

REPRESENTING CLIENTS WITH MENTAL ILLNESS



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December 2020

INTRODUCTORY NOTES

The majority of this publication is reprinted with permission from the Kentucky Department of Public Advocacy, Mental Health and Expert Manual (8th Edition, 2005). We have also included seminar materials prepared by the Indiana Protection & Advocacy Services Commission. The publication is divided into five parts: 1) recognizing and working with mentally ill clients; 2) legal issues and procedures; 3) mental health expert investigation and evaluation; 4) developing, presenting and challenging mental health evidence at trial; and 5) appendix. Information in this publication is subject to change, and should only be used as a starting point for further investigation and study of current law and practice.

The Indiana Public Defender Council disclaims any and all responsibility or liability that may be asserted or claimed arising from or claimed to have arisen from reliance upon the procedures, suggestions, information or utilization of the checklists set forth in this publication by the attorney or non-attorney.

We will attempt to update this publication as we learn of new developments. If you discover information that has been changed or have suggestions for additions to this publication, please contact Jack Kenney at IPDC, 317-232-2490, or jkenney@pdc.in.gov.

Jack Kenney
December 2020

Note: Planning For And Responding To A Mental Health Crisis

If you have a client who is in a mental health crisis, or you have concerns that a client may have such a crisis, the pamphlet, "Planning for and Responding to a Mental Health Crisis," is extremely helpful. You can find the latest version at the following url:

<https://www.dropbox.com/s/dkve4b56tdcqda0/Crisis%20Booklet%203rd%20Edition%20%281%29.pdf>.

This pamphlet is published by NAMI Indiana (National Alliance on Mental Illness). Among other things, it: 1) advises whom to call in an emergency, 2) discusses the legal basis for detention and commitment; 3) provides alternatives to involuntary commitment; and 4) explains the urgent need to immediately contact the Social Security Administration to begin the process to obtain disability benefits.

NOTE REGARDING NEW DSM-5

The American Psychiatric Association has issued the new DSM-5, thus replacing the DSM-IV. Many of the changes in DSM-5 were made to better characterize symptoms and behaviors of groups of people who are currently seeking clinical help but whose symptoms are not well defined by DSM-IV, meaning they are less likely to have access to treatment. See <http://www.dsm5.org/about/Pages/faq.aspx#6>. For highlights of the changes, visit www.psychiatry.org/DSM-5.

Another significant change is that the new DSM-5 is no longer applies a multi-axial assessment. In prior versions of the DSM, a system that included 5 "axes" or dimensions was used for diagnostic and treatment purposes. The axes were:

- [I\) Clinical Syndromes / Disorders](#),
- [II\) Personality Disorders / Mental Retardation](#),
- [III\) Medical Conditions](#),
- [IV\) Psychosocial and Environmental Stressors](#), and
- [V\) Global Assessment of Functioning](#).

The DSM-5 applies a more simplified, non-axial documentation approach. The former first three Axes (I, II, and III) are combined, with separate notations for the other two former Axes, covering psychosocial and environmental factors (IV), as well as disability (V). See <http://www.psyweb.com/content/main-pages/dsm-5-fifth-edition-of-the-diagnostic-and-statistical-manual-of-mental-disorders>.

In practical terms, this means that personality disorders are no longer separated from other disorders.

Finally, please note that most of the articles in this manual refer to the DSM-IV, not DSM-5.

SCREENING FOR MENTAL ILLNESS

It is important to pay attention and recognize signs of mental disorders and disabilities. Chapters 2 and 3 provide important help with recognizing signs of mental illness, but here are a few quick pointers:

- Look at your client's statements
- Observe your client's behavior
- Read the probable cause affidavit. Does it refer to:
 - ID or immediate detention (24-hour-hold)
 - ED or emergency detention (72-hour-hold)
 - CIT (Crisis Intervention Trained) officer
- Ask your client questions.
 - Ever been treated for mental health issues?
 - Ever been treated for substance abuse?
 - On any medications? What are they?
 - Currently in treatment? Where?
- Be sensitive and explain why you are asking these questions (it may impact or expand their options for resolution of the criminal case)
- Get as much detail as possible. With client's permission, contact family or case managers to provide more information.
- Document everything they tell you; they may not remember later.

Signs of psychosis:

- Delusions (fixed false beliefs that don't change even in the face of overwhelming evidence to the contrary.)
- Hallucinations (seeing or hearing things that don't exist)
- Disorganized speech or thought processes (can't stay on track or incoherent)
- Negative symptoms such as flat affect

Signs of a mood disorder:

- Your client seems depressed or hopeless
- Your client seems to have inflated self-esteem or grandiosity
- Your client is hyper-talkative or has pressured speech or racing thoughts
- Your client has anger or other emotions disproportionate to the situation

PROBLEMS REPRESENTING A CLIENT WITH MENTAL ILLNESS

There will be obstacles facing the public defender who is representing the client with a mental illness or disorder. It is important to remember that this is an anxiety-producing situation and, therefore, the person's behavior may not be predictable. Following these tips, you should be able to minimize difficulties in communicating with the individual.

The individual may not be a reliable informant. The person may not be able to remember details when under stress or when pressed for answers. Providing the person with paper and pencil to make their own notes before and after your meetings will help them to remember.

The family may not be dependable. The family may feel guilty about getting the person "in trouble." Family members may be reluctant to appear in court. They may be afraid of the individual.

Information which you may need is privileged, confidential mental health records. Specific consents for release are required.

As the public defender talks to the client, it is not only important to make sure that the client knows what the charges are and what to expect while in court, but it will also be important to determine if the client is competent to stand trial. (I.C. 35-36-3) The public defender will need to assess whether the individual is competent to stand trial at the present time and determine if the client knew what he or she was doing at the time of the event. During the interview process, the public defender will need to assess whether the individual's mental illness will interfere with the client's understanding of the legal process and their ability to defend themselves. The public defender should focus heavily on the individual's state of mind at the time of the events leading up to the arrest. Ascertain what the client was thinking or experiencing at that time. The public defender can also consider requesting that the individual's treatment make a determination as to the individual's competency to participate in the legal proceedings. This information may lead to plea bargaining or an insanity defense plea. The public defender should also familiarize him/herself with various community resources and mental health facilities that can be identified as options as a part of the plea bargaining/sentencing as opposed to consideration only being given to incarceration or probation/parole.

Refer to I.C. 35-35 and 36 on Pleading and Procedure and Pretrial Notices, Motions, and Procedures.

An individual with a mental illness cannot be adequately represented by having brief telephone contacts or quick meetings with his/her public defender.

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Chapter 1

Mental Health Issues – The Heart of the Matter

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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
 - multi-generational 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

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Checklist of Client Behavior Evidencing Mental Impairment

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CHAPTER 2

Checklist of Client Behavior Evidencing Mental Impairments

(Based upon Deana 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	☐ Blurred vision
☐ Self-wounds or wounds suspicious in origin	☐ Need to squint or move closer when reading
☐ "Accidents"	☐ Hearing problems
☐ Difficulty falling asleep	☐ Ringing in ears
☐ Difficulty staying asleep	☐ Headaches
☐ Excessive sleeping	☐ Dizziness
☐ Change in eating habits	☐ Nausea
☐ Loss or decrease in appetite	☐ 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

[illegible]

Chapter 3

Observing Signs of Mental Impairment

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CHAPTER 3

Observing Signs of Mental Impairment



Judges' Guide to Mental Illnesses in the Courtroom

OBSERVATIONS THAT INDICATE A DEFENDANT MAY HAVE A MENTAL ILLNESS

When Mental Illness Seems to Be a Factor, Consider:	
Prevalence: • Serious Mental Illness: 17% of adults booked into jails (31% of women; 15% of men) • Substance Use Disorder: 65% of adults in U.S. corrections systems • Co-Occurring Mental Illness/Substance Use Disorder: 72% of adults with serious mental illnesses in jail also had co-occurring substance use disorders Contextualizing Observations: While these categories of observation are provided to alert judges that an individual may have a mental illness that requires different judicial action and/or attention by a mental health professional, they are not definitive signs of mental illness. Certain contextual elements are important to remember: • Appearing in court is an anxiety-provoking experience for most people. • Individuals may not be prepared to navigate a system as complex and demanding as the criminal justice system. • Individuals may bring to court skills that have allowed them to survive in their communities but are poor fits for interacting with the court (e.g., toughness, argumentativeness, silence).	
Categories of Observation: <i>Do you see something in one of the following areas that <u>does not make sense</u> in the court context</i>	Courtroom Observations: <i>Examples of how behaviors in the observational areas can indicate that the individual may have a mental illness:</i>
Appearance: Age, hygiene, attire, ticks/twitches	• Looks older/younger than listed date of birth • Wears inappropriate attire (e.g., multiple layers of clothing in summertime) • Trembles or shakes, is unable to sit or stand still
Cognition: Understanding/appreciation of situation, memory, concentration	• Does not understand where s/he is • Seems confused or disoriented • Has gaps in memory of events • Answers questions inappropriately
Attitude: Cooperativeness, appropriate participation in court hearing	• Stays distant from attorney or bench • Acts belligerent or disrespectful • Is not attentive to court proceedings
Affect/Mood: Eye contact, outbursts of emotion/indifference	• Does not make eye contact with judge or court staff • Appears sad/depressed or too high-spirited • Switches emotions abruptly • Seems indifferent to severity of proceedings
Speech: Pace, continuity, vocabulary (Note: Can this be explained by discomfort with English language?)	• Speaks too quickly or too slowly • Misses words • Uses vocabulary inconsistent with level of education • Stutters or has long pauses in speech
Thought Patterns and Logic: Rationality, tempo, grasp of reality	• Seems to respond to voices/visions • Expresses racing thoughts that may not be connected to each other • Expresses bizarre or unusual ideas

JUDICIAL INTERACTIONS

Before Interacting with a Defendant, Consider:

- **How the courtroom environment is affecting the defendant:**
 - Are there noises or distractions in the courtroom that are negatively affecting the defendant?
 - Is there a family member or defense attorney who can help calm the person?
- **Safety** for yourself, the court staff, and the individual.
- **What is being asked and said in open court** and how this may affect future proceedings.

While Interacting with a Defendant, Consider:

Courtroom Situations: <i>Examples of commonly-observed scenarios</i>	Immediate Responses: <i>Recommendations for immediate situation management</i>
When a mental illness is affecting a defendant's courtroom participation	• Speak slowly and clearly • Avoid jargon • Explain what is happening • Write down instructions if dates or addresses are involved • Treat the individual with the respect you would give other adults • If appropriate, use the principles of Motivational Interviewing*: • Express empathy • Point out discrepancies between goals and current behavior • Roll with resistance • Support self-efficacy
Loss of reality**: <i>When the defendant appears confused or disoriented</i>	• Ground the defendant in the here and now**
Loss of hope: <i>When the defendant appears sad, desperate</i>	• As appropriate, instill hope for a positive end result • To the extent possible, establish a personal connection
Loss of control: <i>When the defendant appears angry, irritable</i>	• Listen, defuse, deflect • Ask the defendant about why s/he is upset • Avoid threats and confrontation
Loss of perspective: <i>When the defendant appears anxious, panicky</i>	• Seek to understand • Reassure and calm the defendant • Deflect concerns

When Taking Action, Consider:

- **Having the defendant approach the bench:** Would this de-escalate the situation or create a safety risk?
- **Re-calling the case later in the session/calendar:** Could this help the defendant calm down?
- **Determining whether to proceed:** Is a fitness or competency evaluation appropriate?
- **Setting conditions of release:**
 - Does the defendant have the capacity to understand the conditions?
 - Does the defendant have the ability to adhere to the conditions?
 - What effect will these conditions have on the regularity of treatment?
 - What effect will time in jail have on mental health, access to medication, benefits maintenance, etc.?
 - How will conditions/time in jail affect the defendant's access to a primary caregiver?
- **Requesting mental health information:** What exactly do you need to make the decision facing you?
- **Making a referral (to a mental health services provider or other services):**
 - What are the goals of the referral?
 - How might the defendant's cultural background and linguistic needs impact access to services?
 - What are the expectations for reporting back to the court?

* **Motivational Interviewing** is a counseling approach initially developed by William R. Miller and Stephen Rollnick.

**The Loss of Reality, Hope, Control, and Perspective and the immediate responses are based on the LOSS Model developed by Paul Lilley.

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 themselves 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 important 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. Hallucinations, a sign of both psychosis³ 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. 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 sub-groups 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 hyperactivity 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, 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. 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, depression²⁷ 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. 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. 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. Wounds or "accidents" may actually reflect self-mutilation or suicide attempts.⁴⁰ Sleep problems (insomnia, nightmares, hypersomnia) can be a general psychiatric symptom⁴¹ as well as a specific marker of brain damage⁴² 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. 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 illness⁴⁷ 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 signs⁵⁰ 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 illness⁵³ as well as brain damage,⁵⁴ and mental retardation.⁵⁵ These problems can be seen as feelings of low self-esteem⁵⁶ 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 malingers 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. 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 frustrated⁶¹ or who fail to learn from their mistakes⁶² 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. Restless, fidgety, overly talkative behavior (agitation) as well as unusually quick reactions, can be a general sign of mental impairment⁶³ 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 problems⁶⁹ 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 client's 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 disorder⁷¹ 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 problems⁷⁴ including depression, attention-deficit hyperactivity disorder⁷⁵ 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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Chapter 4

Major Mental Illness

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CHAPTER FOUR

Major Mental Illness

I. Schizophrenia

Schizophrenia disorders are diseases of the brain which cause unrealistic thoughts and feelings. The disorder is most likely caused by a chemical imbalance in the brain. The person may have a genetic predisposition for this disease, especially if a parent or other relative has been diagnosed with this disorder. Therefore, it is very helpful to determine whether other family members suffer from a mental illness.

Characteristics

There are a wide variety of characteristics of schizophrenia. An individual may exhibit some or all of these characteristics with a range of intensity levels.

1. The person creates her own reality.
2. Delusions – The individual has thoughts and beliefs about things that do not exist or are distorted, but are that person's reality. For example, Joe thinks he is the President of the United States.
3. Hallucinations – The individual has sensory distortions which are a part of the psychotic ideation process. Auditory hallucinations, which are the most common, are when people hear things that are not occurring. Frequently, people hear voices of others. These voices may be patronizing, mean spirited, commanding or comforting. Visual hallucinations occur when the person sees other people or things that are not present. These visions may range from comforting, to bothersome or scary. Olfactory hallucinations occur when the person smells odors which are not present in the environment. Tactile hallucinations occur when the individual feels things that are not present in the environment. For example, a person may feel as if spiders are crawling on them. Different types of hallucinations may occur in tandem. A person may see and feel spiders crawling on his/her body.

Public defenders are urged to carefully gather information about what role hallucinations may have played in the alleged criminal activity.

4. Disorganized speech – The person may talk in a fragmented speech pattern. As an indication of disorganized thinking, the person may jump from topic to topic without an apparent connection.
5. Inappropriate affect – It is an inappropriate expression of an emotional response to a situation. Affect may be blunted or flattened where the individual appears dull or slow to respond. The person may not be processing what is being said to him because he is preoccupied with what is going on inside his head, such as thoughts, delusions or hallucinations.
6. Lack of motivation – the person does not appear interested in changing the situation or making it better.

