be confused with those suffering from a full-blown Delusional Disorder (characterized by "non-bizarre delusions" that nonetheless represent a break from reality). **[14]**

Persons with the contrastingly non-psychotic, albeit clinically significant paranoid personality disorder may:

(1) suspect that others are exploiting, harming, or deceiving them;

(2) doubt the loyalty of their acquaintances**;**
(3) avoid confiding in others;
(4) perceive harmless behaviors as threatening;
(5) bear a grudge;
(6) misinterpret neutral remarks as character attacks; and
(7) suspect spouses or partners of infidelity. **[15]**

Predictably, building a professional relationship with such clients is fraught with complications. While criminal prosecutions occur in the context of an adversary system, defendants with a Paranoid personality disorder may seem unsure about which side of that system counsel is actually on. Any indication that the defense team is less than fully prepared and supportive is likely to be interpreted as an expression of indifference, a heedless slight, or even an outright declaration of contempt.

Once again, cognitive behavioral therapists have provided the most cogent description of the issues at play in developing a professional understanding with such individuals:

*The first issue … is establishing a working relationship. This obviously is no simple task when working with someone who assumes that others are likely to prove malevolent and deceptive. Direct attempts to convince the client to trust the therapist are likely [to] be perceived by the client as deceptive and therefore are likely to increase the client's suspicions.*

*The approach that proves most effective is for the therapist to openly accept the client's distrust once it has become apparent, and to gradually demonstrate his or her trustworthiness through action rather than pressing the client to trust him or her immediately.* **[16]**

A similar dynamic comes into play when the would-be collaborator is an attorney or investigator instead of a therapist or mental health counselor. Overt attempts at ingratiating oneself are likely to be interpreted quite negatively, while steadily building a track record of responsiveness and reliability is likely to advance the professional relationship significantly.

After all, individuals with a paranoid personality disorder are characterologically *inclined* to be suspicious and distrustful, but this need not be dominant substance or conclusion of every interpersonal contact. This having been said, however, defense team members should remain aware that setbacks are likely to occur from time to time, now matter how assiduously the trust relationship may have been cultivated. **[17]**

Regarding additional details of fostering collaboration and communication with these defendants over time:

It is then incumbent on the therapist to make a point of proving his or her trustworthiness. This includes being careful only to make offers that he or she is willing and able to follow through on, making an effort to be clear and consistent, actively correcting the client's misunderstandings and misperceptions as they occur, and openly acknowledging any lapses that do occur.

*It is important for the therapist to remember that it takes time to establish trust with most paranoid individuals and to refrain from pressing the client to talk about sensitive thoughts or feelings until sufficient trust has been gradually been established …*

Collaboration is always important … in working with paranoid individuals. They are likely to become intensely anxious or angry if they feel coerced, treated unfairly, or placed in a one-down position …

*This stress can be reduced somewhat by focusing initially on the least sensitive topics … and by discussing issues indirectly (*i.e.*, through the use of analogies or through talking about how "some people" react in such situations), rather than pressing for direct self-disclosure.* **[18]**

Patience is not the only virtue taxed by interacting with such clients. Somewhat counterintuitively in comparison to how they at least attempt to deal with many other defendants, members of the defense team must also be prepared to downplay the degree of shared insight, closeness and identification they express with the persons they attempt to assist in these cases:

*[O]ver zealous use of interpretation – especially interpretation about deep feelings of dependence, sexual concerns, and wishes for intimacy – significantly increase [these] patients' mistrust …*

*At times, patients with paranoid personality disorder behave so threateningly that therapists must control or set limits on their actions. Delusional accusations must be dealt with realistically but gently and without humiliating patients.*

*Paranoid patients are profoundly frightened when they feel that those trying to help them are weak and helpless; therefore, therapists should never offer to take control unless they are willing and able to do so.* **[19]**

## SUBSTANCE DEPENDENCE

According to *DSM-IV*, persons who have become dependent on any of a range of substances (including alcohol, cocaine, and others) may share several of the following experiences:
(1) tolerance (needing more to become intoxicated, or not getting as intoxicated with the same amount);
(2) withdrawal symptoms**;**
(3) consuming more, and for a longer time, than intended;
(4) failed attempts or persistent desire to minimize consumption;

(5) increased time spent in obtaining or recovering from the substance in question;
(6) giving up social, occupational, or recreational activities; and
(7) continuing to consume despite knowledge that there is a problem. **[20]**

Several inquiries have proven useful in a very basic, general screening for the presence of alcoholism. One of the most simple and straightforward of these is the CAGE questionnaire:

*CAGE provides a mnemonic device for the exploration of the following areas: Cut down: "Has a doctor ever recommended that you Cut back or stop the use of alcohol?" Annoyed: "Have you ever felt Annoyed or angry if someone comments on your drinking?" Guilt: "Have there been times when you've felt Guilty about or regretted things that occurred because of drinking?" Eye-opener: "Have you ever used alcohol to help you get started in the morning; to steady your nerves?"* **[21]**

Often the substance-dependent defendant is first encountered in the throes of withdrawal from chronic intoxication. The best strategy is to reschedule planned interviews, seeking a continuance on this basis if necessary. Not only will questioning at this juncture provide questionably reliable information and planning; it may also engender considerable resentment on the part of clients who will find it difficult to forget that defense team members chose such an inopportune time to put them through their paces.

"Withdrawal" is likely to be marked by considerable pain and psychological disturbance. **[22]** This is distinct from the longer-term process of "recovery," which involves, among other aspects, the gradual return of the central nervous system to an approximately pre-morbid level of functioning. In the case of long-term alcohol dependence, this component of "recovery" is generally estimated to take between 9 and 15 months. **[23]**

While the incorporation of direct interviewing assistance from family members has been identified as a useful technique in developing a relationship with defendants with, for example, mental retardation, it may become a "two-edged sword" in working with substance-dependent criminal defendants:

*Addicts have most likely been hiding their problems from other family members for a long time, perhaps years. They may have been draining family finances to support their habits, often unbeknownst to anyone else. In some cases, this has gone on with the knowledge of other family members, who have chosen to ignore the problem.*

*When the "truth comes out" in the course of litigation, feelings of guilt and betrayal on both sides add fuel to already simmering resentments. Children reflect on how they have been deprived in the service of someone else's addiction, or identify with a neglected or abused parent. Spouses express additional distress at the thought of how their children's upbringing and educational prospects were impaired as a result of a partner's addictive behavior.* **[24]**

Defense team members need to take special care to gain a full understanding of the addicted client's *comprehensive* legal situation. These persons often lead chaotic personal lives, are likely confused, and frequently have difficulty with trust issues, in a fashion seemingly similar to persons with paranoid personality disorder. **[25]** It is a good idea to go down a full list of potential problems with these persons, conveying at all times the understanding that these are situations which might occur with anyone, and that it is standard procedure to make sure that "all the bases are covered." **[26]**

Comprehension difficulties are a significant issue in these cases. **[27]** While deficits are typically not as profound nor as pervasive as those encountered with criminal defendants with mental retardation, they may still provide a substantial barrier to collaboration and communication:

*Simply put, the addicted client may not understand what you are saying. He or she may be sleep deprived, hung over, or acutely intoxicated. There may be lingering effects of chronic substance abuse, and even permanent organic impairment. It follows that the addicted client who has been technically sober for some time may still have significant difficulties with memory and logical processing.*

*These deficits may be difficult to detect at first, as long as the addict can keep interactions at a social level that does not require complex reasoning …*

*In order to serve the client better, attorneys can also make a point of cycling back to earlier conversations, revisiting specific comments and information to make sure that clients have been following along. [S]trategic planning should proceed in a logical and stepwise fashion …* **[28]**

The trademark attitude (and primary psychological defense) of the addict is *denial*. **[29]** Defense team members should not be surprised when addicted clients resolutely refuse to acknowledge aspects of their cases which would seem readily apparent to anyone else:

*This situation can complicate the attorney-client relationship from its inception. Necessary data gathering is hampered from the beginning. Attorneys are unsure what clients cannot remember, and what they are simply unwilling to recall. What might appear to be evasiveness (or even outright duplicity) on the part of addicts may be explained by their ingrained inability to face certain aspects of their past and present lives.*

*Patience is the key in dealing with this situation. That is not the same thing as acquiescence; clients need to learn as early as possible that attorneys have duties that they must perform, and information that they must obtain. To the extent possible, attorneys need to schedule sufficient time to draw out the addicted client and work through areas of obvious denial. The assistance of a therapist consultant may be particularly useful at this juncture.* **[30]**

## SCHIZOPHRENIA

Criminal defendants who have received a *DSM-IV* diagnosis of schizophrenia will often endure some or all of the following:

(1) delusions;
(2) hallucinations**;**
(3) disorganized speech;
(4) disorganized or catatonic behavior; and
(5) social or occupational dysfunction. **[31]**

Clearly, an active phase of this disorder will probably render a client incapable of effective collaboration and communication, likely make him or her incompetent to stand trial, **[32]** and perhaps have prevented him or her from possessing the requisite mental status for criminal responsibility. **[33]**

In those cases where psychotic symptoms are currently inactive, and thus at least temporarily in "remission," the defense team may be able to obtain useful information from criminal defendants, in addition to forming at least the basis for a working professional relationship.