7. Irrational thought processes – The individual draws conclusions based upon little, if any, fact. Delusions can become the individual's reality. The person can do lots of topic jumping which make sense and has a logical progression to her, but makes no sense to anyone else.
8. Expressed odd beliefs – For example, the person may believe he is protected from aliens by putting aluminum foil on his head, over the windows, etc. The person may believe that he has a hook in his throat and that is why he has a sore throat.

Behaviors

Many observable behaviors of persons with schizophrenia are due to reactions to internal stimuli or the side effects of medication.

1. Disorganized behavior – The person may exhibit bizarre body movements which make a person look odd. For example, you might see repetitive movements (rolling tongue), facial grimacing, shuffling gait, or excessive motor activity.
2. Self-talk – The person may be talking aloud to no one in particular. This may be in response to hallucinations. It could be a coping skill aimed at calming or organizing the person's behaviors.
3. Physical gesturing – The person may strike out, have eye movements or make gestures in response to their hallucinations.
4. Paranoid reactions - Persons with paranoia may express fears that others are out to get them, may use multiple locks on doors, or may isolate themselves. Isolation due to paranoia is usually a self-protection coping mechanism where the individual seeks to reduce external stimuli in order to avoid perceived harm.
5. Isolation – The individual may separate herself from others due to a difficulty in communicating. Perhaps the words elude the person, the person cannot label the feeling or emotion, or the person may not be able to respond to multiple voices. At times, the person may avoid others to keep them from observing their symptoms.
6. Impaired spontaneity – The person may be slow to respond to situations. The individual may not be processing what is happening in his/her environment and/or be unsure of how to respond thereby doing nothing.
7. Agitation – The person may become upset without an apparent trigger. You may observe pacing, finger rolling, eye rolling, heavy breathing, loud speech, verbal threats or threatening posture.

Treatment Options

Treatment with medications can enable a person to function in a reality-based manner and be more aware of their surroundings.

Medication partnered with psychosocial rehabilitative programs and other services will contribute to the most positive prognosis for the individual. Typically, individuals who are seriously mentally ill with schizophrenia may need the structure and repetition of day treatment programs. Due to the cyclic nature of schizophrenia,

some individuals may require periodic, brief inpatient psychiatric hospitalizations to stabilize their symptoms. In most cases, stabilization is the result of medication adjustments.

Treatment is of a long-term nature.

Strategies for Communication

- Maintain eye contact.
- Use short, concise sentences. Do not ramble.
- Make sure the person can focus on you rather than their symptoms.
- Use a quiet room.
- If the person is paranoid, include a significant other that can convey trust to the individual. Be cautious of any implications this may have concerning client privilege.

II. Bipolar Disorder

Bipolar disorder causes dramatic mood swings, from overly “high” and/or irritable to sad and hopeless and then back again, often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood. The periods of high and lows are called episodes of mania and depression.

Characteristics

1. The person may exhibit periods of mania or a frantic “high”.
2. The individual may display an oversupply of confidence and energy leading to unrestrained, uncontrolled behavior.
3. The person may experience devastating lows characteristic of depression. The depression may be so severe that the individual cannot complete activities of daily living, cannot deal with family problems and/or experience poor work performance.
4. Individuals may show little interest in activities that usually bring pleasure to their lives.

Behaviors

During the manic phase the person may:

1. be hyperactive;
2. experience delusions;
3. have racing thoughts and speech;
4. experience sleeplessness without feeling tired;
5. display impaired judgment;
6. be easily distracted and have an impaired ability to focus;

7. be hyper-focused; and/or,
8. spend excessive amounts of money resulting in a depletion of savings or indebtedness.

During the depressive phase the person may:

1. display excessive sleep or lack of sleep;
2. be unable to concentrate;
3. experience weight gain or weight loss; and/or,
4. make suicidal gestures.

Treatment Options

Medication partnered with psychotherapy can be very effective. Depending upon the severity of the illness, some people can do well with outpatient psychotherapy while others require the structure of a day service program. Individuals with this disorder may benefit from services across the entire array of mental health treatment depending upon the intensity of symptoms.

Strategies for Communication

- Determine which phase the person is experiencing at the current time.
- During a manic phase, use a directive approach, maintain eye contact, have the individual repeat what has been said, and set timelines for tasks.
- During a depressive phase use, a supportive approach, outline expectations and set timelines for tasks.

III. Depression

Situational depression is understandable and expected after the death of a loved one, a natural disaster, divorce, etc. Chronic depression is a medical condition that can affect the way a person thinks and acts. This is the most treatable mental illness.

Characteristics

1. One may experience extreme sadness, be tearful the majority of the time, be unable to see any positive in his or her life, and/or have a prevailing feeling of “doom and gloom”. The individual’s level of sadness does not seem to be at an appropriate level of intensity for the trigger.
2. The person may experience extreme irritability, be easily agitated, or be cranky. You may be unable to identify what sets the person off.
3. The individual may have experienced a loss of interest in usually pleasurable activities. One may isolate and no longer associate with friends. The person may make up excuses of why she cannot participate in activities that she used to enjoy.
4. Individuals often have difficulty in concentrating and in memory recall. This is often noted in their work performance. The person may have difficulty completing a task. You may be

asked to repeat things. At times, the individual cannot remember routine information such as the day of week, telephone number, etc.

5. The person may have difficulty in making decisions. She is unable to concentrate and focus; it is difficult or too much work to make decisions. Someone may not make a decision rather than make the wrong one.
6. This person may have suicidal thoughts or thoughts of self-injurious behaviors. One may talk about wanting to kill him/herself. The public defender should ask if the client is having thoughts about the suicidal method that might be used to assess the degree of risk or lethality. A person who verbalizes a plan or a means should be taken very seriously.
7. The person may have a change in eating habits resulting in weight loss or gain. The change may be to console or to deprive oneself. If a noticeable amount of weight change is observed over the course of a month's time, then the public defender should suspect depression and make an appropriate referral for evaluation.
8. Individuals with depression may experience disturbances in sleep habits. There may be complaints of excessive sleep or insomnia. This, too, can affect the ability to concentrate and to recall information. The person may talk about going to bed late and getting up early. Is this a normal sleep pattern or is it a change?
9. The person may complain of loss of energy and fatigue. It may be due to loss of sleep or changes in sleep habits. For an individual who is very lethargic in their behaviors, it may relate back to the loss of pleasure in activities.
10. The individual may express feelings of worthlessness. She does not think anything she does is good enough. She sees no value in herself, or how to make a positive contribution to the home or work environment.
11. The person may encounter overwhelming feelings of guilt and without reason. You may hear statements such as "I shouldn't have done that," "I'm such a bad person," and "I did a bad thing." Such individuals may tend to assume the problems of the world when they really have nothing to do with it or did not do anything to cause the problem.
12. The individual may complain of unexplained physical discomfort, such as headaches, backaches, and stomachaches.

Behaviors

During depressive episodes the individual may demonstrate:

1. Extreme tearfulness;
2. Social isolation;
3. Expressions of worry, rumination;
4. In severe cases the person is unable to complete tasks; for example grooming, housekeeping, work, childcare, etc.
5. Very slow speech;

6. Very slow body movement or reduced motor activity;
7. Increased alcohol consumption; and/or
8. Frequent negative statements, “I hate myself” “I’m not worth the trouble” “I can’t do anything right” “I don’t know why I’m on this earth”

Treatment Options

Antidepressant medication and psychotherapy, which could include stress management and other coping skills.

Strategies for Communication

- Word statements and questions in a positive manner. “Tell me about X”, “What is important about Y”.
- Discussions should be goal directed.
- The individual should not be asked to make multiple decisions during one session.

IV. Anxiety

The person with an anxiety disorder is overwhelmed with tension when there is no real danger. This individual will take extreme action to avoid the source of the fretfulness. The person’s worry is out of proportion to the situation.

Characteristics

1. The person is overwhelmed with excessive worry and finds it impossible to control the apprehensiveness.
2. The individual is very restless. The person feels on edge, cannot relax and may obsess over things they cannot control.
3. The individual may have difficulty concentrating. This can affect work performance because the person has trouble completing a task and needs to ask repeatedly for instructions.
4. Individuals with an anxiety disorder may experience disturbances in their sleep habits. The person may not be able to fall asleep due to worrying or rumination.
5. Persons may become easily agitated. The person can become so anxious that they are easily agitated by simple, routine questions.
6. The individual may experience feelings of fear; always thinking that something bad will happen. The person may be afraid because she cannot control everything in his/her environment.
7. The individual may experience muscle tension. This person is unable to relax resulting in physical discomfort and pains.

Behaviors

During an episode of acute anxiety, the person may:

1. Have difficulty breathing;
2. Rapid heart rate;
3. Have hand tremors;
4. Experience profuse sweating;
5. May have racing thoughts and reports s/he has too many things going on in their head to concentrate;
6. Have headaches;
7. Pace the floor;
8. Pray excessively or in an unusual situation or setting;
9. Have panic attacks where the individual becomes immobilized, and hyperventilates. The individual may feel s/he may pass out, have a heart attack or is going to die. Some individuals may report a sense of claustrophobia. Some panic attacks are unpredictable, while others are triggered by extreme stress and tension;
10. Be unable to identify the source of worry;
11. Be unable to stay focused on a discussion;
12. Be resistant to shaking hands;
13. May make comments about ‘nothing is going to be right’ ;
14. May possess a “doom and gloom” attitude; and/or
15. Be unable to answer questions and report that his/her “mind went blank”.

Treatment Options

Medications are used with other forms of therapy/treatment to help reduce the symptoms. It may take trial and error to find the most effective medication and dosage for the person.

Stress management and relaxation therapies are important coping skills for the person to learn.

Cognitive-behavioral therapy takes the thoughts the person has, looks at how irrational these thoughts may be and helps the person learn how to identify false beliefs, or mistaken ideas. The person learns to replace anxious thoughts with positive, reasonable ones.

Successful treatment may take longer than the individual wishes. Positive reinforcement is important for those small measures of success.

Healthy lifestyle changes are important for the person to manage stress. Diversions, which include community service work, may be beneficial to help the person focus on something besides their own worries. Encourage good nutrition, exercise, and relaxing activities and avoid alcohol and other non-prescribed drugs.

Strategies for Communication

- If the person has a panic attack in your office, reduce the noise levels, encourage the person to do deep breathing, and have the person sit down. If the person is unable to calm down, you may need to call 911.
- Have the individual repeat back any directives given.
- Have person take notes.

V. Obsessive - Compulsive Disorder

Obsessive – Compulsive Disorder is a mental illness characterized by a person’s obsessions (which are unwanted thoughts, images and impulses) which interfere with their daily living and leads to excessive worry, anxiousness and discomfort. At the same time, the person may have compulsions (which are repeated behaviors) that are in response to the obsessive thoughts and are difficult to control. The person suffering from this disorder believes that if they perform these ritualistic behaviors it will reduce stress and anxiety. However, it becomes a vicious cycle that the person cannot break. The individual may spend all of their time on these obsessive thoughts and compulsive rituals so they are not able to give time to work, school or raising a family.

For a person diagnosed with this disorder, stealing may be a symptom of the disorder. The person is trying to control his/her life by obtaining what they feel is necessary to reduce concerns and level of stress.

Characteristics

The characteristics and behaviors of this disorder are very closely linked. The obsessions could be one or a combination of several irrational thoughts.

1. Impending doom;
2. Fear for one’s safety;
3. Cleanliness, or lack of cleanliness;
4. Hitting “hard times “ and having nothing;
5. A need to be “in control”;
6. Worrying; and/or
7. Fear of getting fat.

Behaviors

The behaviors related to this disorder are the person’s actions. The compulsions could be behaviors such as:

1. Fretting;
2. Thought games where sayings, sequences and/or prayers are said to oneself repeatedly to try to gain control over the environment;
3. Repeated checking of the stove, smoke detectors, locking and re-locking doors, etc. Switching light switches on and off, opening and closing doors;

4. Repeated cleanliness behaviors such as hand washing, vacuuming, dusting, showering, etc.;
5. Buying and storing large quantities of food, clothes, and other items which are kept for “emergencies”. The person may collect newspapers, soda cans, or other items which others usually toss out;
6. Organizing, re-organizing to have everything in its place. The person may spend hours arranging and rearranging;
7. Hand wringing, pacing, and ruminating are outward signs of worrying. There could also be other less visible signs or no outward behavior of worrying;
8. Excessive exercise and dieting may lead to extreme weight loss;
9. Late or missed appointments because the person is too busy checking and re-checking or washing to leave home;
10. Repeatedly excusing himself from an appointment to go wash hands;
11. Making numerous, unnecessary medical appointments which would interfere with appointments with the public defender;
12. Drinking, gambling or overeating may also be related behaviors.

Treatment Options

Medication is often prescribed to curb the obsessions. Behavior therapy may also be used to teach people how to change their maladaptive behaviors into more appropriate, constructive ones that will still meet their needs. Developing a support system to assist in breaking the cycle of rituals and provide reassurance can also be helpful.

Strategies for Communication

- Provide client with very specific instructions of what is expected including dates, times and even what to wear.
- Conduct meetings in a clutter free room.

VI. Antisocial Personality Disorder

A person with an antisocial personality disorder has a total disregard for the rules and the rights of others.

Characteristics

1. The person may be very charming, yet lacks a moral component.
2. The individual fails to obey rules established by society.
3. There is no sense of guilt demonstrated nor are any feelings of remorse demonstrated for one's actions.
4. The person can rationalize his/her behavior and sound very convincing.

5. The person tells lies, leaves false impressions and purposefully misleads others.
6. The person is very skillful in convincing others to do what he wants done, like a con-artist. He may recruit others. The individual is very charismatic and can easily manipulate others into believing that this is in their best interest. The person thinks others should take care of him/her.
7. The individual is impulsive which relates to the need for immediate gratification. There is little regard for what may happen to others because of his or her behavior.
8. The person is irresponsible and does not look at the long term consequences of their behavior nor do they care. There is more concern with immediate gratification and being is able to manipulate others and in turn avoid the immediate consequences of his or her behavior.
9. The individual is likeable until confronted with facts and caught at manipulations. When another sees through the charade, then the person can become verbally aggressive.
10. Individuals with antisocial personality disorders can be very manipulative and convincing.

Behaviors

The individual with an anti-social personality disorder may:

1. Not be able to keep a job for an extended period of time;
2. Blame their failures on other people;
3. Not take care of his/her financial responsibilities;
4. Not develop meaningful long-term relationships with others;
5. Not reside in one place for an extended period of time; and/or
6. The best indicator for future behavior is past behavior.

Treatment Options

With this type of personality disorder, change is difficult to achieve, although some individuals do respond positively to effective treatment. At times the best course of treatment may be the natural consequences of behavior.

Strategies for Communication

- Give directive comments and instructions.
- Do not allow time for extraneous conversations.
- Prepare an agenda and do not stray from the topics listed.
- Be aware that individual may portray himself as a victim, keep discussions based on fact and avoid opinions.

- Require verification of any actions taken. If you have given an assignment to complete a task, request proof that the task has been completed. A paycheck is verification of employment.

VII. Borderline Personality Disorder

Borderline Personality Disorder is a mental illness that affects the individual's mood, self-image, and relationships with others. If the individual is highly "annoying" and regularly tests limits while being very dependent upon others, it is very possible that the person has a borderline personality disorder. The person may exhibit persistent patterns of instability in relationships with others, have a poor self-image, fluctuate in moods, and be impulsive.

Characteristics

1. While looking for immediate gratification, the person may take impulsive actions like buying expensive jewelry, having unprotected sex or maxing out a credit card.
2. The person is self-absorbed. Actions and beliefs are centered on wants and desires because of a poor self-image and fear of abandonment. The individual may equate wants and desires with basic needs.
3. The person is unable to establish lasting, meaningful relationships.
4. The individual is very dependent; afraid to be alone, but is also afraid of having close relationships and may be characterized as having a "love-hate" relationship with people.
5. The individual can be very charming and likeable while still demonstrating behaviors which are frustrating to others.
6. The person may give very emotional responses to comments and situations, which you would not anticipate would elicit such a drastic response.

Behaviors

The person with a borderline personality disorder may:

1. Call the public defender multiple times per day with seemingly minor issues or concerns;
2. Exhibit self injurious behaviors such as cutting on the arms and burning oneself with a cigarette;
3. Voice suicidal thoughts;
4. Express inappropriate emotions. Extreme emotionality makes it difficult to moderate his/her emotions;
5. Have mood changes with subtle triggers that are not obvious to others;
6. Have difficulty controlling anger;
7. Express anger more intensely than the situation warrants;

8. Demonstrate attention-seeking behaviors by causing a scene in public, crying hysterically, and pleading for forgiveness;
9. Exhibit a variety of self destructive behaviors by burning him/herself with cigarettes, making superficial cuts, engaging in alcohol or drug use, and/or engaging in risky sexual behavior.

Treatment Options

An individual with a borderline personality disorder may be prescribed medication to control the symptoms of his/her depression, anxiety or impulsivity. Prescribing multiple medications is a typical course of treatment with individuals with this disorder.

Such individuals often require hospitalizations in either a medical/surgical unit or a psychiatric unit due to the self-injurious behaviors.

Persons can benefit from individual and group therapy to deal with issues of concern while improving social skills and behaviors.

Treatment is of a long-term nature.

Strategies for Communication

- Establish a structure for communication and for contacting you.
- Set boundaries and limits with the individual by allowing him/her to call only at designated times, making requests to you in writing, and preparing notes for his/her meetings with you.
- The public defender needs to remain calm and avoid over-reacting to the person's mood swings or attention-seeking behaviors.
- Stick to the facts when talking to the individual. Avoid hypothetical examples and "what-if" scenarios.
- When the person is pointing out injuries from self-harm, respond by not acknowledging the injuries, but by redirecting the person to the reason for the meeting. "I'm glad you are here for our meeting today so we can talk about X."
- Consistency is essential. It may be important to take notes in order to avoid any mixed messages, to reiterate items covered previously and to remain structured and focused during sessions with this individual.

Chapter 5

Breaking Through: Communicating and Collaborating with the Mentally Ill Defendant

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CHAPTER FIVE

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.

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 unrelenting 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 re-surfaced.

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 literal 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, no 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 increases [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 or 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 responsibility³⁷ 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 be 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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Chapter 6

Competency to Stand Trial, Insanity, Guilty but Mentally Ill, and Ethical Considerations When Representing Mentally Ill Clients

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CHAPTER SIX

Competency to Stand Trial, Insanity, Guilty but Mentally Ill, and Ethical Considerations When Representing Mentally Ill Clients

This section includes a variety of statutes, case law, and standards relating to mental health issues. As defense attorneys, we must be creative and diligent in seeking explanations for our clients' behavior. As explained elsewhere in this pamphlet, when dealing with your client, be alert to signs indicating areas that need to be explored. Get information to mental health experts they must have to effectively evaluate clients. Get funds to hire competent, appropriate experts.

In addition to considering your client's competency to stand trial and mental state at the time of the alleged offense, it is important to think about suppression issues based on your client's mental state at the time of police interrogation. See, e.g., Chapter 7, Mental Health Status and Vulnerability to Police Interrogation Tactics (Located in Sect. 2, immediately after this chapter); see also IPDC's Confessions Handbook and the memorandum in support of a motion to suppress defendant's statements as involuntary under the Due Process Clause of the Fourteenth Amendment (Located in Appendix 2).

We must also be creative in finding ways to present mental health information to the jury and the judge in compelling, meaningful fashions. Think about presenting mental health issues in motions practice, in jury selection, in witness preparation, in opening and closing arguments and sentencing hearings.

I. Competency to Stand Trial

A. Overview

Due process requires defendant be competent before being made to stand trial. Drope v. Missouri, 420 U.S. 162, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975). Incompetency refers to the mental or physical inability to understand or assist at critical stages of proceedings. Rather than focusing on the defendant's mental state at the time of the alleged offense, incompetency depends on the defendant's current mental state. Incompetency leads to postponement of the proceedings. See Dragon v. State, 383 N.E.2d 1046 (Ind. 1979), or in the event that there is no substantial probability of a defendant being restored to competence, may lead to the dismissal of charges. See State v. Davis, 898 N.E.2d 281 (Ind. 2008). The procedure for raising and determining competence to stand trial is found at Ind. Code § 35-36-3. Incompetency is not the same as insanity, which is a substantive defense that excuses criminal charges. Insanity, or the "mental disease or defect" defense, refers to the defendant's mental state at the time of the alleged offense. A person is not responsible for having engaged in criminal conduct if, as a result of mental disease or defect, he was unable to appreciate the wrongfulness of the conduct at the time of the offense. I.C. 35-41-3-6. The procedure for asserting the defense of mental disease or defect is found at I.C. 35-36-1-1 and I.C. 35-36-2. For a more comprehensive overview of competency to stand trial, see IPDC Pretrial Manual, Chapter 4.

B. Statutes

I.C. 35-36-3-1

Ability to understand and assist in proceedings -- Hearing -- Appointment of medical experts -- Admission of other evidence -- Procedure on finding of inability.

(a) If at any time before the final submission of any criminal case to the court or the jury trying the case, the court has reasonable grounds for believing that the defendant lacks the ability to understand the proceedings and assist in the preparation of a defense, the court shall immediately fix a time for a hearing to determine whether the defendant has that ability. The court shall appoint two (2) or three (3) competent, disinterested: (1) psychiatrists; (2) psychologists endorsed by the Indiana state board of examiners in psychology as health service providers in psychology; or (3) physicians; who have expertise in determining competency. At least one (1) of the individuals appointed under this subsection must be a psychiatrist or psychologist. However, none may be an employee or a contractor of a state institution (as defined in IC 12-7-2-184). The individuals who are appointed shall examine the defendant and testify at the hearing as to whether the defendant can understand the proceedings and assist in the preparation of the defendant's defense. (b) At the hearing, other evidence relevant to whether the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense may be introduced. If the court finds that the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense, the trial shall proceed. If the court finds that the defendant lacks this ability, it shall delay or continue the trial and order the defendant committed to the division of mental health and addiction. The division of mental health and addiction shall provide competency restoration services or enter into a contract for the provision of competency restoration services by a third party in the: (1) location where the defendant currently resides; or (2) least restrictive setting appropriate to the needs of the defendant and the safety of the defendant and others. However, if the defendant is serving an unrelated executed sentence in the department of correction at the time the defendant is committed to the division of mental health and addiction under this section, the division of mental health and addiction shall provide competency restoration services or enter into a contract for the provision of competency restoration services by a third party at a department of correction facility agreed upon by the division of mental health and addiction or the third party contractor and the department of correction. (c) If the court makes a finding under subsection (b), the court shall transmit any information required by the office of judicial administration to the office of judicial administration for transmission to the NICS (as defined in IC 35-47-2.5-2-5) in accordance with IC 33-24-6-3.

I.C. 35-36-3-2

Attainment of ability to stand trial; certification; return to court; order; trial

Whenever the defendant attains the ability to understand the proceedings and assist in the preparation of the defendant's defense: (1) the superintendent of the state institution (as defined in I.C. 12-7-2-184); or (2) if the division of mental health and addiction entered into a contract for the provision of competency restoration services, the director or medical director of the third party contractor shall certify that fact to the proper court, which shall enter an order directing the sheriff to return the defendant. The court shall enter such an order immediately after being sufficiently advised of the defendant's attainment of the ability to understand the proceedings and assist in the preparation of the defendant's defense. Upon the return to court of any defendant committed under section 1 of this chapter, the court shall hold the trial as if no delay or postponement had occurred.

I.C. 35-36-3-3

Substantial probability of attainment of comprehension to stand trial; certification; commitment proceedings; duration of retention

(a) Within ninety (90) days after: (1) a defendant's admission to a state institution (as defined in I.C. 12-7-2-184); or (2) the initiation of competency restoration services to a defendant by a third party contractor; the superintendent of the state institution (as defined in I.C. 12-7-2-184) or the director or medical director of the third party contractor, if the division of mental health and addiction has entered into a contract for the provision of competency restoration services by a third party, shall certify to the

proper court whether the defendant has a substantial probability of attaining the ability to understand the proceedings and assist in the preparation of the defendant's defense within the foreseeable future.

(b) If a substantial probability does not exist, the state institution (as defined in I.C. 12-7-2-184) or the third party contractor shall initiate regular commitment proceedings under I.C. 12-26. If a substantial probability does exist, the state institution (as defined in I.C. 12-7-2-184) or third party contractor shall retain the defendant:

(1) until the defendant attains the ability to understand the proceedings and assist in the preparation of the defendant's defense and is returned to the proper court for trial; or

(2) for six (6) months from the date of the:

(A) defendant's admission to a state institution (as defined in I.C. 12-7-2-184); or

(B) initiation of competency restoration services by a third party contractor; whichever first occurs.

I.C. 35-36-3-4

Inability to attain comprehension to stand trial; commitment proceedings

If a defendant who was found under section 3 of this chapter to have had a substantial probability of attaining the ability to understand the proceedings and assist in the preparation of the defendant's defense has not attained that ability within six (6) months after the date of the:

(1) defendant's admission to a state institution (as defined in I.C. 12-7-2-184); or

(2) initiation of competency restoration services by a third party contractor; the state institution (as defined in I.C. 12-7-2-184) or the third party contractor, if the division of mental health and addiction has entered into a contract for the provision of competency restoration services by a third party, shall institute regular commitment proceedings under I.C. 12-26.

C. Case Law

1. Due Process and Standard

Drope v. Missouri, 420 U.S. 162, 95 S. Ct. 896, 43 L.Ed.2d 103 (1975) (Due Process requires defendant be competent before being made to stand trial).

Dusky v. United States, 362 U.S. 402, 80 S.Ct. 788, 4 L.Ed.2d 824 (1960) (test in determining defendant's fitness to stand trial is twofold: 1) does accused have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding; and 2) does he have a rational as well as factual understanding of the proceedings against him); see also Wishart v. State, 693 N.E.2d 23 (Ind. 1998).

Riggins v. Nevada, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (absent a finding of necessity and medical appropriateness, the compelled use of anti-psychotic drugs on a defendant violated his constitutionally protected trial rights by possibly altering his appearance, content of his testimony and his communication with counsel).

Sell v. United States, 539 U.S. 116, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003) (forced medication is constitutionally permissible on serious charges if: 1) medically appropriate; 2) substantially unlikely to have side effects which might undermine a trial's fairness; 3) is done only after considering less intrusive alternatives; and 4) is necessary to further important government trial-related issues. Forced medication solely for trial competence may be permitted where important governmental concerns are at stake and the forced medication will significantly further governmental trial-related interests).

State v. Van Orden, 647 N.E.2d 641 (Ind.Ct.App. 1995) (post-conviction court erred in

finding that D was medicated involuntarily to attain competence to assist in her defense at trial; D initially refused to take recommended medication, but thereafter, she voluntarily accepted alternative of medication over hospitalization so that she could proceed to trial; any objection to administration of medication must be renewed at every stage of proceeding).

Godinez v. Moran, 509 U.S. 389, 113 S.Ct. 2680, 125 L.Ed.2d 321 (1993) (competence to stand trial is the same as competence to plead guilty or to waive counsel. But competence is not all that is required to be permitted to plead guilty or to waive counsel which requires knowledge and voluntariness).

McManus v. State, 814 N.E.2d 253 (Ind. 2004) (reliance on psychotropic drugs during trial is obviously to be approached with great care, and competency hearings to evaluate effects on D's ability to appropriately participate in his or her defense are very important; court could not say trial court's competency finding in this case was clearly erroneous).

McManus v. Neal, 779 F.3d 634 (7th Cir. 2015) (Indiana state courts did not reasonably apply federal constitutional standard in affirming trial court's finding that defendant was competent to stand trial, where he suffered panic attacks during trial and was medicated with antidepressants that, according to expert testimony, would make a person drowsy and alter their decision making, perception and judgment; murder conviction reversed; proper question is whether Defendant had present factual and rational understanding of proceedings and capacity to assist his lawyers; Indiana Supreme Court misapplied standard by suggesting Defendant was competent because "the consensus of the witnesses was that the medications assisted McManus in participating in his trial.").

Armour v. State, 948 N.E.2d 810 (Ind. Ct. App. 2011) (where D had been committed by another court and was receiving psychiatric treatment for an extended period, there were reasonable grounds to believe that he lacked the ability to understand and assist in the preparation of a defense; trial court abused its discretion by denying request for expert evaluation).

Leedy v. State, 998 N.E.2d 307 (Ind. Ct. App. 2013) (even though uncontested testimony established that Larue Carter Center in Indianapolis was better equipped to treat D's severe brain injury than DMHA facility (Logansport State Hospital), commitment to DMHA did not violate right to due process because Ind. Code 35-36-3-1 requires commitment to DMHA and the evidence established that the DMHA facility had sufficient expertise to treat D's brain injury).

2. Motion to Dismiss – Incurably Incompetent Defendants

State v. Davis, 898 N.E.2d 281 (Ind. 2008) (it is a violation of basic notions of fundamental fairness as embodied in the Due Process Clause to hold criminal charges over the head of an incurably incompetent defendant when D's pretrial confinement has extended beyond the maximum period of any sentence trial court can impose and when the State has advanced no argument that its interests outweigh D's substantial liberty interest).

Curtis v. State, 948 N.E.2d 1143 (Ind. 2011) (pending criminal charges do not violate D's right to due process if trial court has not involuntarily committed D and has not made an appropriate finding that D will never be restored to competency).

State v. Coats, 3 N.E.3d 528 (Ind. 2014) (while Ind. Code § 35-36-3-1(b) gives the trial court authority to decide whether a defendant is competent to stand trial, Ind. Code § 35-

36-3-3 vests sole authority in DMHA to decide if a defendant can be restored to competency; thus, the trial court does not have discretion to deny State's request to commit a defendant to DMHA where trial court had earlier declared him incompetent).