Similar to difficulties encountered with persons diagnosed with a paranoid personality disorder, those subject to the vicissitudes of Schizophrenia may be prone to overreact to seemingly innocuous remarks and comments, even as more florid aspects of this illness are not readily apparent. From a classic reference designed for the families of persons with schizophrenia:

*Interpretations of this kind may indeed increase the anxiety of the patient and hasten a new psychotic episode … [h]owever, distance is not desirable either and does not promote rehabilitation …*

*A question that comes up quite frequently is the following: Should the recovering patient be told the truth when some terrible event (sudden death or the diagnosis of a serious disease) occurs …?*

*Certainly we do not want to lie to patients or anybody else. However, there is a good time and a bad time for telling the truth. State hospital psychiatrists used to insist that no ill effects have ever resulted from the revelation of bad news. They were referring to a group of patients who, in addition to being ill, often lived in a state of alienation aggravated by the environment.*

*Many of these patients were not able to express their emotions. An apparent insensitivity should not be interpreted as imperviousness. Even a catatonic schizophrenic who seems insensitive and immobile like a statue feels very strongly. A volcano of emotions is often disguised by his petrified appearance.*

*With the recovering schizophrenic we find ourselves in a completely different situation. He is very sensitive … and would not forgive relatives for not telling him the truth. And yet knowing the truth may be detrimental to him when he is still unstable and still struggling to recover fully his mental health.*

*The patient has to be prepared gradually and eventually be told the truth when he has already anticipated in his own mind its possibility and the methods of coping with it.* **[34]**

Does this sound complicated? Somewhat internally contradictory? More than someone would want to attempt on his or her own, or even with the assistance of a group of professional colleagues? Schizophrenia is a diagnosis apart, involving such high stakes and potentially volatile reactions that extreme caution is warranted when considering any significant interaction.

Guidance materials for psychiatrists further underscore this perspective, while lending some practical tips for working with Schizophrenic clients that generalize to other professional endeavors:

*The relationship between clinicians and patients differs from that encountered in the treatment of nonpsychotic patients. Establishing a relationship is often difficult. People with schizophrenia are often desperately lonely, yet defend against closeness and trust; they are likely to become suspicious, anxious, or hostile or to regress when someone attempts to draw close.*

*Therapists should scrupulously observe a patient's distance and privacy and should demonstrate simple directness, patience, sincerity, and sensitivity to social conventions in preference to premature informality and the condescending use of first names. The patient is likely to perceive exaggerated warmth or professions of friendship as attempts at bribery, manipulation, or exploitation.*

*In the context of a professional relationship, however, flexibility is essential in establishing a working alliance with the patient. A therapist may have meals with the patient, sit on the floor, go for a walk, eat at a restaurant, accept and give gifts, play table tennis, remember the patient's birthday, or just sit silently with the patient.*

*The major aim is to convey the idea that the therapist is trustworthy, wants to understand the patient and tries to do so, and has faith in the patient's potential as a human being,*

*no matter how disturbed, hostile, or bizarre the patient may be at the moment.* **[35]**

## BIPOLAR DISORDER

Although it is, of course, clinically distinct from other forms of mental illness, bipolar disorder calls for an interpersonal approach that mirrors to a considerable extent the adaptive procedures employed by defense team members when encountering clients with other psychiatric conditions.

Persons with bipolar disorder may be prey to dramatic fluctuation between manic episodes of seemingly unrestrained agitation and energy on the one hand, and almost catatonic periods of depression on the other. **[36]**

Similar to overtly psychotic phases of schizophrenia and profoundly debilitating manifestations of major depression, the criminal defendant with bipolar disorder may present as incompetent to stand trial or lacking in criminal responsibility **[37]** when experiencing the extreme manifestations of either affective component of this illness.

The defense team may be able to obtain important factual material, and forge some degree of cooperative bonding, between more dramatic changes in the client's overall mood and accompanying behavior. In general, this is more likely to occur when a client is less depressed and more energetic, although a counterproductive irritability may characterize the later phase of his or her illness.

Key to the success of such encounters is a recognition that progress will be episodic. Considerable ground is likely to be lost when a fully realized manic episode eventually ensues. Contrastingly, there will likely be periods during which the patient's mood appears to balanced that no mental illness is readily apparent. **[38]**

If interaction must be sustained during intermittent depressive stages of bipolar disorder, the approach will likely be substantially similar to that described *supra* for a free-standing case of major depression.

## CONCLUSION

Attorneys, investigators, and other defense team members will encounter a myriad of mental conditions in their clients. While they are not encouraged to diagnose or treat mental illness, they are frequently compelled to interact with afflicted criminal defendants without the assistance of mental health professionals. When this occurs, there are various approaches to collaboration and communication that are specific to certain pre-identified diagnoses.

While they may not always be in a position to express their appreciation directly, clients will always benefit when legal services are delivered with consideration for (and adaptation to) the individual's unique personal circumstances.

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20. *DSM-IV*, supra note 1, at 181.
21. Edgar Nace, *The Treatment of Alcoholism* 52 (1987).
22. *See* James Massman & Donna Tipton, "Signs and Symptoms Assessment: A Guide for the Treatment of the Alcohol Withdrawal Syndrome," 20 *J. Psychoactive Drugs* 443-44 (1988); and Alan Rosenbloom, "Emerging Treatment Options in the Alcohol Withdrawal Syndrome," 49 *J. Clinical Psychiatry* 28-31 (1988).
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24. Eric Drogin & Curtis Barrett, "Addictions and Family Law," in *1998 Wiley Family Law Update* 61-106, at 86 (1998).
25. *See* Phil Moring, "Trust, the Counselor and Containment in Counseling the Drug-Addicted Client," 3 *Psychodynamic Counseling* 433-46 (1997) for further discussion of both sides of this trust relationship.
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31. *DSM-IV*, *supra* note 1, at 285.
32. *See* Sean Kaliski, "Violence, Sensation Seeking, and Impulsivity in Schizophrenics Found Unfit to Stand Trial, 23 *Bull. Am. Acad. Psychiatry & L.* 147-55 (1995).
33. *See* Joseph Bloom et al., "The Involvement of Schizophrenic Insanity Acquittees in the Mental Health and Criminal Justice Systems, 15 *Psychiatric Clinics North Am.* 591-604 (1992).
34. Silvano Arieti, *Understanding and Helping the Schizophrenic* 156-62 (1979). This family-oriented reference won the National Book Award for Science upon its release over twenty years ago.
35. Kaplan & Sadock, *supra* note 11, at 489.
36. *See DSM-IV*, *supra* note 1, at 350-91.
37. *See* Wayne London & Barbara Taylor, "Bipolar disorders in a Forensic Setting," 23 *Comprehensive Psychiatry* 33-37 (1982).
38. *See, generally* William Reid et al., *The Treatment of Psychiatric Disorders* 225-33 (3rd ed. 1997). ■

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# Chapter 31: Sample Testimony of Forensic Social Worker

## CAROL GOOD, MSW - DIRECT EXAMINATION
## by Ernie Lewis
### *Commonwealth v. Randy Haight*, Capital Case


**INTRODUCTION**

**CREDENTIALS AND EMPLOYMENT HISTORY**

**METHODOLOGY**

**HER FACTUAL BASIS: WHAT SHE REVIEWED WHO SHE TALKED TO**

**INTRODUCTION OF THE SOCIAL HISTORY AND TIMELINE**

**THE MARRIAGE WAS A BAD ONE**

**RANDY'S FIRST FIVE YEARS OF LIFE**

**HAIGHT HISTORY: 1957 - 1959**

**HAIGHT HISTORY: 1959-1964**

**THE DECISION TO PLACE RANDY BACK WITH MOTHER, BETTE HAIGHT**

**THE MANNER IN WHICH RANDY'S FAMILY SHAPED AND DISTORTED HIM**

**THE APPROPRIATENESS OF THE SOCIAL SERVICES INVOLVEMENT IN THIS CASE**


**INTRODUCTION**

1) Name and address.

2) Present occupation.

*Associate Professor of Social Work at EKU.*

3) What courses do you teach?

*Introduction to social work and junior and senior field placements.*

4) What other positions do you have at EKU?

¨ *Coordinator of Field Placement.*

¨ *Consultant/Trainer for the Training Resource Center Project.*

¨ *Consultant to Social Service Dept. at Pattie A. Clay Hospital in Richmond.*

5) Where else are you employed?

*Work part-time as a social worker for Hospice.*

6) What was your involvement in this particular case?

7) Why did you become involved?

8) Who is paying for your time?

**CREDENTIALS AND EMPLOYMENT HISTORY**

1) Describe your education for the jury?

¨ *BA in sociology at Colby College.*
¨ *MSW from UK in 1983.*

2) What professional licenses do you hold?

*Certified Social Worker.*

3) What jobs have you held since first becoming a social worker?

¨ *1966—food stamp eligibility worker.*
¨ *1967-1970—service worker.*
¨ *1970-1974—senior social worker.*
¨ *1974-1984—field office supervisor.*
¨ *1985—began to teach at EKU.*

4) What were your job duties as a senior social worker?

5) What were your job duties as a field office supervisor?

6) How often have you rendered testimony?

a) On whose behalf have you usually testified?
b) On what issues?

**METHODOLOGY**

1) What is a social worker?

2) What is a family and children's services social worker?

3) What training does a social worker have in assessing families and the effects of families on individuals within the family?

4) How often did you assess families?

5) How often did you deal with troubled families?

6) How often did you make decisions about troubled families?

7) What opinions have you offered in the past for courts?

**HER FACTUAL BASIS:**
**WHAT SHE REVIEWED WHO SHE TALKED TO**

1) What did you review in preparation for this case?

¨ *Records from the Methodists Children's Home in Worthington, Ohio.*
¨ *Records from the Franklin County, Ohio Child Welfare Board.*
¨ *Records from the Ohio Public Schools.*
¨ *Records from Franklin County Children's Services.*
¨ *Records from the Franklin County Domestic Court.*
¨ *Psychological reports.*

2) Who did you talk with?

¨ *Randy Haight*
¨ *Lana Walker*
¨ *Sam Walker*
¨ *Bette Smith*
¨ *Thornton Haight*
¨ *Karen Sue Rice*
¨ *Eugene Haight*

**INTRODUCTION OF THE**
**SOCIAL HISTORY AND TIMELINE**

1) What is a social history?

2) Based upon your work, were you able to develop a social history of Randy Haight?

3) Does this social history accurately reflect Randy's early history?

*MOVE THE ADMISSION OF THE SOCIAL HISTORY — (do not give to jury at the time)*

4) I would like to show you a timeline of the Haight family.
a) Have you reviewed this before?
b) Does it fairly and accurately reflect the chronological history of the Haight family?

*MOVE THE ADMISSION OF THE TIMELINE — (do not give to jury at the time)*

**THE MARRIAGE WAS A BAD ONE**

1) When were Bette and Thornton Haight first married?

*1947.*

2) What do the records reflect regarding the marriage between Thornton and Bette Haight?

*The marriage was unstable and emotionally disruptive.*

3) What evidence of family violence during the first few years of marriage is there?

*According to Bette, Thornton Haight beat her shortly after they were married, and lost the pregnancy.*

4) When did the Haight family first come to the attention of the authorities?

*In 1950 the Haight family was first investigated by Social Services.*

5) What were the issues the Haights brought before the court?

*Alcohol abuse, physical abuse, and infidelity.*

6) How did the Haights relate to their children?

*They used the children to manipulate each other.*

7) Were the Haights capable of raising children?

¨ *No—the records indicate that they were "incapable*

*of assuming responsibility for the care of the children."*
*¨ Records reflected in CWB Haight Family History, p. 10 that: "neither Mr. or Mrs. Haight will ever be able to make a home for their children. Mr. Haight is too unstable and dependent himself and is actually not interested in his boys...Mrs. Haight...is unable actually to provide a suitable emo-tional and physical environment for these boy.*

**RANDY'S FIRST FIVE YEARS OF LIFE**

1) Randy was born in 1952?

*Yes.*

2) I would like to focus on Randy's first four years of life. What are the important developmental issues during that period of his life?

*The opportunity to develop trust in others; the ability to accept limits on behavior and to develop self control.*

3) How does trust develop in the young child?

*Through the responsiveness of the caregiver to the needs of the child, and the ability of the caregiver to supply affection, physical sustenance, and consistent love and care.*

4) What do the records reflect regarding Thornton and Bette's responsiveness to the needs of Randy, and their ability to supply affection, physical sustenance, and consistent love and care?

5) How does a child learn to accept limits on behavior and to develop self control?

*Through a sense of concern and love expressed by the caregiver, and by the caregiver meeting the child's physical and emotional needs.*

6) What do the records reflect regarding whether Randy's parents expressed a sense of concern and love, and met his physical and emotional needs during the first four years of his life?

*¨ Few meals were cooked.*
*¨ No housekeeping standards were kept.*
*¨ They were sometimes left without adult supervision.*
*¨ The house was full of garbage, spoiled food and feces.*

7) What do the records reflect and what did you learn regarding family violence between mom and dad during these years?

*The parents were often angry with each other and fought often both verbally and physically.*

8) What is the importance of this?

9) What kind of parents were Thornton and Bette to Randy and his brothers during the first 5 years of Randy's life?

*They were emotionally immature and unable to put their children's needs before their own.*

**HAIGHT HISTORY: 1957-1959**

1) What occurred in 1957 that had a serious impact on Randy and his family?

*¨ His mother developed mental problems and was admitted into the hospital.*
*¨ Thornton appeared in court to complain that she was not feeding the children.*
*¨ Bette began to complain about an affair Thornton was having with Betty Conley.*
*¨ Thornton filed for divorce in this year.*

2) As a result of these problems, what happened to Randy?

*¨ On 5/6/58 Randy was taken out of the home and taken to Franklin Village on an Emergency Court Order.*
*¨ On 6/6/58 he was committed to the Child Welfare Board.*
*¨ On 8/20/58 he was admitted to the Meth-odist's Children's Home in Worthington, Ohio.*

3) What happened to Randy's brothers?

*They were also taken out of the home and placed in the Methodist's Children's Home.*

4) Upon Randy's admission to MCH, how was he described?

*Rambunctious, nervous but appealing, with little concept of authority and limits.*

5) What was the parents' response to their children being taken away?

*They continued to battle with each other and to use the children to manipulate each other.*

6) Can you give us an example of this manipulation?

*Bette hit the kids and threw them against the car when Thornton threatened to leave.*

7) How often did Randy's parents visit him during this time?

*Sporadically—sometimes Randy did not see his mom and dad for 8-9 months.*

8) What effect did all of these problems have on Randy's school?

*He had to repeat the first grade and the third grade.*

9) What do the records reflect regarding Randy's reaction to a home visit after Christmas of 1958?

*Ms. McMillian notes in transfer summary on 5/13/59 that Randy was rocking, having night sweats, excessively masturbating, anxious, tense, destructive, and unable to work in school.*

10) What are the important developmental issues for a child from 5-7 years of age?

*A child wants to find out what he can do and whom he should be like; they imitate adults and learn from these role models.*

11) How did what occurred during 1957-1959 effect these developmental milestones for Randy?

*The insecurities and inconsistencies of his parents did not provide positive behaviors to imitate.*

12) What was the effect of his removal from the home on his development?

*¨ It represented a disruption of his bonding and created fear, anxiety, and insecurity.*
*¨ The many separations created problems associated with trust, security, and a sense of belonging; all that was familiar was removed.*

**HAIGHT HISTORY: 1959-1964**

1) What happened during these years?

*Chaos and disruption resulting from a series of placements.*

2) When was Randy first placed in a foster home?

*September, 1960.*

3) How successful was this placement?

*Bette opposed it and went to court to get Randy back.*

4) What was the reaction of the CWB and MCH?

*They strongly opposed placing Randy back with Bette; they said his very future was at stake.*

5) What did the court do?

*Placed Randy back with mom.*

6) How long did he stay?

*Just a few months.*

7) What happened?

*Thornton complained that Bette was neglecting Randy and he was taken back to the MCH.*

8) What evidence of neglect was there?

*¨ She took her 8 year old to work at night and he stayed in the car with her.*
*¨ She failed to send him to school.*

9) How did he do in school?

*¨ He failed the 3rd grade; could not even tell time until he was 10 years old.*

*¨ He went to many schools; frequent moves affected his ability to keep up.*

10) How long did he stay in MCH?

*Until December of 1961.*

11) Where was he placed then?

*Spires foster home.*

12) How many placements were there during these years?

*He was in 9 placements in 2 years.*

13) How was Randy treated in these placements?

*¨ There is some evidence of sexual abuse.*
*¨ There is some evidence of being placed in closets as a form of discipline.*

14) What are the reactions of children when they have significant losses?

15) What should be done when children are suffering losses?

16) What can be anticipated if loss and separation are not dealt with?

*¨ The child will have difficulty developing relations, developing trust.*
*¨ The child will act out in patterns of passive or aggressive behavior.*
*¨ This acting out will extend over into adulthood.*

17) What did Randy lose during these years?

*Family, clothes, toys, room, familiarity of surroundings, teachers, peers.*

18) From the records that you reviewed, what was done in this case to adjust to these losses and to deal with the feelings Randy was having?

19) What effect did this failure to deal with separation and loss have on Randy as he developed from a child into an adult?

20) What are the other important developmental issues during these years?

*A development of accomplishment or failure and inadequacy.*

21) How did the disruptions of these five years effect Randy?

*¨ Randy did not feel he was successful; he always felt rejected.*
*¨ The many disruptions contributed to feelings of rejection and inadequacy.*
*¨ He did not feel loved.*
*¨ He became and insecure and potentially angry child.*

**THE DECISION TO PLACE RANDY BACK WITH MOTHER, BETTE HAIGHT**

1) What progress did Randy make in foster home?

*¨ He had settled down and was no longer the anxious and upset child he had been.*
*¨ He had learned to live in a family setting with respect for each member's rights.*
*¨ He had responded well to the love, affection, and realistic limitations imposed.*

2) What did CWB decide to do with Randy?

*They placed him back home.*

3) In your opinion was this an appropriate decision?

*¨ This was a typical decision in the sense of trying to keep families together as much as possible.*
*¨ There was no evidence that Bette was prepared to deal with two children at this point.*

**THE TEENAGE YEARS**

1) When was Randy placed back in the Haight household?

*In August of 1964.*

2) Who was there?

*Bette, Eugene, and Rick.*

3) What do the records reflect about the parenting provided by Bette during those years?

*¨ Bette set no limits; she was more like one of the children.*
*¨ Bette was at the restaurant during the day, and out with boyfriends at night.*
*¨ There is little evidence of parental control.*
*¨ The family was chaotic and disorganized.*
*¨ House was described as in a shambles.*

4) What behavior problems developed?

*¨ Rick stole BB guns, and Randy accompanied them. These were used to shoot out 18 windows in the home.*
*¨ The boys completely destroyed a home they were living in.*
*¨ Truancy in school.*
*¨ Acts of delinquency.*

5) What was the response of the CWB?

*¨ They noted the family was deteriorating.*
*¨ They noted in the Haight Family History at p. 16 that she "cannot give of herself emotionally at all to the children. She continues to upset the children regularly by going with numerous men, staying out late at night, sometimes not returning at all."*
*¨ By 1966 CWB decided to place Randy back at MCH.*

6) What happened?

*When Randy resisted, they left him at home.*

7) What other placements were there during these years?

*Franklin Village.*

8) How often did Randy run away from home?

*Many times to his father's, usually in the summer months.*

9) How did Randy do in school?
*¨ Very poorly.*
*¨ Often truant.*
*¨ Missed half of school in 1966-1967.*
*¨ Described as hyperactive; problems with attention "defect."*
*¨ By 16, he read at a 4th grade level.*

10) When did Randy drop out of school?

*When he was sixteen.*

11) What evidence is there in the records of sexual abuse during these years?

*Sexual abuse occurred earlier; at 15, he was abused by an adult named Tiny.*

12) What was the effect of this on Randy?

*¨ Another example of the abusive environment and lack of supervision.*
*¨ It was one of the only ways he felt loved or accepted.*

13) When did Randy try living with his father?

*Many summers; in Oct. 1968 he moved there.*

14) Was that successful?