Gross v. State, 41 N.E.3d 1043 (Ind. Ct. App. 2015) (due process required dismissal of Class B felony child molesting and Class D felony dissemination of matter harmful to minor charges filed in 2003, where D's pretrial confinement extended beyond maximum time allowed by law and superintendent at the facility at which he is confined determined that there is a substantial probability he will never be restored to competency).

Jones v. State, 918 N.E.2d 436 (Ind.Ct.App. 2009) (where sentences for each of three misdemeanors would have to run consecutively because D committed the offenses while released on his own recognizance, the 756 days D has spent in either jail or committed to DMH has not exceeded the maximum sentence for one of the misdemeanors; thus, motion to dismiss the third misdemeanor should have been denied).

Denzell v. State, 948 N.E.2d 808 (Ind. 2011) (when the record reflects that defendant can be restored to competency, but he purposely decompensates, he may not assert a due process violation).

Habibzadah v. State, 904 N.E.2d 367 (Ind.Ct.App. 2009) (trial court properly denied motion to dismiss attempted murder charges against incompetent D because it is possible that D may be restored to competency and he has not been confined for longer than potential maximum sentence he faces; Mathias, J., concurring, believes that "our criminal justice procedures are inadequate to consider and resolve issues presented by defendants suffering from long-term or permanent mental illness," and urges legislature or Indiana Supreme Court through its rule-making process to promulgate for truly long-term, incompetent criminal defendants an earlier and intervening opportunity for a determination of competency at the time of the crime alleged rather than years later); see also Anderson v. State, 74 N.E.3d 1212 (Ind. Ct. App. 2017) (concurring opinion urging mental health treatment instead of criminal charges and incarceration).

Thomas v. Murphy, 918 N.E.2d 656 (Ind.Ct.App. 2009) (noting "deficient" statutory framework for treatment of developmentally disabled and mentally ill in criminal courts of Indiana, Court suggested "an earlier and intervening procedure to determine competency retroactively to the time of the alleged crime. Perhaps we as a society need to consider the concept of a defendant being *unchargeable* because of mental illness, and not just guilty but mentally ill. The commitment proceedings would protect society and best care of the defendant involved. In limited circumstances, the pendency of criminal charges might also be dispensed with.")

3. No Waiver of Due Process Rights

Pate v. Robinson, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966) (criminal defendant cannot be tried unless he is competent; a hearing is required by statute and due process only when there is evidence before the court that creates a reasonable doubt as to the defendant's competency; there can be no valid waiver of due process rights by a person who is incompetent to stand trial.)

Mast v. State, 914 N.E.2d 851 (Ind.Ct.App. 2009) (D received ineffective assistance of counsel where counsel advised him to plead guilty without waiting for results of two competency evaluations); *Cf. Barber v. State*, 141 N.E.3d 35 (Ind. Ct. App. 2020) (trial counsel was not ineffective for failing to raise competency of D with intellectual

disability and low I.Q to plead guilty).

4. Burden of Proof

Medina v. California, 505 U.S. 437, 112 S.Ct. 2572, 120 L.Ed.2d 353 (1992) (State may put burden of proof on the defendant to prove by a balance of probabilities he is incompetent to stand trial and may establish a rebuttable presumption that defendant is competent.)

Cooper v. Oklahoma, 517 U.S. 348, 116 S.Ct. 1373, 134 L.Ed.2d 498 (1996) (State cannot require defendant to prove incompetence by clear and convincing evidence.)

5. Juveniles

Matter of K.G., 808 N.E.2d 631 (Ind. 2004) (although juveniles alleged to be delinquent have the constitutional right to have their competency determined prior to delinquency proceedings, Indiana's adult competency statute is not applicable to this determination; I.C. 31-32-12-1, which authorizes mental or physical examinations and treatment under certain circumstances when a physician determines them appropriate and consistent with the statute, is the proper vehicle to accomplish a competency finding in a juvenile proceeding).

J.S. v. State, 937 N.E.2d 831 (Ind. Ct. App. 2010) (where it was clear that juvenile was not going to regain competency before turning 18 and juvenile court lost jurisdiction, juvenile court did not abuse its discretion by dismissing case even though mental health expert did not make a finding that he would never be restored to competency).

6. Probation and Community Corrections

Donald v. State, 930 N.E.2d 76 (Ind.Ct.App. 2010) (due process requires a competency evaluation if there are reasonable grounds to doubt competency in probation revocations).

Compare Hutchison v. State, 82 N.E.3d 305 (Ind. Ct. App. 2017) (trial court did not commit fundamental error by failing to conduct competency evaluation before revoking defendant's probation).

Luster v. State, 130 N.E.3d 131 (Ind. Ct. App. 2019) (due process requires consideration of D's competency in context of community corrections revocation hearing).

D. ABA Criminal Justice Mental Health Standards

Standard 7-4.2. Responsibility for raising the issue of incompetence to stand trial

- (a) The court has a continuing obligation, separate and apart from that of counsel for each of the parties, to raise the issue of incompetence to stand trial at any time the court has a good faith doubt as to the defendant's competence, and may raise the issue at any stage of the proceedings on its own motion
- (b) The prosecutor should move for evaluation of defendant's competence to stand trial whenever the prosecutor has a good faith doubt as to the defendant's competence. The prosecutor should further advise

defense counsel and the court of any information that has come to the prosecution's attention relative to defendant's incompetence to stand trial.

(c) Defense counsel should move for evaluation of the defendant's competence to stand trial whenever the defense counsel has a good faith doubt as to the defendant's competence. If the client objects to such a motion being made, counsel may move for evaluation over the client's objection. In any event, counsel should make known to the court and to the prosecutor those facts known to counsel which raise the good faith doubt of competence.

(d) A motion for evaluation should be in writing and contain a certificate of counsel indicating that the motion is based on a good faith doubt that the defendant is competent to stand trial and that it is not filed for purposes of delay. The motion should also set forth the specific facts that have formed the basis for the motion.

(e) In the absence of good faith doubt that the defendant is competent to stand trial it is improper for either party to move for evaluation. It is improper for either party to use the incompetence process for purposes unrelated to incompetence to stand trial such as to obtain information for mitigation of sentence, to obtain favorable plea negotiation, or to delay the proceedings against the defendant.

(f) In making any motion for evaluation, or, in the absence of a motion, in making known to the court information raising a good faith doubt of defendant's competence, the defense counsel should not divulge confidential communications or communications protected by the attorney-client privilege.

Commentary

Can be found online at www.abanet.org/crimjust/standards/mentalhealth.pdf.

II. Insanity

I.C. 35-41-3-6 Mental disease or defect

- (a) A person is not responsible for having engaged in prohibited conduct if, as a result of mental disease or defect, he was unable to appreciate the wrongfulness of the conduct at the time of the offense.
- (b) As used in this section, "mental disease or defect" means a severely abnormal mental condition that grossly and demonstrably impairs a person's perception, but the term does not include an abnormality manifested only by repeated unlawful or antisocial conduct.

I.C. 35-41-4-1(b) Standard of proof; insanity defense

[T]he burden of proof is on the defendant to establish the defense of insanity [I.C. 35-41-3-6] by a preponderance of evidence.

I.C. 35-36-2-2

Admissibility of evidence; psychiatrists, psychologists, or physicians

(a) At the trial of a criminal case in which the defendant intends to interpose the defense of insanity, evidence may be introduced to prove the defendant's sanity or insanity at the time at which the defendant is alleged to have committed the offense charged in the indictment or information.

(b) When notice of an insanity defense is filed in a case in which the defendant is not charged with a homicide offense under IC 35-42-1, the court shall appoint two (2) or three (3) competent disinterested:

- (1) psychiatrists;
 - (2) psychologists endorsed by the state psychology board as health service providers in psychology; or
 - (3) physicians;
- who have expertise in determining insanity. At least one (1) of the individuals appointed under this subsection must be a psychiatrist or psychologist. The individuals appointed under this subsection shall examine the defendant and testify at the trial. This testimony shall follow the presentation of the evidence for the prosecution and for the defense, including the testimony of any mental health experts employed by the state or by the defense.
- (c) When notice of an insanity defense is filed in a case in which the defendant is charged with a homicide offense under IC 35-42-1, the court shall appoint two (2) or three (3) competent disinterested: (1) psychiatrists; (2) psychologists endorsed by the state psychology board as health service providers in psychology; or (3) physicians; who have expertise in determining insanity. At least one (1) individual appointed under this subsection must be a psychiatrist and at least one (1) individual appointed under this subsection must be a psychologist. The individuals appointed under this subsection shall examine the defendant and testify at the trial. This testimony must follow the presentation of the evidence for the prosecution and for the defense, including the testimony of any mental health experts employed by the state or by the defense.
- (d) If a defendant does not adequately communicate, participate, and cooperate with the mental health witnesses appointed by the court after being ordered to do so by the court, the defendant may not present as evidence the testimony of any other mental health witness: (1) with whom the defendant adequately communicated, participated, and cooperated; and (2) whose opinion is based upon examinations of the defendant; unless the defendant shows by a preponderance of the evidence that the defendant's failure to communicate, participate, or cooperate with the mental health witnesses appointed by the court was caused by the defendant's mental illness.
- (e) The mental health witnesses appointed by the court may be cross-examined by both the prosecution and the defense, and each side may introduce evidence in rebuttal to the testimony of a mental health witness.

Case law

McCoy v. Louisiana, 138 S. Ct. 1500 (2018) (trial counsel's formal concession of guilt against defendant's wishes violated defendant's Sixth Amendment-secured autonomy, which guarantees a defendant the right to decide that the objective of his defense is to maintain innocence at all costs, even when counsel believes that client was mentally ill and admitting guilt offers the best chance to avoid the death penalty).

Galloway v. State, 938 N.E.2d 699 (Ind. 2010) (3-2 opinion; trial court erred in rejecting insanity defense because evidence of insanity was without conflict, notwithstanding one psychologist's initial opinion that D was sane, because psychologist withdrew his opinion once he learned more about D and ultimately decided to render no opinion about D's sanity).

Barcroft v. State, 111 N.E.3d 997 (Ind. 2018) (3-2 opinion; trial court may ignore unanimous conclusion of three mental health experts that D was insane at the time of the crime and find D guilty but mentally ill based on demeanor evidence or other evidence of probative value from which a conflicting inference can be drawn); see also Thompson v. State, 804 N.E.2d 1146 (Ind. 2004) (conflicting lay testimony is not required for trier of fact to reject expert testimony).

Payne v. State, 144 N.E.3d 706 (Ind. 2020) (3-2 opinion; Court distinguished "Barcroft's sparse medical record," from "Payne's long history of mental illness [that was] consistent and thoroughly documented."

Coupled with unanimous expert opinion of insanity, Payne's consistently documented record "fully undermines the probative value of any relevant demeanor evidence" and left no "reasonable [or] logical inferences to draw from the evidence in support of the verdict.").

Kelley v. State, 2 N.E.3d 777 (Ind. Ct. App. 2014) (trial court erred in finding D guilty but mentally ill when two psychiatrists found she was insane when committing the offense and where no testimony was taken, the parties stipulated to police reports and the two psychiatrists' reports were offered; "there was no lay witness testimony and little demeanor evidence from which the court could have deduced, contrary to the two psychiatrists, that [D] was sane at the time of the incident.").

But see Barany v. State, 658 N.E.2d 60 (Ind. 1995) (jury is free to disregard testimony and unanimous opinion of experts that D was insane at time of crime, and rely on testimony of lay witnesses re: D's normal demeanor before and after crime),

But see Moler v. State, 782 N.E.2d 454 (Ind.Ct.App. 2003) (noting that Barany has made it very difficult to successfully raise the insanity defense, even with defendants with well-documented mental illness, especially mental illnesses like schizophrenia, which are known to cause delusional or hallucinogenic episodes).

Berry v. State, 969 N.E.2d 35 (Ind. 2012) (although a person who has abused intoxicants to the point where it has produced mental disease such that he is unable to appreciate the wrongfulness of his conduct may be found insane, a person who is temporarily insane due to voluntary intoxication cannot; here, evidence of insanity was conflicting because one expert testified that D's psychosis was caused by voluntary alcohol use, i.e., either intoxication or withdrawal); see also Townsend v. State, 45 N.E.3d 821 (Ind. Ct. App. 2015) and Bloomfield v. State, 61 N.E.3d 1234 (Ind. Ct. App. 2016).

Esmond v. State, 20 N.E.3d 213 (Ind. Ct. App 2014) (psychiatric examination of D by State's expert is not a critical stage requiring presence of counsel).

Zamani v. State, 33 N.E.3d 1130 (Ind. Ct. App. 2015) (where D did not give notice of insanity defense until well after the statutory time limit, trial court did not abuse its discretion in denying his belated request to assert it).

Crawford v. State, 770 N.E.2d 775 (Ind. 2002) (in murder prosecution, trial court erred by allowing expert witnesses it appointed to examine D to be called out of order at trial. I.C. 35-36-2-2 clearly requires that court-appointed mental health professionals be called following all evidence presented by State and by D).

Miller v. State, 623 N.E.2d 403 (Ind. 1992), *habeas corpus granted*, 162 F.Supp.2d 1057 (N.D. Ind. 2000) (when a defendant opens the door to his psychological profile, State may rebut evidence he presents; here, D called psychologist to testify that D had no indication of any sadistic tendency, and State was permitted to rebut such evidence by introducing testimony of other alleged victims of D's physical and sexual abuse).

Robinette v. State, 741 N.E.2d 1162 (Ind. 2001) (although plea of insanity opens door for admission of testimony about D's entire life, raising insanity defense does not allow admission into evidence of testimony obtained in violation of D's Miranda rights).

Pierson v. State, 73 N.E.3d 737 (Ind. Ct. App 2017) (expert's incorrect testimony that the insanity defense required a showing of psychosis, such as hallucinations or delusions, was not fundamental error because the full context of the expert's testimony advised the jury of the correct standard for insanity).

Caldwell v. State, 722 N.E.2d 814 (Ind. 2000) (because prosecutor created erroneous impression of what would happen to D if he was found not responsible by reason of insanity, trial court's failure to either admonish jury or give tendered instructions on consequences of verdicts GBMI and not responsible by

reason of insanity was reversible error).

Georgopolus v. State, 735 N.E.2d 1138 (Ind. 2000) (when verdict options before jury include not responsible by reason of insanity or GBMI, and D requests jury instruction on penal consequences of these verdicts, trial court is required to give appropriate instruction or instructions as case may be. Here, there was no error in refusing to give D's instruction because jury did not have erroneous impression of law about consequences of insanity or GBMI verdict); see also Alexander v. State, 819 N.E.2d 533 (Ind.Ct.App. 2004) (trial court erred in not providing an instruction on the penal consequences of a "not guilty by reason of insanity" verdict).

Patterson v. State, 110 N.E.3d 429 (Ind. Ct. App 2018) (Court rejected D's claim that the State has the burden of proving he was sane beyond a reasonable doubt. The State must prove the offense, including mens rea, beyond a reasonable doubt, but need not disprove insanity. I.C. 35-41-4-1(b) places burden of proof on D to establish insanity defense by a preponderance of the evidence).