*Randy moved back to Columbus in May of 1969 after Thornton refused to feed and clothe Randy.*

15) When was Randy married during these years?

*He was married to Diane Fraley when he was 16; they divorced one year later.*

16) Were any psychologicals performed during this time?

*1967 by Dr. Gussett.*

17) What were the important findings he made?

*¨ 72 IQ.*
*¨ Lack of intellectual development was due to the negative influences of emotional factors.*
*¨ Randy said he knew of no one who loved him.*
*¨ When confronted with stress, Randy was said to be capable of unpredictable behavior.*
*¨ Described as impulsive and capable of acting out emotional reactions without much control.*
*¨ Attention defect and hyperactivity.*
*¨ Overwhelmed by feelings of inferiority.*

18) What did the report indicate about his home life?

*¨ It offered him little in the way of psy-chological warmth. This boy has strong feelings of rejection and feels that his home has seldom offered him much in the way of security...appears to have never had a close satisfying relationship with any adult figure.*

19) What did the report indicate about his ability to control himself?

*¨ He was said to have little control of his emotions. This boy has a very low tolerance for frustration, and his perception of reality suffers due to the pressure of internal needs.*
*¨ When "he cannot withdraw from stress, he loses his ability to exercise judgment and is capable of unpredictable and acting out behavior.*

20) What was the psychologist's recommendation?

*¨ A well structured environment where he can develop close, intimate relationships with warm and understanding adult figures. He especially needs contact with a strong adult male figure who can serve as a model for him to identify with.*

21) What kind of education was recommended?

*Special classes.*

22) When was Randy released from his commitment to CWB?

*1970.*

23) What are the important developmental issues of the teenage years?

*The success or failures of the earlier developmental stages are played out.*

24) What is your analysis of what happened with Randy?

*The deficits in parenting, affection, stability and nurturing throughout his early life were reflected in his behavior.*

## THE MANNER IN WHICH RANDY'S FAMILY SHAPED AND DISTORTED HIM

1) What is a healthy family?

2) What is the importance of the family to the development of the individual?

3) What does a family do for a child in terms of development of personality and mental health?

4) What does a family do for a child in terms of consistency, security and stability?

5) What is the families' role in terms of limit-setting of a child?

6) What is the families' role in terms of giving and accepting affection?

7) What effect does the lack of normal nurturing such as feeding, clothing, cleaning have upon children?

8) What is your analysis of Randy's family? How healthy or unhealthy was it?

9) How did Randy's family help form him?

10) Describe the quality of the parenting that you found in these records?

    a) What kind of mother was Bette Haight?
    b) What kind of a father was Thornton?

11) Describe the effect of Randy's family on him in terms of:

    a) Consistency
    b) Security
    c) Limit setting
    d) Affection
    e) Provision of physical needs

12) How has Randy's family contributed to his feelings about himself?

13) What effect did the intra-family violence have on Randy?

14) What effect did Randy's mother's mental illness have on his development?

15) What is your opinion regarding why all three Haight boys have been in prison, but their half sister has not been?

16) What effect did being taken away from his family have on Randy?

17) What is the significance of Randy being in foster homes and a children's home from his 5th through his 12th birthdays?

18) What was the level of neglect and abuse of Randy Haight when he was a child?

19) How would you compare this case to the hundreds in which you have been personally involved as a caseworker?

20) What kind of chance did Randy Haight have of becoming a mature and responsible adult growing up like he did?

**THE APPROPRIATENESS OF THE SOCIAL SERVICES INVOLVEMENT IN THIS CASE**

1) What is your opinion regarding the ap-propriateness of the actions of the different social services agencies in this case?

2) Had you been the caseworker, what would you have done to try to help this child?

**RANDY HAIGHT AT 18**

1) What was Randy Haight like at the point of termination of involvement?

*He was suspicious, untrusting, impulsive, with little self-control, with no consistent role model for love and affection, who had been lied to and disappointed all of his life.*

**EXPECTED AREAS OF CROSS FOR CAROL GOOD**

1) You are "just" a social worker.

2) Name 1 book or paper that says a family effects the way you are as an adult.

3) Name 1 book or paper that says family upbringing effects violence.

4) Isn't Randy just an outlaw from an outlaw family?

5) At least the state intervened here.

6) Lots of kids are from bad homes and do not kill anyone.

7) He was a teenage criminal. ■

# Chapter 32: TIME LINE FOR RANDY HAIGHT CASE

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 1. Thornton Haight, Randy's biological father, is born. | 1927 | | |
| 2. Bette Smith, Randy's biological mother, is born. | 1928 | | |
| 3. Bette Smith marries Charles Williams, and is pregnant with Lana. | 1945 | | |
| 4. Bette Smith and Charles Williams divorce. | 1946 | | |
| 5. Lana Mercurio born to Bette Smith Williams. Lana is given and later adopted by Mr. & Mrs. Mercurio, Bette's mother and step-father. | 3/25/46 | | |
| 6. Thornton and Bette married, Bette pregnant. | 8/9/47 | | |
| 7. Bette loses child due to Thornton beating her. | 1947 | | |
| 8. Eugene Haight, Randy's brother, is born. | 11/2/48 | | |
| 9. Rick Haight, Randy's brother, is born. | 10/19/50 | | |
| 10. First contact by Thornton and Bette Haight with the court. | 1950 | | |
| 11. | 7/18/52 | | Randy Born in Columbus, Ohio. |
| 12. | 1952-1956 | | Randy lives at home with Thornton & Bette. |
| 13. | 1957 | 4 | Randy is living at home. |
| 14. Thornton files for divorce; accuses Bette of neglecting the children. Bette accuses Thornton of having affair with Betty Conley. | 6/25/57 | 4 | |
| 15. Betty hospitalized at Receiving Hospital. Her diagnosis was that of a "character disorder with emotionally unstable personality." Thornton appears in court to complain that Bette is not feeding the children. Bette jailed for a few hours. Bette receives electro-shock therapy. | 8/30/57 | 5 | |
| 16. | 9/12/57 | 5 | Randy, Rick, and Eugene made wards of court. |
| 17. | 1958 | 5 | Randy begins year at home with mom and dad. |
| 18. | 5/6/58 | 5 | Randy and his two brothers are taken out of the home and taken to Franklin Village on Emergency Court Order. |
| 19. Bette's psychiatrist indicates that Bette is "unable to cope with her own problems and consequently could not provide proper care for her children." neglecting the children. Bette accuses Thornton of having affair with Betty Conley. | 6/6/58 | 5 | Randy committed by court to Child Welfare Board (CWB), but remains at Mercurios, his grandparents. |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 20. Conflicts develop between Bette and Thornton and Mrs. Mercurio. Letter from Mrs. Mitchell states the reason for the admission is the "parents' emotional neglect of these boys and the emotional instability of both parents." | 8/20/58 | 6 | Randy admitted to Methodist Children's Home (MCH). |
| 21. | 9/58 | 6 | Randy begins first grade. |
| 22. Dr. Baker diagnosis Mrs. Haight as depressed, upset emotionally because of her marital situation, and not able to care for her children. | 9/30/58 | 6 | |
| 23. Thorton and Betty Conley have a child. | 11/58 | | |
| 24. | 1959 | 6 | Randy begins year at MCH. |
| 25. | 1959 | 6 | Randy repeats the first grade. |
| 26. | 5/13/59 | 6 | Ms. McMillian of CWB notes in transfer summary that after Christmas visit with parents, Randy was rocking, having night sweats, excessively masturbating, anxious, tense, destructive, and unable to work in school. |
| 27. MCH states desire to place Haight boys in foster home or for adoption. | 11/12/59 | 7 | |
| 28. Bette Haight calls CWB to complain that Thornton Haight is beating her up. | 11/59 | 7 | |
| 29. Mrs. Haight uses the time to see whether Mr. Haight and Mrs. Conley are seeing one another. | Christmas, 1959 | 7 | Boys spend two nights at home with Mrs. Haight. |
| 30. | 1960 | 7 | Randy begins year at the Methodist Children's Home. |
| 31. Bette separates from Thornton Haight. | 1/12/60 | 7 | |
| 32. Divorce petition filed. | 2/26/60 | 7 | |
| 33. Thornton and Bette divorced. | 5/9/60 | 7 | |
| 34. Dr. Shelton psychological exam conducted. Randy has full scale IQ of 86, and verbal IQ of 76. | 6/2/60 | 7 | |
| 35. | 7/5/60 | 7 | |
| 36. Thornton gets injunction keeping Bette Haight away from him. She files complaint against him. | Summer, 1960 | 7 | Inter-agency conference results in placing Randy in a foster home; adoption considered. |
| 37. | 9/26/60 | 8 | Randy placed in foster home at the Harvey Warne home. |
| 38. Bette goes to court to stop placement of Randy in foster home. CWB and MCH workers warn that Mrs. Haight was not competent and that placing Randy with her | 9/27/60 | 8 | |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 39. Mrs. Licklitner notes in letter to CWB that since commitment to CWB and placement with MCH Randy has made "gradual progress in his ability to distinguish right from wrong on a moral basis." | 9/30/60 | 8 | |
| 40. Mrs. Licklitner of CWB writes letter opposing returning Randy to Mrs. Haight. | 10/11/60 | 8 | |
| 41. Letter from Marilou Mitchell of CWB urges the court to leave Randy at foster home. She states "the future of this child is at stake." | 10/17/60 | 8 | |
| 42. | 11/5/60 | 8 | Court sends Randy back home with mom. |
| 43. Bette takes all three boys over to Mr. Haight's and Betty Conley's house. | Christmas 1960 | 8 | |
| 44. Haight boys are living with Thorton Haight and Betty Conley. | 1961 | 8 | Randy begins 1961 with his mother. Randy is being "physically abused and emotionally neglected" accord- ing to records. |
| 45. | 2/61 | 8 | Randy kept in the car at night while Bette worked at Western Electric on the night shift. |
| 46. | 2/61 | 8 | Randy kept out of school because Bette Haight feared the police would snatch Randy away. |
| 47.Thornton Haight calls CWB saying Randy is "pale," "frightened" and "upset" regarding the activities of the adults at his house. Decision is made to take Randy out of Bette's home. | 2/61 | 8 | |
| 48. Randy taken away from Bette Haight back to MCH. He is described as more "manicky and hyperactive." | 2/15/61 | 8 | Randy expresses that he does not want his parents to know where he is. |
| 49. Juvenile Police come to Conley house saying Bette Haight had said Thornton and Betty Conley were living together. | 3/6/61 | 8 | |
| 50. Hearing held in order to secure support order on Bette Haight. Bette Haight's attorney claims she is too ill to work. | 4/10/61 | 8 | |
| 51. Thornton arrested for nonsupport hiding under the bed at Betty Conley's house. | 4/20/61 | 8 | |
| 52. Bette files motion to get children back. | 5/61 | 8 | |
| 53. Bette promises a birthday cake for Randy's birthday, but fails to come to MCH. | Summer 1961 | 9 | Randy and other boys look forward to party. |
| 54. | 11/22/61 | 9 | Randy expresses concern that Bette will be told where he is in foster home, because he does not want her "to come get me again...because she'd just make trouble." |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 55. Randy placed in Spires foster home. Neither parent gives Randy a Christmas present as he goes to foster home. | 12/22/61 | 9 | Randy leaves a Christmas present for mom and dad. |
| 56. | 1962 | 9 | Randy begins 1962 in the Spires foster home. |
| 57. Thornton Haight is $5000 in arrears on child support. | 2/62 | 9 | |
| 58. Mitchell report states Randy is "slowly stabilizing" in foster home. | 5/31/62 | 9 | |
| 59. Bette petitions court to have all three boys returned to her. Hearing is held. Eugene is placed with Mrs. Mercurio. Court orders Mr. Haight to never visit his sons nor to have them placed with him. | 6/29/62 | 9 | Ricky and Randy remain in their foster homes. |
| 60. Bette takes boys for ride on MCH grounds in convertible with top down. | 9/62 | 10 | Randy falls out of car. |
| 61. Eugene said to have developed emotional and sexual problems. | 10/26/62 | 10 | |
| 62. | 1963 | 10 | Randy begins year with the Spires foster home. |
| 63. Eugene Haight placed in the Starr Commonwealth in Michigan. | 3/63 | 10 | |
| 64. | 1964 | 11 | Randy begins year with the Spires foster home. |
| 65. Carlin letter to juvenile court states that Randy is "no longer the anxious, unsettled, and highly emotionally upset youngster he was in his early placement. He has learned to live in a family setting with respect for other member's rights and his ability to stand the stress of conformity is much greater. Randy has an excellent relationship with his foster parents who are unique in their ability to give love and affection and impose realistic limitations." Carlin recommends Randy be placed with his mother. | 7/28/64 | 12 | |
| 66. | 8/2/64 | 12 | Randy placed back with his mother. |
| 67. Bette reports to CWB that Rick Haight is unmanageable since Randy's placement at home. | 8/18/64 | 12 | |
| 68. Case note on consultation with Dr. Brush states that Randy and Ricky say Bette goes out with various boyfriends at night leaving them alone. Bette said to be "bordering on possible nervous breakdown." | 10/20/64 | 12 | |
| 69. "Don" moves in with Bette. | 1965 | 12 | Randy begins year living with his mother and brothers. |
| 70. | 10/65 | 13 | Randy & brothers tear up the house they are living in. |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 71. C. Gray of CWB notes "How long this family situation can be held together is highly questionable...Not only in her [Mrs. Haight's] inability to care for [the boys] but the fact that she has been unable to relinquish the boys legally and stood in the way of possible adoption at an earlier date and she could not at all release them emotionally. Even though she has not been able to provide suitable physical and emotional environment for the boys, she is still holding on to attempting to keep them." | 10/23/65 | 13 | |
| 72. CWB notes that Eugene, who had dropped out of school, calls up school and tells them he is a parent and that Ricky and Randy will not be at school. | 11/65 | 13 | |
| 73. CWB visits home and finds it to be "very run down and quite disorganized." | 11/65 | 13 | |
| 74. | 1966 | 13 | Randy begins the year living at home with mom and his brothers. |
| 75. CWB notes that Randy was truant, and the family was "deteriorating". CWB explored placing Randy back with the MCH and the Spires foster home. Bette Haight opposes the move. | May | 13 | |
| 76. | May | 13 | Mr. Carlin arrives to transport Randy to MCH. Randy refuses to go "to that prison." CWB changes decision, and decides to leave Randy with Bette Haight. |
| 77. | Summer | 13 | Randy and Eugene go to father's house in Kentucky. Randy comes back to Columbus and enrolls in the 7th grade. |
| 78. | 10/10/66 | 14 | Randy taken to Detention Home for destruction of property. |
| 79. Juvenile hearing conducted | 10/25/66 | 14 | Randy placed in Franklin Village. Court orders psychiatric exam of Randy. |
| 80. | 12/22/66 | 14 | Randy back with mom. |
| 81. | 1966 | 14 | Randy misses half the school days in 1966-1967, and fails most of his subjects. |
| 82. | 1967 | 14 | Randy begins 1967 living with his mother. |
| 83. McClain of CWB notes the family is deteriorating, and that it is caused by "Mrs. Haight's ineffectiveness as disciplinarian." The house is described as "constantly in a shamble." | July 11, 1967 | 14 | |
| 84. Thornton Haight picks up Randy and Ricky without permission of CWB or Mrs. Haight and takes them to Kentucky. | 5/67 | 14 | |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 85. Dr. Gussett report for FCCS states that "this boy has had a very unstable and unhappy home life. He has been tossed from one placement to another...This unstable background has had an unfavorable influence on the boy." Possible attention deficit disorder noted. Said to "have difficulty exercising judgment appropriately at all times; he is capable of unpredictable behavior when confronted with stress...He is inclined to be impulsive and is capable of acting out emotional reactions without much control. This boy is very suggestible and easily manipulated." Randy is described as "overwhelmed by feelings of cautiousness and inferiority." "His home has offered him little in the way of psychological warmth. This boy has strong feelings of rejection and feels that his home has seldom offered him much in the way of security." "The subject has never had a close, sustained relationship with a significant adult." Special classes were recommended. | 5/18/67 | 14 | Randy's IQ is 72, with a 70 verbal scale IQ. |
| 86. Bette picks up Ricky and Randy from Mr. Haight in Kentucky and take back to Ohio. Thornton initially refused to permit the boys to go. Bette Haight threatens to call the police. Eugene is in the Army. | 8/67 | 15 | Referral by CWB made to Big Brothers for Randy. CWB notes that "Randy at times is defiant towards his mother possibly because of the resentment he feels in regards to the rejection he has experienced." |
| 87. | 9/8/67 | 15 | Randy runs away to West Virginia to avoid having to testify to what he saw two filling station attendants do to young girl. He was threatened by the young men. |
| 88. | 10/67 | 15 | Randy living with Bette in the Mercurio's house. |
| 89. | 10/67 | 15 | Randy suspended from school for 3 days due to truancy. |
| 90. Ricky joins the Army. | 11/67 | 15 | |
| 91. | 11/20/67 | 15 | Randy was sodomized by "Tiny," who works at mother's store. |
| 92. Martha Ames of CWB expresses chief concern that Randy is not "receiving enough adult supervision at home." | 11/27/67 | 15 | |
| 93. | 1968 | 15 | Randy begins year living at Mercurios with his mother. |
| 94. | 1/21/68 | 15 | Randy steals $1300 from his grandfather, and runs away from home to Thornton Haight in Kentucky. Leaves note admitting his role in the theft. |
| 95. | 4/7/68 | 15 | Bette picks up Randy from Thornton's house in Kentucky and takes back to Columbus. |
| 96. | 4/18/68 | 15 | Randy suspended from school. Randy is reading at 4th grade level. |

| FACTS IN RANDY'S LIFE | DATE | RANDY'S AGE | RANDY'S LIFE |
|---|---|---|---|
| 97. Martha Ames transfers case. She notes that "he has been shifted from pillar to post by caseworker after caseworker..." | 4/23/68 | 15 | |
| 98. Support hearing held to try to get child support from Thornton. | 5/29/68 | 15 | |
| 99. Hearing held due to Randy's participation in stealing girl's pocketbook out of car. | 6/22/68 | 15 | |
| 100. | 9/68 | 16 | Randy does not enroll in school. |
| 101. | 10/68 | 16 | Randy moves to Kentucky to Thornton's home. |
| 102. | 1969 | 16 | Randy begins year living in Kentucky with Thornton Haight. |
| 103. Bette tells CWB that Thornton "refused to feed and clothe [Randy]." | May 1969 | 16 | Randy returns to live with mother when relationship with father "began to deteriorate." |
| 104. | 1969 | 16 | Randy marries Diane Fraley. |
| 105. | 1969 | 16 | Randy works at horse stables after coming back to Columbus. |
| 106. | 1970 | 17 | Randy begins year living with mother. |
| 107. | 1970 | 17 | Randy and Diane Fraley are divorced. |
| 108. CWB and FCCS terminate Haight case. | 5/19/70 | 17 | |

# Chapter 33: Sample Testimonies

**THE PSYCHOLOGIST**

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Elzie Morton, Capital Case

**DIRECT OF DR. ROBERT NOELKER**
**GUILT PHASE** - Ed Monahan

I. Qualifications

1. Name
2. Address
3. What profession?
   - clinical psychologist
4. Education
   - BA, UK, 1967 - Biological Sciences
   - UC, MA, 1968 - Clinical psychology
   - UC, Ph. D. 1970 - Clinical psychology
5. How long does it take to get a Ph.D. in psychology?
6. Membership and Professional Organizations
7. Publications, Research and Papers
8. Professional Conference Presentations
9. Honors, Awards and Fellowships
10. Community Presentations
11. Professional Conferences
12. Are you licensed? - Where?
13. What does it take to be licensed?
14. Are you Board Certified?
15. What does being Board Certified mean?
16. How long have you been practicing?
17. In those years, what sort of diagnoses and treatment have you done?
18. During your years of education did you ever have the opportunity to work under supervision?
19. When? Under supervision of whom?
20. Are you or have you been on the staffs of any hospitals?
21. How many patients have you seen in your years of practice?
22. Have you specialized in any area or areas?
23. Present job responsibilities?
24. Do you teach or have you taught? What? Where?
25. Explain difference between psychiatrist, social worker, and psychologist.
26. What is forensic psychology?
27. Have you any forensic psychology experience?
28. What is your forensic psychology experience?
29. Have you every testified in civil cases?
30. Have you every testified for the prosecution or defense in criminal cases?
31. Explain?
32. In what states have you testified?
33. What's the difference between a psychologist and a clinical psychologist?
34. Explain standard methodology of psychologists
35. What is ultimate result of your methodology?
    - conclusions are judgments based on education, experience, skill, ob-servation, testing, interview, etc.