Kutscheid v. State, 592 N.E.2d 1235 (Ind. 1992) (suggesting that counsel would be more ineffective for not investigating D's insanity than he was for waiving right to speedy trial).

McWilliams v. Dunn, 137 S. Ct. 1790 (2017) (concluding defendant was entitled to access to psychiatrist at state expense to assist in evaluating, preparing, and presenting defense in capital sentencing).

III. Other Defenses Involving Mental State at Time of Offense

A. Negating Mens Rea Element

Brown v. State, 448 N.E.2d 10 (Ind. 1983) (low mental capacity is not proper subject of expert testimony where insanity defense is not raised; here, trial court did not err in granting state's motion in limine to bar psychological evidence regarding D's low IQ).

See Brown v. Trigg, 791 F.2d 589 (7th Cir. Ind. 1986) (Cudahy, J., dissenting) ("...[u]se of standard IQ tests would have indicated that defendant generally functioned five years below her grade level, had an IQ of 78 and was borderline mentally retarded. Certainly, such tests are far more widely recognized as reliable and probative than are the opinions of psychiatrists about the relation of personality disorders to the formation of criminal intent. Because these tests were ordered by the juvenile court and admitted into evidence for the purpose of binding Brown over for trial as an adult... they should have been admitted on the subsequent issue of her knowledge of the possible consequences of her actions.").

Cardine v. State, 475 N.E.2d 696 (Ind. 1985) (trial court did not err in refusing to admit evidence that D had been treated for alcoholism for several days after his arrest; excluded evidence would have invited jury to evaluate diminishing influence of alcohol consumption upon D's mental capacity existing at time of incident).

Neaveill v. State, 474 N.E.2d 1045 (Ind.Ct.App. 1985) (Mental condition may be offered to negate capacity to form criminal intent. Here, trial court's instruction adequately covered capacity to form criminal intent and there was no error in refusing D's tendered instruction re: diminished capacity).

Pierson v. State, 73 N.E.3d 737 (Ind. Ct. App. 2017) (D's intellectual disability did not prevent him from forming requisite intent to knowingly and voluntarily commit neglect of a dependent resulting in death).

B. Effects of Battery

Marley v. State, 747 N.E.2d 1123 (Ind. 2001) (Trial court did not err in requiring D to raise her defense of dissociative state resulting from battered women's syndrome only within confines of Effects of Battery statute, I.C. 35-41-1-3.3 & I.C. 35-41-3-11, which requires filing notice of insanity defense. Effects of battery applies to D who either raises insanity defense or claims self-defense, &, in conjunction with either, raises issue that D was at time of alleged offense suffering from effects of battery as result of past course of conduct of individual who is victim of alleged crime. I.C. 35-41-3-11. Statute also requires victim of crime to be . . . abused individual's cohabitant or former cohabitant. I.C. 35-41-1-3.3(2). Here, D lived with one of victims, her uncle who molested her years ago. When uncle told D that she wanted molesting, D killed victim & severely injured another who was present. Defense expert diagnosed D with post-traumatic stress disorder, dysthymia, polysubstance abuse, & mixed personality disorder. Where, as here, D claims that BWS has affected her ability to appreciate wrongfulness of her conduct, legislature has determined that she must proceed under & comply with requirements of insanity defense statute. Because D was not merely trying to negate intent element through evidence of BWS but claimed "dissociative state" as result of BWS, she was asserting insanity defense, & was therefore properly held subject to requirements of insanity statute. Indiana has long held that D may not submit evidence relating to mental disease or defect except through insanity defense).

Schermerhorn v. State, 61 N.E.3d 375 (Ind. Ct. App 2016) (alleged victim's actions against third party irrelevant under effects of battery defense).

Isaacs v. State, 659 N.E.2d 1036 (Ind. 1995) (In murder prosecution, trial court did not abuse its discretion in admitting State's rebuttal testimony re: battered woman's syndrome; purpose of expert's testimony was to refute notion that D and victim had friendly relationship prior to her death).

Carnahan v. State, 681 N.E.2d 1164 (Ind.Ct.App. 1997) (no error in admitting expert testimony regarding battered woman's syndrome, particularly involving cycle of violence and reasons battered women do not leave their husbands, to explain why complaining witness recanted her earlier allegation of abuse).

Odom v. State, 711 N.E.2d 71 (Ind.Ct.App. 1999) (fact that victim testified as to why she recanted statement prior to trial did not make expert testimony on battered woman's syndrome irrelevant; although expert testimony explaining why victim recanted is usually admissible, expert testimony must also be based upon some fact presented in hypothetical or some reasonable inference drawn therefrom; here, expert's suggestion that victim might have recanted because she had learned to forgive her assailant was not based on hypothetical because there was no evidence that D had apologized to victim or that victim had forgiven him).

Allen v. State, 566 N.E.2d 1047 (Ind.Ct.App. 1991) (BWS evidence was admitted at sentencing for woman convicted of killing her abuser).

C. Miscellaneous Defenses

McClain v. State, 678 N.E.2d 104 (Ind. 1997) (where D claimed he was unable to form criminal intent on night of offense due to automatistic state of mind that precluded voluntary behavior, he was entitled to present evidence of dissociative state resulting from sleep deprivation to show whether he acted voluntarily; D's evidence of automatism as pleaded should not be classified as mental disease or defect within meaning of I.C. 35-41-3-5 and need not be presented under insanity defense).

Schlatter v. State, 891 N.E.2d 1139 (Ind.Ct.App. 2008) (because D acted voluntarily in becoming intoxicated, he cannot claim that his actions which resulted from his intoxication were involuntary, and because he cannot claim that his actions were involuntary, the automatism defense was unavailable to him).

Reed v. State, 693 N.E.2d 988 (Ind.Ct.App. 1999) (evidence that transient ischemic attacks placed D in state of confusion and disorientation was not evidence of diminished capacity or "mental disease or defect within meaning of insanity statute but rather evidence of negating intent).

IV. Intellectual Disability - Death Penalty and Life without Parole Cases

I.C. 35-36-9-2 Individual with mental retardation

As used in this chapter, "individual with an intellectual disability" means an individual who, before becoming twenty-two (22) years of age, manifests: (1) significantly sub-average intellectual functioning; and (2) substantial impairment of adaptive behavior; that is documented in a court ordered evaluative report.

I.C. 35-50-2-9 Death Sentence; Life without parole

...[T]he state may not proceed against a defendant under this section if a court determines at a pretrial hearing under I.C. 35-36-9 that the defendant is an individual with an intellectual disability...

I.C. 35-36-9-3 Petition —Evaluation of defendant

- (a) The defendant may file a petition alleging that the defendant is an individual with an intellectual disability.
- (b) The petition must be filed not later than twenty (20) days before the omnibus date.
- (c) Whenever the defendant files a petition under this section, the court shall order an evaluation of the defendant for the purpose of providing evidence of the following:
 - (1) Whether the defendant has a significantly subaverage level of intellectual functioning.
 - (2) Whether the defendant's adaptive behavior is substantially impaired.
 - (3) Whether the conditions described in subdivisions (1) and (2) existed before the defendant became twenty-two (22) years of age.

I.C. 35-36-9-4 Hearing on petition

- (a) The court shall conduct a hearing on the petition under this chapter. (b) At the hearing, the defendant must prove by clear and convincing evidence that the defendant is an individual with an intellectual disability.

I.C. 35-36-9-5 Determination within ten days of trial

Not later than ten (10) days before the initial trial date, the court shall determine whether the defendant is an individual with an intellectual disability based on the evidence set forth at the hearing under section 4 of this chapter. The court shall articulate findings supporting the court's determination under this section.

I.C. 35-36-9-6 Dismissal of death sentence charging instrument

If the court determines that the defendant is an individual with an intellectual disability under section 5 of this chapter, the part of the state's charging instrument filed under I.C. 35-50-2-9(a) that seeks a death sentence against the defendant shall be dismissed.

I.C. 35-36-9-7 Sentencing

If a defendant who is determined to be an individual with an intellectual disability under this chapter is convicted of murder, the court shall sentence the defendant under I.C. 35-50-2-3(a).

Rondon v. State, 711 N.E.2d 506, 516-17 (Ind. 1999) (mental retardation statute is not retroactive).

Smallwood v. State, 773 N.E.2d 259, 261-63 (Ind. 2002) (failure to timely invoke statutory procedures results in waiver of the protections; here, because defense did not seek pre-trial determination of mental retardation, LWOP not prohibited).

Pruitt v. State, 834 N.E.2d 90 (Ind. 2005) (placing burden of proof on defendant to prove mental retardation does not violate U.S. Constitution, but clear and convincing standard of proof does. Defense can only be required to show mental retardation by preponderance of the evidence).

Penalty Phase

Evidence of a defendant's mental or emotional difficulties may lead a jury to conclude that a defendant is less culpable than defendants without such difficulties. Penry v. Lynaugh, 492 U.S. 302, 319 (1989), *abrogated on other grounds by* Atkins v. Virginia, 536 U.S. 304 (2002). For instance, evidence that a defendant is "borderline mentally retarded," Williams v. Taylor, 529 U.S. 362, 396 (2000) (internal quotation marks omitted), or has severe PTSD from military combat, *see* Porter v. McCollum, 558 U.S. 30, 35-36 (2009), or has severe learning and behavioral disabilities, frontal lobe injuries, and brain damage from drug and alcohol abuse, *see* Sears v. Upton, 561 U.S. 945, 955-56 (2010), is potentially mitigating.

V. Guilty but Mentally Ill

I.C. 35-36-1-1 Definition

"Mentally ill" means having a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function; "mentally ill" also includes having an intellectual disability.

I.C. 35-36-2-5 Finding or plea of guilty but mentally ill; evaluation; sentence; treatment

(a) Except as provided by subsection (e), whenever a defendant is found guilty but mentally ill at the time of the crime or enters a plea to that effect that is accepted by the court, the court shall sentence the defendant in the same manner as a defendant found guilty of the offense.

(b) Before sentencing the defendant under subsection (a), the court shall require the defendant to be evaluated by a physician licensed under I.C. 25-22.5 who practices psychiatric medicine, a licensed psychologist, or a community mental health center (as defined in I.C. 12-7-2-38). However, the court may waive this requirement if the defendant was evaluated by a physician licensed under I.C. 25-22.5 who practices psychiatric medicine, a licensed psychologist, or a community mental health center and the evaluation is contained in the record of the defendant's trial or plea agreement hearing.

(c) If a defendant who is found guilty but mentally ill at the time of the crime is committed to the department of correction, the defendant shall be further evaluated and then treated in such a manner as is psychiatrically indicated for the defendant's mental illness. Treatment may be provided by:

- (1) the department of correction; or
- (2) the division of mental health and addiction after transfer under I.C. 11-10-4.

(d) If a defendant who is found guilty but mentally ill at the time of the crime is placed on probation, the court may, in accordance with I.C. 35-38-2-2.3, require that the defendant undergo treatment (e) As used in this subsection, "individual with an intellectual disability" has the meaning set forth in I.C. 35-36-9-2. If a court determines under I.C. 35-36-9 that a defendant who is charged with a murder for which the state seeks a death sentence is an individual with an intellectual disability, the court shall sentence the

defendant under I.C. 35-50-2-3(a).

I.C. 11-10-4-2 Providing care and treatment

The department shall provide for the care and treatment of every confined offender who is determined to be mentally ill by a psychiatrist employed or retained by the department. To provide that care and treatment, the department may: (1) establish and operate its own mental health facilities and programs; (2) transfer offenders to the division of mental health and addiction, subject to the approval of the director of the division of mental health and addiction; or (3) contract with any city, county, state, or federal authority or with other public or private organizations for the provision of care and treatment.

Truman v. State, 481 N.E.2d 1089 (Ind. 1985) (GBMI statute adds nothing to guilt finding); but see Georgopolus v. State, 735 N.E.2d 1138, 1141 (Ind. 2000) (“...there are indeed consequences to a jury verdict of guilty but mentally ill that are different from a verdict of guilty”).

Harris v. State, 499 N.E.2d 723, 726 (Ind. 1986) (I.C. 35-36-2-5 does not give right to treatment but affords opportunity to receive necessary psychiatric treatment while sentence is carried out; pleading GBMI does not foreclose imposition of death penalty); but see Prowell v. State, 741 N.E.2d 704 (Ind. 2001) (failure to seek GBMI plea for a capital client found to be ineffective assistance of counsel, because in practice defendants found GBMI are generally not sentenced to death).

Archer v. State, 689 N.E.2d 678 (Ind. 1997) (trial court is required to make finding that D was guilty but mentally ill at time of offense when it accepts D's plea of guilty but mentally ill).

VI. Ethical Considerations When Representing Mentally Ill Clients

To the extent reasonably possible, the lawyer should maintain a normal lawyer-client relationship with the impaired client. However, attorneys must be careful in conveying information to, or obtaining tactical and strategic information and decisions from, such clients.

Indiana Rules of Professional Conduct, Rule 1.14 Client with Diminished Capacity

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

(d) This Rule is not violated if the lawyer acts in good faith to comply with the Rule.

Comment

[6] In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state

of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.

Chapter 7

Competence Evaluations

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CHAPTER SEVEN

COMPETENCY EVALUATIONS

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 defense 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 competent 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 competent 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 *California 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 Evaluations 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 tape record 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.

End Notes

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*, *supra*, 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 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.
 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. Renfro*, 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 Manual 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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EXPERTS AND COMPETENCE TO STAND TRIAL: SUGGESTIONS AND APPROACHES IN DEALING WITH EXPERTS

by John T. Philipsborn

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Since the publication in 1988 of Dr. Thomas Grisso's influential discussion of the competence to stand trial assessment process, there have been a number of developments aimed at improving the performance of defense counsel in that process.¹ The need for lawyers to be familiar with the definitions, assessment processes, and methods of adjudication of the accused's (in)competence to stand trial has been underscored by rulings from the U.S. Supreme Court on competence to stand trial definitions, the development of state-specific case law amplifying existing state statutory definitions of the competence assessment process, scholarly research on that process leading to several influential publications, and ongoing training for defense counsel.

The objective of this article is to review basic information that should be integrated into the evidence presented in a hearing or trial of a person's incompetence to stand trial. Part one will emphasize background information that counsel should be aware of and should collect to better understand who conducts competence assessments, and how to probe the qualifications and professional competence and methodology employed by experts. Part two will review how lawyers can "operationalize" the legal definitions of competence to stand trial and the professional standards applicable to the mental health assessment process in order to either effectively present evidence of incompetence or attack unreliable or invalid opinions of competence.

Participating In the Assessment Process

The basic premise is, admittedly, both simple and simplistic. When lawyers understand the education and training of mental health experts, the professional standards on which *they* rely, and the practice of competence assessment as defined in the literature, they can effectively present (or where necessary attack) competence assessment evidence. There is enough written about competence assessments to allow lawyers a measure of control over, and input into, the competence adjudication process. Conversely, problems arise where lawyers are unable to participate in the assessment and adjudication of competence because *they* have failed to educate themselves.