36. What is DSM?
37. What is DSM III?
    - Move to have him declared expert able to render expert opinions in his field.

II. What Have You Done With Elzie

1. How did you get involved in this case?
   - contacted by defense counsel, who asked if I'd be willing to evaluate Mr. Morton, and render an objective opinion about his personality, mental status at time of his acts on June 9, 1984, and a lot of other questions
   I said yes, and clarified for them that they could expect an objective assessment that they may or may not want to present as part of the case.

2. Describe fee arrangement
3. Does fact that receiving fee affect your personal judgment
4. How many times have you seen Elzie?
5. How much time have you spent with him?
6. How much time have you spent working on this case?
7. Outline what you've done with Elzie
   - a history of Elzie
   - diagnostic clinical interview
   - series of structured, objective tests
   - reviewed all prior testing and evaluation of him supplied by you
   - reviewed a large amount of other information about this case sup-plied to me by you
8. What specific tests have you administered to Elzie?
   Battery of tests:
   - MMPI
   - WAIS - R
   - California Psychological Inventory
   - Bender-Gestalt
   - TAT
   - House, tree, person
   - Rorschach
   - wide range achievement teat
   - Halsteadetin neuropsychological battery
   - Benton
   - Incomplete sentencer
   - Diagnostic clinical interview

9. What's the purpose of running these tests, reviewing prior evaluations and tests, and reviewing other case information in addition to interviewing Elzie?
   - the more information you can obtain, the more certain you can be in making judgments - testing is more objective

10. Is this a common practice in your profession?

III. Individual Tests

1. Let's talk awhile about each individual test you administered, what it is, how administered, and results.

IV. House/Tree/Person

1. Explain what this test is
2. How developed?
3. How administered?
4. What is the rationale behind this test and draw tests in general?
5. Results?
6. How subjective/objective is this test?
7. Degree of confidence in results of this test/limitations

V. Bender-Gestalt

1. Explain what this test is
2. How developed?
3. How administered?
4. What is rationale behind this test?
5. Results
6. How widely used is this testing technique?
7. How subjective/objective is this test?
8. Degree of confidence in results of this test/limitations

VI. Rorschach

1. Explain what this test is
2. How administered?
3. Rationale
   a. 1st phase, free association phase, examiner avoids active involvement
      - 10 inkblots
      - subject told "no right or wrong answers"
      - one at a time
      - telling the examiner what he sees
      - not limited in number of responses to each inkblot
      - inquiry
   b. 2nd phase: inquiry (examiner becomes more active)
      - examiner asks questions to clarify his understanding of the way that the subject has perceived the inkblots, *e.g.*...
   c. Interpretation
      - location
      - determinant
      - content
      - popularity – originality
   d. Social interaction between 2 people; qualitative aspects of this interaction
      - variant of the interview where examiner and subject engaged in a personal exchange

- In what way does the subject accept and respond to the ink-blot talk presented to him?
- In what ways does the subject react to the examiner?
- What is the emotional tone of the subject's behavior?
- Are there discernible themes that run through subject's responses?
- How comfortable does the subject seem to be in handling the Rorschach cards and in coping with the testing situation?
- Does the subject seek to obtain the assistance of the examiner in "solving" the test presented to him?

4. Results
5. How widely used
   - among the most widely used personality instruments
   - has proved practically useful to clinical workers because of characteristics other than its perceptual scores.
6. How subjective/objective
7. Degree of confidence/limits

VII. Incomplete Sentence

1. Explain what this test is.
2. How developed?
3. How administered?
4. What is rationale behind this test?
5. Results?
6. How widely used is this testing technique?
7. How subjective/objective is this test?
8. Degree of confidence in results of this test/limitations

VIII. Wide Range Achievement Test

1. Explain test
2. How developed?
3. How administered?
4. What is rationale?
5. Results?
6. How subjective/objective?
7. Degree of reliability/limits?

IX. Benton

1. Explain what this test is.
2. How developed?
3. How administered?
4. What is rationale behind this test?
5. Results
6. How widely used is this testing technique?
7. How subjective/objective is this test?
8. Degree of confidence in results of this test/limitations

X. WAIS - R

1. Explain test
2. How developed?
3. How administered?
4. What is rationale?
5. Results?
6. How subjective/objective?
7. Degree of reliability/limits?
8. How widely used/in what contexts?

XI. Halstead Retin Neuropsychological Battery

1. Explain what this test is.
2. How developed?
3. How administered?
4. What is rationale behind this test?
5. Results?
6. How widely used is this testing technique?
7. How subjective/objective is this test?
8. Degree of confidence in results of this test/limitations

XII. California Psychological Inventory (CPI) (introduce blowup)

1. Explain test
2. How developed?
3. How administered?
4. What is rationale?
   - developed from 1948-57
   - similar to MMPI in several respects
   - personality characteristics for social living and interaction
   - 480 questions, 18 scales; norms from over 600 men and 7000 women
   - Among the scales:
   - Dominance
   - Sociability
   - Self-acceptance
   -Self-control
   - Sense of well-being
   - Validity scales
   - Goal: prediction of everyday social behavior
   - High level of sophistication used in constructing CPI

5. Results?
6. How subjective/objective?
7. Degree of reliability/limits
8. How widely used/in what contexts?

XIII. Minn Multiphasic Personality Inventory (MMPI) (introduce blow-ups)

1. Explain test
2. How developed?
3. How administered?
4. What is rationale?
   - objectively scored personality test
   - answers 566 questions about how he thinks, feels behaves
   - result is formulated as a personality profile that tells a psychologist what this person is like and gives an indication of how and why he may react
   - used since 1942
   - the questions pertain to attitudinal and emotional reactions; behavior and symptoms; aspects of subject's past life
   - 3 validity scales
   - 10 clinical scales
   - Hypochondriacal
   - Depression
   - Hysteria
   - Psychopathetic
   - Masculinity/femininity
   - Paranoid
   - Psychasthenia
   - Schizophrenia
   - Mania
   - Social introversion
   - Anxiety
   - Repression
   - and many other special scales
   - categorizes patients and gives a comprehensive personality description

5. Results?
6. How subjective/objective?
7. Degree of reliability/limits?
8. How widely used/in what context?
   - most widely used self-report questionnaire
9. Has Elzie been given other MMPI's?
10. When?
    a. 7/77 - Lexington Comp Care
    b. 10/77 - Dr. Marx
    c. 7/79 - Dennis Wagner
    d. 2/80 - Leppert
    e. 8/82 - Leppert
11. What do these tell you about Elzie's personality over time?
    - progressive deterioration in his personality over time

XIV. Results of all Your Tests

1. How many tests have you administered and evaluated over your years of practice?
2. What are your basic conclusions from the results of all of these tests?

XV. Previous Tests (introduce blowups)

1. Has Elzie previously taken psychlogical teats that you have information about?
2. List those tests and when taken
   a. Lex. Comp. Care - 1977
      -MMPI
      - Shipley Institute of Living Scale (7/27/77)
   b. Dr. Marx - 1977
      - MMPI (10/77)
   c. KCPC (Wagner) - 1979
      - QT
      - MMPI (7/79)
   d. LaGrange - 1979
      - Revised Beta Examination (Beta-II) (9/14/79)
      - 1980 - MMPI (2/22/80)
      - 1980 - WAIS (2/25/80)
      - 1982 - MMPI (8/23/82)

3. Evaluate those test results
   - Discrepancies in Shipley
   - Discrepancies in Leppert's WAIS
   - Others
4. How do those tests results compare to what you found?
   - Shows deterioration
   - Can you fake tests, especially MMPI?