Frequently, defense counsel in jurisdictions in which there is a centralized mechanism for competence evaluations - such as a designated forensic assessment center, a state hospital, or a court forensic assessment unit - will lament that their opportunity for input into the assessment process is minimal and access to qualified independent experts is limited. These complaints are often valid, though part of the problem is that the defense bar in a number of geographical areas has not developed a proactive approach to the competence assessment process. It often comes as a surprise to some members of the defense bar that their colleagues will make a record of their communications with state hospital doctors while sending packets of information and referral questions to be addressed. They do this in part to demonstrate their interest in participating and the availability of information from defense counsel. Certain lawyers will make the effort to request to be present during "staffings" of particular clients. These lawyers will request the opportunity for input into the assessment process and an opportunity to present data. Where such legitimate requests are rebuffed, as noted below, the basis for foundational objections emerge, as do opportunities to attack the integrity and reliability of the process.

The approach encouraged here, besides advising defense counsel to be involved in the assessment process (whether as active participant or active observer is a strategic and tactical issue not addressed here), is for lawyers to carefully assess the principal foundational aspects of competence assessments so that valid and reliable work can be recognized, and "bad" science and unprofessional approaches can be unmasked and effectively challenged.

In order to deal effectively with the issue of (in)competence to stand trial, it is critical to understand: (1) how experts are trained; (2) how to assess the significance of their training and professional affiliations; (3) where to find the standards that apply to their work; and (4) how to prepare to present or challenge their opinions.

History of the Diagnostic and Forensic Assessment Process

One useful starting point to this discussion is the history of the endeavor. Competence to stand trial, according to the U.S. Supreme Court's opinion in Cooper v. Oklahoma, is a concept that has been around our legal tradition for at least 300 years.² It was some time, however (and often not until the middle of the 20th century in the United States), before legislatures enacted the "modern" competence tests in this country. Moreover, it was not until the latter part of the 20th century that the U.S. Supreme Court reiterated, in its current formulation, the basic elements of competence to stand trial.

The legal concepts have been around much longer than the sciences, diagnostic criteria, education curricula, and assessment methodologies in use by the psychologists and psychiatrists charged with evaluating the competence to stand trial of defendants in criminal cases. Thus, it is helpful to have some notion of how well established some of these important aspects of the foundation for competence opinions are. For example, the lawyer who goes into session without the vaguest idea of the development of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) may be surprised by a cross-examination that points out that when the *Manual* was first published in 1952 it covered a limited number of diagnostic criteria. The DSM underwent significant changes in each edition, most dramatically between the second and third editions - and it can be described as a work in progress not particularly well suited for literal use in courtrooms.

Therefore, one could use the DSM as a sword or a shield in the examination of an expert to point out that as the DSM has "aged," it has changed. This demonstrates that mental illnesses and conditions are the subject of ongoing inquiry, and mental health experts continue to refine their approaches to them. Moreover, the DSM explains, when ". . . employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis."³ And since many mental health evaluators use the DSM as a diagnostic gold standard, both the history of its evolution and knowledge of its stated limitations are important.

It is also important to know that there has been an evolution in the level of development and professional regulation of the forensic mental health sciences up to the present time. Having in mind a few significant historical reference points, and discussing them to provide a context to the assessment in the case in question, will be helpful.

Here are a few of these reference points.

- **1952** Publication of DSM-I.
- **1965** Robey's Research and Basic Inventory on Competence to Stand Trial (one of the first instruments developed specifically for forensic mental health).
- **1967** Classification of psychiatric illnesses is addressed in the Comprehensive Textbook of Psychiatry.
- **1968** DSM-II published.
- **1968** The American Academy of Psychiatry and the Law founded.
- **1969** The American Board of Forensic Psychology founded.
- **1973** *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* published by the American Psychiatric Association.
- **1980** DSM-III published, involves a large expansion of diagnostic categories.
- **1986-1988** Thomas Grisso begins publishing on the evaluation of competency to stand trial, and urges regard for standards in the assessment and report writing.

- **1987** Melton et al., publish updated edition of *Psychological Evaluation for the Courts*, covering protocols and methods to be applied to a wide variety of examinations (updated and newly published in 2007 in its Third Edition).
- **1994** Publication of DSM-IV
- **2000** Publication of DSM-IV-TR.
- **2011** Publication of *DSM-V*.

Concentrating On Education, Ongoing Training, and Experience

Every legal system in the United States has some basic statement of the requirements applicable to experts. Under the California Evidence Code, an expert is a person who has "... special knowledge, skill, experience, training, or education sufficient to qualify him [or her] as an expert on the subject to which his [or her] testimony relates."⁴ The Federal Rules of Evidence set forth a similar threshold definition, providing that an expert is "a witness qualified . . . by knowledge, skill, experience, training, or education...."⁵

Too many practitioners involved in the competence assessment process concede that a proffered expert possesses the basic qualifications to testify regarding the assessment of competence to stand trial - either in preparing to present, voir dire, or otherwise cross-examine that expert. Often they do so out of expediency, because the report is "favorable," or so "negative" that it seems impossible (or impractical) to fight. But even an experienced mental health expert may be an inadequate and unqualified expert on trial competence.

A few observations are in order regarding the training and credentials of psychologists. Psychologists often have (though not always) a Ph.D. obtained after completion of a course of graduate study of between five and seven years. A dissertation helps to define the expert's area of concentration as a doctoral student. Rarely will it have been on the subject of the assessment of competence to stand trial - or even on some related topic.

This observation leads to this point: other than obtaining some school-based training that provided a foundation for forensic work, little in the expert's academic education may have centered on material of direct use to forensic work, and especially to the assessment of competence to stand trial. The exception may be the graduate of some of the newer programs in forensic mental health.

But for the "mainstream" expert, the process of preparing for the hearing should include the careful review of the expert's course of study and consideration of its relevance to the establishment of expertise in competence assessments. With the exception of those who happened to have studied in areas that are obviously relevant, it is possible that either for the purposes of direct examination or cross-examination, the expert's academic training will prove to be of little use in establishing relevant expertise. It will often be nothing more than some continuing legal education time and "OJT," i.e., on-the-job training.

It was not until relatively recently that the American Board of Professional Psychology (ABPP) began awarding specialty certificates in several fields of psychology, including: clinical psychology; forensic psychology; clinical neuropsychology; counseling and school psychology. Those possessed of ABPP certificates demonstrate credentials including the appropriate doctorate; post-doctoral training in their area of specialty; at least five years of experience; recommendations and endorsements from people in the field; and suitable results on a field-specific examination.

Psychiatrists follow different courses of study than do psychologists. Many, though not all, study medicine and complete medical internships before going on to further study and residency programs in psychiatry as part of a course of medical studies. Not all psychiatrists, however, are licensed physicians. Training courses other than medical school education may provide a basis for practice as a psychiatrist, including (at least in some states) obtaining a final degree as a Doctor of Osteopathy.

Some physicians who completed residency programs in psychiatry may not have received prolonged exposure to areas of study such as psychopharmacology, neurochemistry, or the

neurobiological bases of behavior (beyond basic courses). Thus, these experts may not have easily demonstrable academic training in the effects of certain classes of medications that may be of issue in a given case. Their initial training and continuing education may not have emphasized areas that are critical to a given competency inquiry. These are matters into which counsel should inquire.

Several specialty organizations certify physicians in specialty areas. For example, the American Board of Psychiatry and Neurology certifies physicians in psychiatry, neurology, and child neurology. The American Academy of Psychiatry and the Law emphasizes forensic practice and forensic credentials. It is one of the organizations that has coordinated with the American Medical Association and the American Psychiatric Association in the development of sub-specialty expertise, specialty certificates, standards for education, and requirements for continuing education.

Each of the pertinent organizations or boards explains its relationship (if any) to the predominant organizations. Some of these credentialing bodies publish materials that are useful either in establishing or attacking the approaches and methods used by a given examiner. For example, the American Board of Psychiatry and Neurology commissioned reports on *Core Competencies for Psychiatric Practice*, which are published by the American Psychiatric Press. The title speaks for itself.⁶

Psychiatrists who have completed their residency in psychiatry and have acquired the relevant experience may develop sub-specialty expertise and be awarded either specialty certificates or Board certifications (depending on the credential-awarding organization). Not all of those who conduct forensic examinations will possess board certification or specific training in forensic psychiatry. Establishing how a given expert has demonstrated his or her expertise in forensic examinations may prove to be a critical part of the competence adjudication proceeding.

There are various groups providing credentials to psychiatrists and psychologists. Some are highly legitimate and professionally prized, and others less so. The major organizations mentioned here, including the American Medical Association, American Psychiatric Association, and American Psychological Association, all have Web sites that explain the information set forth here (as does some of the pertinent literature).⁷ The American Academy of Psychiatry and the Law sets forth standards specific to forensic psychiatry. Similarly, Division 41 of the American Psychological Association provides a wealth of information about forensic psychology, including the standards applicable to forensic assessments.

The reason for this tour of the sources of information (and credentialing bodies) is that lawyers are sometimes not fully aware of what training psychiatrists or psychologists may have had. Both the American Psychiatric Association and American Psychological Association (and their sub-specialty affiliates) regularly publish practice-related standards and information about continuing education. They maintain and publish ethical codes and standards, including guidelines on the qualifications of test users. The failure to pay attention to these sources of information will deprive a lawyer either of the ability to demonstrate a given expert's adherence to, or departure from, current standards of practice.

Academic programs in psychiatry and psychology changed over a period of time. The advent of programs that offer concentrated training in forensic psychiatry or forensic psychology has changed the educational "baggage" that experts possess, depending on when or where they were trained.

For example, many psychologists trained and licensed in clinical psychology, particularly more than 20 years ago, may have had no academic or supervised training at all in forensic psychology and no clinical experience that would have involved competence to stand trial assessments. Thus, their knowledge of the competence to stand trial assessment process may have been learned on the job and as a result of *some* continuing education. Indeed, it is surprising to note how many "experts" on competence assessments have little formal training of any kind specific to such endeavors. Similarly, psychiatrists may have had little or no forensic training. Furthermore, they may have had no exposure to the competence to stand trial assessment process until after they left their residency programs and were in practice - and they may not be able to establish any formal relevant training.

People V. Ary

The importance of inquiries into qualifications can be illustrated by a brief description of the evidentiary hearing held in People v. Ary, a case remanded by a California Court of Appeal to a trial court for a retrospective competence assessment.⁹ James Ary was evaluated at the time of his initial trial proceedings (though not specifically for his competence to stand trial). Evidence of his possible incompetence, however, was argued as a critical issue on appeal. During the post-conviction retrospective competence assessment, at least eight mental health professionals, the majority of them psychologists, gave opinion testimony about Ary's competence to stand trial. Some of the experts were retained by the state, others by the defense. Two were considered "court experts;" though they were nominated by the parties. Not all of the experts actually examined Ary, but several did. All of the experts professed to have some opinion about his competence.

The most recently educated psychologist had obtained doctoral training (and a doctorate in clinical psychology), and then had completed a post-doctoral program in forensic psychology that added 2,000 hours of specific training in forensic issues, including the assessment of competence to stand trial. The majority of the other experts had obtained their doctoral degrees at least 20 years before the commencement of the hearing (one had been a practicing psychologist for at least 40 years). None of these "older" experts had any training during the course of their education that touched either on forensic issues or on the assessment of competence to stand trial. Only three of the experts professed to have ever been asked about their training in, and knowledge of, the assessment of competence to stand trial in any detail during their careers prior to the hearing.

Only half of the experts purported to have recently read cases involving the definition of competence to stand trial, though most recognized that Dusky v. United States and Drope v. Missouri were case names related to the definition of competence to stand trial.¹⁰ Only two of the eight could even state the formulation of the basic competence test by the U.S. Supreme Court. Three of the eight professed to be aware of the discussion of the attributes of competence as discussed in Godinez v. Moran - though all three had been asked to review the decision by counsel.¹¹

Almost all of these experts were aware of and described Dr. Thomas Grisso as an acknowledged expert on the assessment of competence. Only three, however, professed any recent review of Grisso's *Evaluating Competencies*, Melton's *Psychological Evaluations for the Courts*, or Sadock and Sadock's *Comprehensive Textbook of Psychiatry* - and each of these had been asked about these sources in advance of the hearing.

Prior to the hearing, two of the experts indicated awareness of the research on the CAST-MR (the Competency Assessment for Standing Trial of Defendants with Mental Retardation). Half of the experts had reviewed literature pertinent to the CAST-MR (which had been administered to the accused). Only two of the experts professed to be conversant on the limitations of competency assessment instruments, including the CAST-MR.¹²

All of the experts at issue had previously qualified as experts in criminal cases, some on many occasions. The experts quizzed on the reasons for the variation in their foundation noted the differences in the approaches of the lawyers they were working with to prepare their testimony.

Admittedly, evidence from one case is an insufficient basis from which to generalize. Anecdotal information from mental health experts and lawyers alike, however, suggests that both professions have highly varied knowledge of competence assessment tools and methodologies - to say nothing of the variations of knowledge about the combination of the definitions of (in)competence found in statutes and case law. There is some reason to be concerned that it is uninformed lawyering that is allowing uninformed experts to continue to operate without the need for current knowledge. Anecdotal information from lawyers handling criminal appeals indicates that it is relatively rare for there to be an extensive inquiry into the basic expertise of a psychiatrist or psychologist testifying on the question of competence to stand trial.¹³

Assuming that defense counsel prepares by reviewing relevant literature and case law, the defense

can bear its burden of proof in part by defining the standard of practice that applies to an expert's assessment of competence to stand trial. The expert who can specifically link the elements of a given competence assessment to the U.S. Supreme Court's rulings on competence (as well as to any seminal state rulings) and to the state statutory scheme will establish a baseline of relevant knowledge.

Approaching the presentation of evidence of competence (at least from the defense's viewpoint) with these basics in mind has another advantage - it diminishes the possibility that counsel will rely on essentially uninformed experts to set the tone in the competence assessment adjudications. It is rarely helpful to endorse an expert's "I know it when I see it" approach. If an expert is unable during preparation sessions to make the basic connections between the legal definitions and the assessment process that he or she used, that expert is unlikely to make a good impression on cross-examination. Why do experts get away with displays of blissful ignorance of the legal definitions and contents of relevant professional literature? Part of the reason is that lawyers let them do so.

Prepare the Packet

There is a way to avoid the problem of the experienced expert whose foundation on competence issues seems weak. Counsel should prepare a relevant packet of information about the competence assessment process. The packet should include not only copies of the pertinent statutes and relevant case law, but also copies of the literature, including Grisso, Melton, and others whose information will be useful to establishing the adequacy of the work done by the defense expert and the standards that should be used in a competence assessment process. While this seems to be a basic insight into the obvious, few lawyers seem to do it. Unlike other areas of expertise that could involve extensive preparation, the task just outlined can be accomplished by accessing a few easily available legal standards and a few excerpts from widely available literature. Some lawyers will make it a point to make the packet part of the record so that the judge reviews it as well.

Using such a packet can also force opposing counsel to pay careful attention to phrasing questions in terms of the actual language of the cases and quoted literature. Also, it is a relatively easy way of showing a jury (in those jurisdictions that allow the question of competence to be tried by a jury) that there is a body of written information that plays a part in defining terms and processes applicable to competence to stand trial.