XVI. Previous Evaluations

1. Has Elzie been previously evaluated by mental health professionals?
2. List by who, their profession, when
   A. Lexington Comp Care
      a. Dr. Ruiz - psychiatrist
         - 7/77 - 2/78
      b. Diane Fullenwider
         - certified psychologist
      c. Dave Rodenheffer -
      d. Ed McChord
         - courts and jails project supervisor
      e. Dr. Marilyn Marx
         - psychologist - 9/23/77
      f. Dr. Martin Gebrow
         - psychiatrist - 9/15/77 & 10/13/77

   B. VA Hospital
      - 11/7/77 - 2/21/78
      a. Suzanne Dozier
         - psychological nurse
      b. Charles Powell
         - social worker
      c. Dr. Kenneth Moore
         - psychiatrist

C. KCPC - 7/11/79 - 8/2/79
   a. Dr. Pran Ravani
      - psychiatrist
   b. Robert Hopps
      - social worker
   c. Dennis Wagner
      - psychologist

D. Lagrange - 1979 - 1984
   a. Norb Leppert
      - psychologist
   b. Claude Turpin

E. Lexington Comp Care
   a. Gail Trumpe-Morrow
      - 1984

F. For this Trial
   a. Dr. Lange, April, May 1985

3. What were their major findings?
4. How do their feelings compare to what you have found?

XVII. Interview with Elzie

1. How long did you spend interviewing him?
2. Did you interview anyone else?
   - Yes, Elzie's mother, sister, father
3. Why didn't you talk to his other sister, Mary?
   - She lives out of state
4. Why didn't you interview Elzie's brother, T.G.?
5. Was this length of time sufficient to get a good, accurate evaluation of him?
6. Why?
7. Explain interviewing process, its importance
8. Detail information you received from interviews

**(ASK FOR RECESS)**

XVIII. Diagnosis

1. Doctor, based on all this information and analysis have you found a diagnosis?
2. What is it?
   - personality disorder
3. What is a personality
   - PERSONALITY. Deeply ingrained patterns of behavior, which include the way one related to, perceives, and thinks about the environment and oneself.
   -DMI-III p. 366

4. What is a personality trait?
   - Personality traits are prominent aspects of personality, and do not imply pathology. Personality disorder implies inflexible and mal-adaptive patterns of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.
   - DSM III, p. 366.
5. What is a personality disorder?
   -Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute Personality Disorders. The manifestations of Personality Disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age.

   Many of the features characteristic of the various Personality Disorders, such as Dependent, Paranoid, Schizotypal, or Borderline Personality Disorder, may be seen during an episode of another mental disorder, such as major Depression.
   - DSM III, p. 305.

6. How does a personality trait become a personality disorder?
7. When do personality disorders begin?
8. What are the criteria for diagnosing one who has personality disorder?
   - The diagnosis of a Personality Disorder should be made only when the characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.
9. What personality disorder does Elzie have?
   - Borderline
10. Explain what this is
11. What are the features associated with that disorder?
12. Any impairments?
13. Any complications?
    - stress produces decompensation
14. Explain why Elzie has this disorder
    - Multiple factors some known, some unknown
15. Does he have indications of other personality disorders?
16. How do you explain Trumpe-Morrow's diagnosis of passive-aggressive or schizoid?
    - Any given time, not as disturbed
17. How do you explain Marx' diagnosis of dissocial reaction in a passive-aggressive personality, passive type?
    - agree, but doesn't adequately explain depth of problem
18. How does your diagnosis fit with your testing
    - other testing?
    - other evaluations
    - other diagnosis
    - your interview

- basically progressive deterioration over time prediction of this act - not out of line

19. How sure are you of your judgment, this diagnosis?
-Within psychological certainty

20. Why?

XIX. The Crimes/Mental State

1. Have you read Elzie's 2 confessions?
2. Have you listened to the 2 tapes of his confessions?
3. Have you reviewed the police chronology and reports?
4. Doctor, based on what you know about Elzie and the offenses, do you have an opinion within reasonable psychological certainty as to Elzie's mental state on June 9, 1984 for the act of raping Lin Jung Chen?
-Elzie intended to rape someone that night
5. What is it?
6. ...for the act of *killing* Lin Jung Chen on June 9, 1984?
7. What is it?
8. Explain?
9. Did Elzie act under the influence of extreme emotional disturbance?
1O. Explain?
11. Was there a reasonable explanation or excuse, the reasonableness of which is to be determined from Elzie's viewpoint in Elzie's situation under the circumstances he believed to exist?
12. What was it?
- distortion of reality
- borderline
- through development of chronic severe emotional disorder he has, among other things, hatred of women, border line personality disorder
- at time of killing had disassociative psychotic break
- rage; he was so furious and angry he had to react and did
- symbolic killing mother
- stress
- movie
- show
13. Brief reactive psychosis, is this what happened?
14. Explain what that is?
- extreme stress produced fear, loss of control, rape.
15. Explain again why this happened?

XX. Bad Facts (play parts of confes-sion)/Confessions

1. Isn't there a lot to show intentionality of rape (and impliedly to murder) that is contrary to your diagnosis:
- torn towels in knapsack
- "I went to University to see if I could find a girl to rape her"
- waited until she was alone
- snuck up on her
- told her to take her clothes off
ANS: rape kit not that uncommon among rapists
2. Isn't there a lot to show intentionality of murder contrary to your conclusion and judgment
- choked her for 1/2 hour
- put her head in toilet for 15 to 30 minutes to - keep her from talking
- to silence her
- so she wouldn't identify me and to drown her
ANS: no, not inconsistent with my diagnosis
- this is evidence of psychotic break
- gaps in memory
- need to punish self for this horrible crime
- how does it make sense for Elzie to confess so readily if he killed victim to silence her so she wouldn't identify him?

XXI. Reemphasis of EED

1. Explain again what Extreme Emotional Disturbance is
- includes any psychological dis-turbance, either acute or chronic, which exhibits itself in reduced self-control, excessive influence of emotion, stress, panic, hallucinations, rage or distortion of thinking and reality.

It includes a transitional, situational reaction in which an individual with no apparent mental disorder, when exposed to an extreme, unusual, overwhelming stress has an extreme emotional reaction to it, which may result in a sudden, impulsive, blind, irrational outburst.

It includes an emotional condition where a person is directed by emotions or feelings, rather than by reason. One's passions, excited beyond intellectual control, take over. Rage is then the predominant feature.

It includes an increased irritability associated with sporadic and unpre-dictable explosions of aggressive behavior, upon even minimal or no provocation.

2. Explain what intention means
- ability to maturely and meaningfully deliberate, reflect and have conscious objective to do something in the absence of mental disease or defect

XXII. Stress

1. Explain stressors
- stress from person's viewpoint vs. objective stress
2. What stress was Elzie under of long and short duration?

- recently paroled
- new job
- living with mother
- continued and consistent effect of mother
- dysfunctional fairly
- T. G.
- Dad
- divorce(s)
- being a convict
- stress of Job from Elzie's viewpoint
- stress of going to psychologist, who was a female
- stress of parole officer
- argument with mother on Friday evening
- no friends, male or female
- no socializing
- associal not antisocial
- unconfronted anger, rage
- confusion
- self concept

3. What was degree of stress Elzie had in his life?
   - severe and chronic
4. What does stress lead to for Elzie?
   - led to depression, more anger, decompenstion
5. Did this contribute to his acts on June 9?
6. How?
7. Was Elzie able to handle this stress?
   - no
8. Why not?
   - culmination of multiple, pre- existing active and dormant personality characteristics

XXIII. Anger

1. Explain rage, anger
2. What anger does Elzie have through his life?
   - repressed rage
3. When does his anger, rage begin to develop?
   - double bind messages
4. What rage did he feel June 9 at the time of his acts?
5. Did the rage contribute to his acts of June 9?
   - yes
6. How?
7. Was Elzie able to handle this anger?
   - no
8. Why not?
   - no ego strength, emotion over rational thinking
9. Is this the reasonable explanation or excuse?

XXIV. Control

1. Explain control of one self
2. Did Elzie have problems with control in his life?
3. Did Elzie have problems with control on June 9?
4. How so?
5. Was he able to completely control his actions in life and that night?
6. Why not?

XXV. His Understanding of Disorder

1. What level of understanding does Elzie have of his personality disorder(s)?
   - superficial; constantly preoccupied with rage and maintain controls.
2. Why doesn't he have a better understanding
   - limited insight is common charac-teristic of borderline personality disorder

XXVI. How Did Elzie Get This Way

1. How did Elzie end up this way? What factors in his life caused this?
   - summarize answer that will be fully explored in your penalty phase testimony

XXVII. Rape

1. Are there different kinds of rape?
2. What are they?
   - anger, control, sadistic
3. Explain?
4. Why do people rape?
   - rage, hatred, aggressiveness
5. How stressful would this crime of rape be to Elzie?
6. How does that make sense - seems ridiculous?
7. Is it a sexual act?
   - behaviorally, not psychologically, it is an act of rage and anger.

XXVIII. Elzie's Goal

1. Do you have an opinion of whether Elzie wanted to stay out of trouble?
   - very much did
2. How'd he try to do that?
   - isolated himself
3. How'd that affect his chances of staying out of trouble?
4. Did he understand how it affected his chances?

XXIX. Affect/Meanness

1. What is affect?
   - feeling
2. What was and is Elzie's affect?
   - flat, depressed
3. Is he a mean person who enjoys raping?
   -no
4. Why?
   - disturbed painful but compulsive behavior, no control over it
5. How does that match up with his affect?
6. How does that fit in with the behavior evidence of his crimes?
7. Testimony from some people who took confessions,

that he was not bizarre, funny, unusual, strange; rather, calm, odd, flat, polite, cooperative.

XXX. Reemphasize Diagnosis/Mental State

1. What are you most sure about Elzie in terms of his personality?
2. How sure are you that he's mentally ill?
3. Why are you so sure?
4. Is that any doubt in your mind that he's mentally ill?
5. Was the murder premeditated?
6. Once again Dr., what are you saying his mental state was on June 9, 1984?
   - severe emotional disturbance
   - dissociative psychotic break
   - decompensation of previous active mental disturbance
   - Elzie has had this potential for a long time
   - greatest tragedy is not that this happened but that it was predicatable and we (my profession) did nothing to reduce the chances of it happening.

**MOVE TO INTRODUCE EXHIBITS**

XXXI. Possible Questions by Prosecutor on Cross-Examination

1. AREN'T YOU BEING PAID BY THE DEFENSE, AND THEREFORE GIVING DEFENSE OPINION?
   - Not being paid for opinion only professional services

2. ISN'T THIS JUST YOUR OPINION?
   - No, background, experience, other evaluations, etc.

3. AS TO OPINION ON MENTAL STATE AT TIME OF OFFENSES, IT'S NOT REALLY VALID IS IT BECAUSE YOU SAW HIM SO LONG AFTER OFFENSES?
   - You don't have to see it snow at night to say snow on the ground in the morning, if it's there.