In addition to the materials just described, this packet might include materials on standards of practice applicable to the relevant areas of mental health expertise - an area often overlooked.

Conclusion

We have now looked at the basic issues that must be reviewed in dealing with an expert on the assessment of competence to stand trial. The emphasis here has been on understanding what background that expert brings to the assessment, and what gaps in the expert's understanding of the issues may have to be addressed early in the interaction between counsel and expert. In part two of the article, we will focus more specifically on methodology and approach, and how to ensure that an expert is either properly supported or appropriately challenged in rendering a competence-related opinion.

Excerpts from this piece appeared in Matthew Bender's California Criminal Defense Practice Reporter in November 2006. They are reproduced by permission.

Notes

1. Thomas Grisso, *Competency to Stand Trial Evaluations: A Manual for Practice* (1988).
2. 517 U.S. 348, 356-357 n.9 (1996), noting that the concept was recognized in reported cases in the 17th century, and embodied in the Criminal Lunatics Act of 1800.

3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (DSM-IV-TR) at xxxii-xxxiii (2000).
4. CAL. EVID. CODE § 720(a).
5. FED. R. EVID. 702.
6. Core Competencies for Psychiatric Practice: What Clinicians Need to Know (Stephen Scheiber et al. eds., 2003).
7. As with psychologists, a good primer on the credentials available to psychiatrists can be found in Virginia Sadock & Benjamin Sadock's *Comprehensive Textbook of Psychiatry* (8th ed.).
8. APA: *Guidelines for Test User Qualifications*, 56 Am. Psychol. 1099 (2001).
9. *People v. Ary*, 118 Cal.App.4th 1016 (2004).
10. *Dusky v. United States*, 362 U.S. 402 (1960); *Drope v. Missouri*, 420 U.S. 162 (1975).
11. *Godinez v. Moran*, 509 U.S. 389 (1993).
12. See Richard Rogers & Daniel Shuman, *Fundamentals of Forensic Practice* 175-176 (2005).
13. The anecdotes were not collected in a methodical way, but involved the writer's contacts with lawyers litigating competence to stand trial issues in several California state and federal cases.

DEALING WITH EXPERTS ON COMPETENCE TO STAND TRIAL: SUGGESTIONS AND APPROACHES – PART TWO

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Standards Related to Experts and Opinions

In many court systems, the same experts are involved in competence assessments time and time again. A number of lawyers hold the view that judges and juries (where juries make competence determinations) generally disfavor contested competence adjudications, in part because *they* are viewed as an unnecessary challenge of a usually familiar expert's views by the defense.

Thus, some lawyers counsel against contesting a client's incompetence even where it likely could be contested because the systemic "realities" are felt to work against the defense. A similar, though more strategic, issue raised by lawyers concerned with the competence adjudication process is that the state (or federal government) obtains insight into the client that would otherwise not have been provided had there been no competence inquiry.

It appears that some of these concerns are raised because lawyers feel they cannot control the competence assessment process well enough to ensure the correct outcome where the client is indeed incompetent.

Some of this lack of "control" is attributable to lawyers' lack of familiarity with the standards of practice and ethical rules pertinent, to psychiatry and psychology. While there are indeed many variables in any given case that lawyers cannot control, they *can* point out where mental health professions do not adhere to their own rules in conducting an assessment, in arriving at a diagnosis or opinion, or in offering courtroom testimony. Armed with some sense of how to define proper from improper practice in the mental health professions, lawyers can more effectively address the process and outcome of a competence assessment.

The Ethical Principles of Psychologists and Code of Conduct, published by the American Psychological Association, covers a number of issues involved in the practice of psychology, including the assessment process, bases for assessments, test construction, and interpretation of test results. *Ethical Principles* defines a number of the limitations that psychologists should reflect in stating opinions depending on what data is available.

Similarly, for psychiatrists, the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* is viewed as defining standards of practice applicable to the profession. It has been referred to not only in some of the leading publications, but also in rulings of the U.S. Supreme Court.¹

A legitimate question can arise about how influential these organizational ethical principles are to an expert who professes not to belong to a given organization. Nevertheless, both in decisions of reviewing courts on constitutional law and criminal procedure issues, as well as in civil case decisions pertinent to practice and malpractice by psychologists and psychiatrists, courts have made reference to the predominant ethical codes and standards of practice of the dominant organizations. In specialty areas, several well known professional groups publish ethical guidelines or specialty guidelines. For example, the American Academy of Psychiatry and the Law publishes *Ethical Guidelines for the Practice of Forensic Psychiatry*. Likewise, guidelines are also published by organizations such as the American Academy of Forensic Psychology as well as the American Board of Forensic Psychology.

As is pointed out in the Federal Judicial Center's *Reference Manual on Scientific Evidence*, the American Medical Association (AMA) issued a report and a set of recommendations to state licensing boards urging that erroneous testimony by physicians be included as a type of malpractice and be subject to discipline.² These recommendations clearly would affect psychiatrists. Indeed, the AMA and several states have discussed expert medical testimony as a form of medical practice. This is an important development, as it emphasizes the concern for adherence to standards.

The advantage of a lawyer's familiarity with ethical rules for psychology and psychiatry, as well as with the announced standards of practice for these professions, is that they form the basis not only of establishing for the trier of fact that there is a baseline, but also that departure from these standards must be viewed as evidence of questionable practices. For example, the evaluator of competence to stand trial who professes to function under pertinent rules should be the subject of a wide-ranging voir dire or cross-examination where he or she: (1) has not maintained his or her knowledge of the field, including knowledge of pertinent literature and case law, and (2) has failed to obtain continuing education on the assessment of competence to stand trial. Counsel who have previously asked limited questions on an expert's qualifications should prepare more detailed inquiries and should obtain continuing education and professional certification records for the proposed expert. A surprising number of experts have simply not kept up.

A defense attorney should review foundational issues - even when making contact with a familiar expert. What literature on competence assessments does the expert use as standard references? Because a surprisingly high number of experts use a general understanding of the competence standards in the assessments, ask what statutory or case authority the expert keeps on hand. In some states, Florida and Nebraska for example, the "elements" of a competence inquiry as set forth in controlling law are more detailed than elsewhere. Moreover, other than Richard Rogers and Daniel Shuman, few publications address these differences.³ How recently has the expert received training on competence to stand trial either as a subject or as an assessment process? It makes sense to ask these questions, and they provide the basis for counsel to provide a "packet" of information to the expert that includes pertinent literature, legal standards, and case-specific material. (*See THE CHAMPION*, January/February 2008 at 15.) This is true (tactical considerations aside) regardless of whether the expert is friendly or adverse.

In addition to the general standards of practice and generalized ethical standards pertinent to the mental health professions, there are a number of standards that govern in the arena of competence to stand trial assessments.

Standards Exist For Competence Assessments

Experienced lawyers will seek to have an expert define how he or she approaches the assessment of competence. Is it done the same way in every case? Is the design of the assessment case specific? How did the examiner decide how to structure the examination or assessment in this case? This is not a matter of guesswork; it is a subject addressed in the literature. According to Melton et al., while the assessment of competence to stand trial is rooted in the U.S. Supreme Court's definitions, it is conducted in a specific context:

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....⁴

Melton et al. are not alone in this observation. A similar observation appears in the *Comprehensive Textbook of Psychiatry*.

The impairment must be considered in the context of the particular case or proceeding. For example, mental impairment that renders an individual incompetent to stand trial in a complicated tax fraud case may not render that individual incompetent for a misdemeanor trial.⁵

Because of the dearth of detailed analysis in the case law, it is hard to find language that specifically anoints this view of a competence assessment (though there is some in certain state court decisions). Since this is the literature often relied upon by the mental health professions, however, such language is

important, if for no other reason than to establish what an expert knows or has not bothered to consider.

There is another critical issue that often arises in a competence assessment, particularly when it is conducted by a court-appointed expert who is paid a flat (usually low) rate and thus can devote only little time to it. The issue surfaces even when the assessment is undertaken in a state hospital setting where time should not be as precious. The issue is whether contact should be made with the attorney of record to obtain data pertinent to competence. The literature recommends contact between the evaluator and the attorney representing the accused - particularly on the question of ability to assist counsel. Melton et al. are quite clear:

The consultation process should not be conceptualized as unidirectional, however. 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.⁶

Indeed, it is important to note that Melton et al. acknowledge the phrasing contained in Medina v. California that it is defense counsel who will "... often have the best informed view of the defendant's ability to participate in his defense. ..."⁷

This same point was made by Dr. Thomas Grisso in his 1988 *Competency to Stand Trial Evaluations*, though at that point his view on the subject was narrower than as stated since. He noted 'that in attempting to obtain back-ground information, "... the examiner should attempt to learn from the defendant's attorney those specific behaviors of the defendant that raised doubt concerning the defendant's competency."⁸

While other mental health professionals have published primers and practice guides related to the assessment of competence to stand trial, the above quoted sources are significant because of their influence. It is surprising, particularly when the problem revolves around the accused's ability to assist counsel (or cooperate in the preparation of a defense), that lawyers do not focus on an expert's failure to contact them.

Many experienced lawyers will pro-actively contact competence examiners to try to spur communication, or at least to make a record that counsel tried to make the contact. Lawyers in those jurisdictions in which competence assessments are conducted in a hospital or locked ward setting, or where competence restoration "work" is done in such settings, should formulate a specific strategy on communication with the mental health experts. The actual practices of the legal profession in this area vary a great deal. Clearly, examiners in state or federal hospital settings have no better gauge than do their colleagues in the community on what issues are encountered by defense counsel in a specific attorney-client relationship unless they confer with counsel. They have little understanding of the demands of a specific case, or how the communication between the lawyer and client has occurred.

The lawyer who has created a trail of communication with the examining expert, or who has at least created a paper trail evidencing efforts at communication, is in a good position to raise omissions by mental health experts where counsel's attempted input was ignored.

Knowledge of Available Formats of Competency Evaluations

In establishing or testing expertise in this area, counsel should become familiar with the various approaches to competence evaluations. Richard Rogers and Daniel Shuman, two well known scholars in the field of forensic mental health, have noted that there are basically three approaches to the diagnostic process in forensic practice. The first is *unstandardized*, depending on a clinical interview, plus some record review and collateral interviews as well (i.e., interviews of people other than the defendants). An unstandardized approach emphasizes the "I know it when I see it" type of expertise. It is difficult to validate because it is dependent on one person's judgment. And it is not unusual for experts relying on an unstandardized approach not to write very detailed reports, making their opinions even more subject to

individual judgment rather than verifiable work.

This unstandardized approach can be contrasted with the *standardized diagnosis* based on structured inter-views empirically validated for use in competence assessments (and including collateral interviews and record review as well as examination of the accused). The notion is that these diagnoses are based in some verifiable methodology and in techniques that can be replicated by another examiner.

Third, according to the Rogers and Shuman view, there are *extrapolated diagnoses*. These are based on investigating the relationship between results on psychological tests designed and associated with broad diagnostic groups that are related to a clinical assessment process of the individual at issue.⁹

While other scholars have described the diagnostic process in other ways, the Rogers and Shuman description has a great advantage for lawyers. It is simple and easily establishes that a mental health evaluation is a process that can be subjected to some level of analysis. Lawyers often miss the point in this area. Lawyers often question how a mental health professional arrived at a given opinion, but they do not know how to ask what process was involved. Did you do something that another expert can review and try to validate? Did you use techniques that have been subject to research and review? Did you write a report according to any published standards or approaches? (Grisso points out the importance of standardized report writing methods.)

Having a compact and easy way to describe the diagnostic process is important in a hearing or competence trial. Counsel has to find a way to differentiate between the methods used by examiners, and to introduce language into the court hearing or trial that differentiates between approaches used by experts. Basically put, lawyers have to be able to explain why the "drive by" evaluation - consisting of some time spent with the accused and some time spent reviewing records - does not produce an easily verifiable opinion. Developing the ability to explain to the trier of fact with explanations of how a diagnostic process can be verified (and where it cannot) is what results from understanding the various approaches to competence assessments.

Competence to stand trial assessments often involve the use of fairly well known instruments that may be described as structured interviews, inventories, or tests. Usually, such instruments - such as the Competence Assessment Instrument (CAI), the MacArthur assessment tools (including the MacCAT), and Rogers' Evaluating Competence to Stand Trial-Revised (ECST-R) - are *an* ingredient in a more methodical process than the "drive-by."

Expertise is established when the following items are included as part of the statement of an expert's back-ground: (1) knowledge of the different categories and types of assessments; (2) knowledge of the different assessment tools; and (3) varied opportunities for acquisition of information on competence to stand trial. (Conversely, when this information is used on cross-examination, it opens up the expertise to question.) Not only does this information establish expertise, it also serves to establish the strengths and weaknesses of any given competence to stand trial assessment process. It serves to establish a description of the science of competence evaluations, as well as their weaknesses - especially in the assessment of the so called "aid and assist" counsel element of the legal test of competence. There are no particularly well established or validated approaches in that area - particularly if one understands the need for examiner contact with counsel to mean that this is an area in which examiners must at least try to acquire data from counsel

Experts Offering 'Relevant' Evidence

Dr. Thomas Grisso has written that, historically, mental health examiners were viewed as failing to provide testimony that was relevant to the law's concerns, and also that many examiners seemed to be ignorant of the nature of the legal inquiry.¹⁰ As he puts it:

Something more is needed, therefore, than a mere diagnosis of mental disorder, a reference to an individual's inadequate contact with reality, or a statement about general mental retardation. For clinical information to be relevant in addressing legal questions of

competence, *examiners must present the logic that links these observations to the specific abilities and capacities with which the law is concerned.*¹¹

Others have explained that "... forensic clinicians must consider individually the clinical issues associated with each Dusky prong?"¹² Attention needs to be paid to the "clinical operationalization of the competency standard."¹³

These comments frame some inter-related points that will be lost on lawyers who approach competence to stand trial hearings as though the objective were simply to present some expert opinions on an individual's disorders and how they are manifested - with the legal issues left to be explained through counsel's arguments. Even relatively experienced judges often do not have in mind all of the essential formulations and phrases of the U.S. Supreme Court's competence definitions. *They* may reference a statute, ruling, or (where employed) jury instruction that is clearly out of step with the Supreme Court's requirements. This is true, for example, of the California statutory definition that was formulated in 1967. It is a significant oddity since the statutory definition has not been changed to incorporate the more recent rulings.

From a tactical standpoint, the failure to make use of an expert's understanding of the various competence to stand trial definitions, and to have the expert explain how each activity engaged in during the assessment (the interview, record review, testing, consultation with counsel, observation of the accused with counsel, etc.) relates to an understanding of *this* individual's competency to stand trial, represents a failure to explain basic linkages between definitions in an assessment process.

It is in part for this reason that counsel are urged to work carefully with experts to ensure that they are fully aware of the content of the case law. Counsel must make sure they have thought how their work as psychologists or psychiatrists in the particular case has addressed the salient questions set forth in the law.