4. AREN'T YOU BASING OPINION ON INFORMATION FROM MAN WITH MOST EXTREME REASON TO FALSIFY?
   - no - basing on test data, other evaluations, *never* base opinion on what accused tells me

5. YOU CAN'T GUARANTEE HE WILL BE CURED, CAN YOU?

6. YOU CAN'T GUARANTEE US THAT HE'S NOT DANGEROUS, OR WILL BE DANGEROUS, CAN YOU?
   - No, I can't.

7. YOU CAN'T REALLY PREDICT HIS BEHAVIOR, CAN YOU?
   - depends on environmental circumstances

8. YOU'RE NOT SAYING HE'S NOT CAPABLE OF BEING VINDICTIVE, ARE YOU?
   - don't know what that means, please explain

9. YOU CAN ONLY TALK ABOUT YOUR GUESS AS TO THE KIND OF PERSON HE IS AND NOW WHAT HE DID AT THIS INCI-DENT, CAN'T YOU?
   - No, see above

10. YOU CAN'T SAY HE DID NOT ACT CONTRARY TO HIS PER-SONALITY DURING THIS INCIDENT, CAN YOU?
    - No, ln fact he did.

11. HE KNEW FULL WELL THAT SOMEBODY COULD BE HURT, DIDN'T HE?
    - Not in the sense that you and I know of

12. HIS MOTHER IS NOT COMMIT-TING CRIME, SO HIS MOM ISN'T THE REAL PROBLEM IS SHE?
    -she set him up, unintentionally for major problems

13. ISN'T THE ULTIMATE WAY FOR A CRIMINAL TO PROVE HE'S A MAN FOR THE CRIMINAL IS TO KILL SOMEBODY?
    - no, that's extremely simplistic

14. PSYCHOLOGY IS NOT AN EXACT SCIENCE?
    - true

15. ITS SUBJECTIVE?
    - only to an extent, it is a science, mostly objective

16. PSYCHOLOGISTS DIFFER EVEN ON SOME DATA?
    - sure

17. PSYCHOLOGISTS IN THIS CASE EACH HAVE A DIFFERENT DIAGNOSIS
    - Not really, different words to describe same behavior

18. NO TWO EXPERTS THE SAME?

19. HE HASN'T EVER TOLD YOU HE'S SORRY?
    - don't know, good, will ask Elzie

20. YOU HAVEN'T TALKED TO PEOPLE WHO SAW HIM SHORT-LY BEFORE OR AFTER?
    - eyewitness accounts are scientifically unreliable
    - total body of scientific literature in the "Psychology of Perception"

21. DON'T KNOW HOW HE AP-PEARED PHYSICALLY, DEMEAN-OR?
 - No, not relevant

22. CRIMINAL BEHAVIOR IS ANTI- SOCIAL
 - Yes, by definition

23. YOU CAN ONLY GUESS WHAT ELZIE'S STATE OF MIND WAS THE EVENING OF JUNE 9?
 - No, can make conclusion based on deductive logic, and experience, and other _____ to exhibits, etc.

**PSYCHIATRIST**

I. Introduction

II. What is a Psychiatrist?

III. The Personality

IV. This Case

V. Findings out Elzie

VI. The Crime Itself

VII. Summary

VIII. The Crime Itself

Elzie Morton, Capital Case

**DIRECT OF DR. ROBERT LANGE**
**GUILT PHASE** - Ernie Lewis

I. Introduction

A. Name, present address

B. Where were you born?

C. Where were you educated?

D. What training did you receive to become a psychiatrist?
1. Describe the specific training you received following medical school.

E. What is a fellowship? What did you do a fellowship?
1. What is a child psychiatrist?
2. How does that differ from someone with a traditional psychiatrists' training?

F. What are boards?
1. What does that entail?
2. Are you board certified?

G. Have you published?

H. What experience have you had in the practice of psychiatry?

I. To what professional organizations do you belong?

MOVE T0 ACCEPT HIM AS AN EXPERT IN THE FIELD OF PSYCHIATRY.

II. What is a Psychiatrist?

A. What do psychiatrists do?

B. How is what you do different from a clinical psychologist?

C. How do you find out about a person differently from the way a clinical psychologist does?

D. In what way do you use what psy-chologists find out about a person?

E. What methodology do you use in order to find out about a person?
1. How does that differ from what a psychologist does?
2. Is one or the other any more or less legitimate as a way of discovering what a person is about?

III. The Personality

A. What is it?

B. What does it develop?

C. Why is a personality important?

D. How is personality related to behavior?

E. What is a personality trait?

F. What is a personality disorder?
1. When do personality disorders begin?
2. Can a personality disorder be serious?
3. How serious?
4. How debilitating can a personality disorder be?
5. How is this different from have a *bad personality*?

IV. This Case

A. How did you become involved?

B. What is the fee arrangement?
1. Do doctors work for free?
2. Does this mean we have bought your opinion in some way?

C. Of what importance is the personal interview?
1. How many times did you see Elzie? Was this adequate?
2. What do you do in such an interview?
3. What can you find from such an interview?
4. How can you evaluate some-one's person in three interviews?

D. Other Materials
1. What other mental health re-cords did you review?
2. What is it important to review these?
3. What materials did you receive concerning the crime itself?
4. What else did you receive? What was the quality of the materials you received and reviewed?

E. Did you receive enough material and spend enough time with Elzie to get a psychiatric picture of him?

F. Did you do a report? Why not?
1. Were you available and willing to talk with the prosecution?
2. Would you have shared your findings with them?

V. Findings Out Elzie

A. Diagnosis
1. Based upon this information, do you have an opinion, to a reasonable psychiatric certainty, regarding Elzie Morton's mental status? What is it?
2. What are the meanings of these diagnoses?
a. What is a *bordering person-ality disorder*? Is this from the DSM-III?
i. How serious is this?
ii. Can it lead to *psycho-sis*? What does that mean? How is stress related to the appearance of psychosis?
iii. What is the most ser-ious personality disorder? What is that?
iv. In what way does this describe Elzie?
- unstable relationships
- inappropriate and intense anger
- identity disturbance
- affective instability
- emptiness and boredom

b. What is a *schizotypal personality disorder*?
i. How serious is this?
ii. In what way does this describe Elzie?

c. What are *paranoid* traits?
i. How does this describe Elzie?
- jealousy
- quick to take offense
- appears cold
- exaggerates difficulties
- social isolation
- odd speech

ii. How are his long pauses in conversation related to this trait?
iii. How would this effect feelings toward siblings? Girlfriends?

B. Other Diagnoses
1. You stated that you reviewed other diagnoses and evaluations of Elzie Morton?
2. Are they consistent or inconsistent with their findings with what you have stated today? Explain:
a. You were aware of Dr. Ravani's analysis?
b. What do you think of it?

3. Did you notice any progression from Elzie's first evaluation in 1977, when he was 24 years of age, and today?

C. The Cause
1. What has caused Elzie to become this way?
2. When did this develop?

D. The Person as he Operates in the World
1. How does Elzie view the world?
2. What kind of self image does he have?
a. Why is self image important?
3. How does he view others?
4. How does he relate to other persons?
5. What effect does stress have on him?
6. What does he want to do with his life?
7. What is an affect?
8. What is Elzie's affect and what does it mean?

E. How certain are you of your diagnosis?

VI. The Crime Itself

A. How do you know about the crime?

B. What stress was Elzie under during the spring of 1984?
   1. What would that stress do to Elzie?

C. What emotions were going on during the Spring of 1984?

D. What was going on with Elzie emo-tionally on June 8, 1984?

E. What is your analysis of the factors which contributed to the rape and killing of Lin Jung Chen?
   - mother
   - Martha, oriental sister-in-law
   - emotions boiled over

F. Control
   1. Under how much control was Elzie?
   2. What was he unable to control himself?

G. Was he experiencing this personality disorder at the time of the crime?
   1. What was the degree or intensity of his emotion that night?
   2. What reasonable explanation or excuse was he acting upon?
   3. What is that reasonable from his perspective?

H. In what way did this crime occur as a result of this personality disorder?

I. In your opinion did he kill her to silence her?
   1. Why would he say that he did?

J. How certain are you of the opinions which you have rendered to-day?

VII. Summary (Next Day of Trial)

A. Please summarize your diagnosis of Elzie Morton.
   1. What is your primary diagnosis?
   2. How serious is this personality disorder?
   3. Is this:
      a. A bad personality?
      b. A problem?
      c. A serious disturbance?

VIII. The Crime Itself

A. How do you know about the crime?

B. What stress was Elzie under during the Spring of 1984?
   1. What would that stress do to Elzie during that period of time?
   2. Is it important to view stress from our perspective or the per-son's perspective?

C. What emotions was Elzie feeling from April 6, 1984 until June 8, 1984?
   1. What was going on emotion-ally at the time of the crime?
   2. What was the degree of intensity of these emotions?
   3. What is your analysis of the factors which contributed to the raping and killing of Lin Jung Chen?
   4. Sexual Sadism
      a. Where is it in the DSM?
      b. This is a disorder?
      c. An illness?
      d. What does this indicate about whether he has a normal or abnormal sexual identity?
      e. Why is this important?
      f. DSM indicates that this disorder begins in childhood.
      g. DSM also indicates that brutality often occurs in families of individual with this disorder?
      h. Where does this fit with the other primary or predominant personality disorders which you have described?
   5. How important was rage that Elzie was experience?
   6. What is the source of the rage?
   7. Why was Elzie enraged? At whom?
   8. How does it make sense to kill someone you don't know due to rage at your mother, Martha Morton, and other family members?
   9. What was the effect of the per-sonality disorder on Elzie's behavior that evening?

D. Control
   1. Under how much control was Elzie on the night of June 8, 1984?
   2. Why was he unable to control himself?
   3. He was not insane, was he?
   4. He was not acting, thinking, or feeling normally, was he?

E. How certain are you that Elzie was suffering from the described personality disorders, and the accompanying emotions, at the time this occurred? ■