Supporting the Basic Showing Of Incompetence

It has been pointed out that the U.S. Supreme Court has never required proof of a specific disorder to establish incompetence or otherwise specified what evidence will establish incompetence. Some state statutes, however, create a linkage between proof of an underlying mental disorder or developmental disability and incompetence to stand trial. Whether this linkage would pass constitutional muster if properly challenged is beyond the scope of this piece. Suffice it to say that when contemplating the presentation of evidence of incompetence, lawyers often contemplate calling one or more mental health experts who are important to the process, in part because they provide the diagnostic information.

Some thorough examiners and lawyers will also call upon a variety of supporting witnesses to flesh out their understanding of the client's functioning, including family members; jail and prison visitors, inmates, staff, and mental health experts; witnesses (including experts) from prior hospitalizations; and prior diagnosticians.

It appears that in the cases in which counsel have been successful in establishing incompetence, the trier of fact was presented with ample, sometimes redundant, testimony from a wide variety of witnesses. Indeed, often the government will seek to rebut the defense evidence by calling the same types of witnesses the defense will call - notably jail, prison, or state hospital personnel who are often offered as sources of information about an individual's behavior when the light of a mental health examination is not on them, and when (according to the arguments usually proffered) the accused's guard is down. Clearly, proactive counsel who undertake the burden of demonstrating the existence of incompetence should avail themselves of this wide range of evidence.

Exercise care in choosing lay witnesses on competence. Without doubt, some triers of fact will believe a credible lay witness over an expert. But some care should be taken to develop specific parts of the evidence of incompetence through the corroborating witnesses. Often, these witnesses are called to establish that the accused is demonstrating confusion, incoherence, or paranoia (to name a few) even

when no lawyers, doctors, or other "officials" are looking.

Several reported cases discuss, in some detail, the witnesses called on the issue of competence or restoration to competence in a way that may assist counsel in formulating plans. One series of such cases centered on New York's Vincent Gigante. Over a period of time, Gigante was the subject of several different competence adjudications.¹⁴ The Gigante saga is of importance because it involved well known psychologists and psychiatrists who lined up on the two sides of the issue, and because it chronicled the various lay witness opinions that were introduced.

After the tortured litigation of the competence issues, Gigante eventually made certain admissions on the record in his federal case to the effect that he had been faking certain aspects of his apparent incompetence. This admission led, among other things, to editorials and commentaries by well known mental health professionals questioning (once again) the usefulness of the injection of mental health opinion evidence in forensic settings.

Another discussion of the subject is found in United States v. Duhon, a federal district court case that offers a rich discussion of competence law and literature pertinent to competence inquiries, as well as a review of the testimony of various witnesses in a competence restoration proceeding.¹⁵ Duhon also involved the use of an attorney-expert, i.e., a lawyer called to explain how defense of the case necessitated attorney-client communication.

The suggestion to use lawyer-experts in competence proceedings has been made over a period of time.¹⁶ The attorney-expert contemplated is one who would explain, either specifically (in the appropriate case) or generally: the demands placed on a client in that type of case; the components of the effective representation of an individual given the charges; the existence of the various standards, including *ABA Standards* (or *ABA Guidelines* in death penalty cases) that require the lawyer to do specified things to assist the client; the various choices and decisions defined by the Fifth and Sixth Amendments that clients face; the nature of the discussions that take place between counsel and client in a given type of case; and the strategic decisions that would need to be discussed as well, according to the case law.¹⁷

Use of an attorney-expert provides an alternative for lawyers who are of the view that some evidence from counsel is needed but where counsel of record may not be an appropriate source of information.

Defining the Problem; Setting the Stage For a Solution

There is an overarching theme that defense counsel may need to address in a competence case. This involves describing how the competence issue impacts the integrity of the process, and what the prospects for restoration of competence may be. Indeed, many of the suggestions offered above might be viewed as secondary to the one discussed here, which is that counsel should have a basic, fact-driven, explanation of how a client's paranoia, psychosis, or other symptom has compromised the conduct of the criminal proceedings.

Focusing on this theme is particularly important when the issue of competence is left to a jury's determination, as well as where the case law requires proof of changed circumstances before a second or third competence to stand trial determination may be undertaken in the same case.

Lawyers who practice in jurisdictions (such as California) where a jury ultimately decides competence have expressed concerns that jurors will view the competence issue as a way of avoiding criminal liability. Surprisingly, however, counsel often do not elicit evidence (through mental health professionals, lawyers, or retired judges, all of whom have been called as experts on such issues) that the systemic response to declarations of incompetence is to try to achieve restoration of competence with the aim of finishing the case. Such evidence would help defuse the notion that the process involves an "out" for the accused.

Counsel who are used to making proportionality and comparison of punishment arguments at sentencing often censor themselves in the presentation of data that can remind a trier of fact (judge or jury) that the actuarial tables favor the resumption of the case when competence is at issue.

This theme may be less dubious to a trier of fact where the underlying disorder can be treated with medication, and where there is evidence that the accused has "gotten better" when medicated. Some experienced lawyers have recommended that their own experts consult with others who work in competence restoration programs that are likely to receive the accused. Competence restoration staffers are often more than happy to review their relative success rates, thus providing the foundation for some testimony on the issue. Hearsay objections can be circumvented through use of official records and official reports, as well as through the calling of administrators responsible for the programs at issue. This is not an area to neglect, as judges or jurors may have little idea what actually happens in the aftermath of a determination of incompetence.

It is also of some importance for counsel to be specific in describing how an accused's incompetence is compromising the defense even if this statement is made in a submission under seal or in some other protected format. A generalized statement that the accused is unable to assist may be useful at an early time of crisis in the case, but it becomes less useful if it becomes necessary for the same lawyer to raise the client's incompetence a second or third time in the same case. Case law often requires a showing of change in circumstances, and the possibility that competence may have to be addressed again should be contemplated by counsel.

Conclusion

In many jurisdictions, the adjudication of an accused's incompetence to stand trial is taken care of through stipulations to the admission of experts' reports and other devices that have avoided the need for lawyers to get involved in and become acquainted with contested competence hearings or trials. Defense lawyers often assume that there is significant resistance to finding an accused incompetent even though the facts merit such a finding. While this may be a provable assumption, available evidence suggests that well-prepared lawyers have been able to demonstrate a client's incompetence by exhibiting care in preparing to present the relevant evidence. Some of the valuable lessons learned from successful competence litigations have been described in this writing in the hope of assisting other counsel when it comes to clients who are mentally incompetent to stand trial.

Excerpts from this piece appeared in Matthew Bender's California Criminal Defense Practice Reporter in November 2006. They are reproduced by permission.

Notes

1. In *Washington v. Harper*, 494 U.S. 210, 223 fn.9 (1990), the Court noted that it assumes psychiatrists (and other physicians) obey the ethics of the medical profession, citing specifically the "annotations especially applicable to psychiatry" of the American Psychiatric Association; see also the discussion of medical ethics in Virginia Sadock and Benjamin Sadock's *Comprehensive Textbook of Psychiatry* (8th ed.).
2. Federal Judicial Center, *Reference Manual on Scientific Evidence* 448 fn.37 (2d ed. 2000). The *Reference Manual* is considered an authoritative resource in the federal courts. It devotes an entire chapter to medical testimony.
3. Richard Rogers & Daniel Shuman, *Fundamentals of Forensic Practice* 157-161 (2005).
4. Gary B. Melton et al., *Psychological Evaluations for the Courts* 122 (2d ed. 1997). This subject is also covered in the new Third Edition.
5. Virginia Sadock & Benjamin Sadock, *Comprehensive Textbook of Psychiatry*, 3285-86 (7th ed. 2000).
6. See Melton et al., endnote 4, at 150.
7. *Id.* at 130, relying on *Medina v. California*, 505 U.S. 437 (1992), which affirmed *People v. Medina*, 51 Cal.3d 870 (1990). The observation at issue was actually first set forth by the California Supreme Court in its *Medina* opinion.
8. Thomas Grisso, *Competency to Stand Trial Evaluations: A Manual for Practice* 41 (1988).
9. Rogers & Shuman, *Fundamentals of Forensic Practice* 405 (2005).
10. Thomas Grisso, *Evaluating Competencies* 12-13 (2d ed. 2002).

11. *Id.* at 13, emphasis in original.
12. Rogers & Shuman, *Fundamentals of Forensic Practice* 167 (2005); see *Dusky v. United States*, 362 U.S. 402 (1960).
13. *Id.* at 161.
14. *United States v. Gigante*, 982 F. Supp. 140 (E.D.N.Y. 1997); *United States v. Gigante*, 996 F. Supp. 194 (E.D.N.Y. 1998).
15. *United States v. Duhon*, 104 F. Supp. 2d 663 (W.D. La. 2000). This is a very useful case that has been cited with approval, usually on other issues. See, for example, *United States v. Valenzuela-Puentes*, 479 F.3d 1220, 1227 (10th Cir. 2007).
16. The writer of this piece has been involved in several publications suggesting the use of attorney-experts. Fortunately, some of these writings have been supported by other established defense counsel. See, for example, Iversen, Thomson & Philipsborn, *1368 Revisited: Can Your Client Rationally Assist You?* (CACJ Forum, 1988, in two parts); Philipsborn, *Assessing Competence to Stand Trial: Re-Thinking Roles and Definitions* (American Journal of Forensic Psychiatry, Volume II, Issue One, 1990); Burt and Philipsborn, *The Assessment of Competence in Criminal Cases: The Case for Cooperation Between Professions* (published in the June 1998 issue of THE CHAMPION, as well as in CACJ Forum and California Death Penalty Manual). The last of these articles was cited by the U.S. District Court in *Duhon*, see endnote 15.
17. Many of the activities that would be contemplated to take place between a lawyer and client, including discussions of specific pleas, waivers of rights, and strategic decisions, are found in *Godinez v. Moran*, 509 U.S. 389 (1993). A useful discussion is also repeated in *United States v. Duhon*, *supra* note 15. The ABA Standards referred to here are the *Standards on the Defense Function*. The ABA Guidelines are the 2003 ABA *Guidelines on the Appointment and Performance of Counsel in Death Penalty Cases*.

About the Author

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EMOTIONAL COMPETENCE AND RATIONAL UNDERSTANDING: A GUIDE FOR DEFENSE COUNSEL

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Originally printed in April 2009 issue of *The Champion* and Reprinted with permission from Terry A. Maroney

The legal standards for adjudicative competence¹ appear simple: as the U.S. Supreme Court declared in *Dusky v. United States*, the substantive test is whether a criminal defendant “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.”² It is clear, too, that the defendant has a fundamental constitutional right not to be tried, convicted, sentenced, or executed while incompetent,³ and the procedure by which competence is raised and determined is relatively straightforward.⁴ But this apparent clarity is deceiving. Despite its evident importance⁵ and solid historical pedigree, adjudicative competence remains surprisingly ill-defined. The substantive meaning of *Dusky* — notably the distinction between “rational” and “factual” understanding — has escaped significant elaboration. Implementation of *Dusky* is also highly unpredictable, as it generally falls to forensic experts to whom courts defer heavily but to whom guidance is seldom given. Forensic experts and legal theorists have collaborated to define and measure competence-relevant facts, but these standardized tests are not yet widely used.

A coherent theory of competence is possible, and it promises greater clarity and uniformity. The “rational understanding” component of *Dusky* should be understood to require “decisional competence,” that is, a defendant’s capacity to make, communicate, and implement minimally rational, self-protective choices within the context of the criminal case. The crucial, yet to date entirely unexplored, next step is to recognize that both cognition and emotion — colloquially, thinking and feeling — make important contributions to such capacity. Thus, assessment of *Dusky* competence requires careful attention to both the cognitive and emotional influences on rational decision-making.

This article takes on both aspects of the argument. It first shows how decisional competence forms part of the *Dusky* standard. It then proposes a framework for defining such competence and illustrates how that framework informs cases involving cognitively impaired defendants, particularly those suffering from thought disorders (such as paranoia and schizophrenia). Turning to the role of emotion in rational decision-making, it shows how profound emotional dysfunction — including severe depression and certain forms of brain damage — also can defeat *Dusky* competence.

I. ‘Rational Understanding’ and Rational Decision-Making

Adjudicative competence doctrine, like all law-relevant competencies, traditionally has sought to balance competing interests. On the side of finding competence wherever possible are respect for a defendant’s autonomy and the state’s interest in enforcing its criminal law; the countervailing interest is that of protecting those who cannot protect themselves. For the adversary system to have legitimacy the defendant must be meaningfully present as an autonomous actor capable of taking, should she so choose, permissible steps to attempt to protect herself from the assertion of state power.

Adjudicative competence therefore may be implicated at any stage in a criminal proceeding at which it appears that the defendant may lack self-protective capacity. At whatever stage competence is examined, the proper inquiry is whether the defendant is capable of making at least minimally rational decisions in service of her defense. While this focus on “decisional competence” has not been explicitly endorsed by the Supreme Court, it is implicit in the case law; indeed, it is hard to imagine a viable concept of competence that excludes it.

The roots of the decisional competence construct may be found in the “rational understanding” component of *Dusky* itself. *Dusky* involved a schizophrenic defendant who “understood what he was

charged with, knew that if there was a trial it would be before a judge and jury, knew that if found guilty he could be punished, ... knew who his attorney was and that it was his duty to protect the defendant's rights," and could furnish at least some relevant historical information with substantial accuracy. His incompetence, experts testified, stemmed not from inability to grasp factual concepts but, rather, from "confused thinking" caused by his mental illness, which rendered him unable to "interpret reality from unreality." Nonetheless, the district court found Dusky competent. The Supreme Court disagreed, holding that factual understanding was necessary but not sufficient for competence. What was also required was some sort of "rational understanding," which, though apparently crucial, remained undefined.

Subsequent cases attempting to define what evidence would raise a bona fide doubt as to Dusky incompetence have yielded some additional hints as to what types of irrationality might be relevant. The Court, while resisting any attempt to define a general standard, has delineated certain facts that generally warrant further inquiry — such as a "history of pronounced irrational behavior"⁶ or a recent suicide attempt — and others that are insufficient to foreclose the inquiry even if relevant to the ultimate determination — such as lucid speech and behavior in the courtroom. Despite these clues, the value added by "rational" understanding remained unclear.

That situation changed somewhat with Godinez v. Moran,⁷ in which the Court answered a debate as to whether different substantive standards of competency applied to different aspects, or at different stages, of a criminal proceeding. The short answer was no. The Ninth Circuit had asserted there was a difference between a defendant's capacity for 'reasoned choice' among the alternatives available to him"⁸ and Dusky competence, with a showing of the former being additionally required before a Dusky-competent defendant could discharge counsel and proceed pro se. The Court disagreed, asserting instead that the concepts were the same. Listing the array of choices required of defendants whether they go to trial or plead guilty, the Court held that the same standard applied to both universes of decision-making. The only sense in which a higher standard might apply is that certain decisions — such as to discharge counsel and plead guilty — additionally require a separate determination that they were made knowingly, intelligently, and voluntarily.

Decided more than three decades after Dusky, Godinez represents the Court's most specific effort to explain "rational understanding." Though some have read the Court's failure to use the term "decisional competence" as a sign that decision-making abilities need not be considered in determinations of adjudicative competence, this conclusion is belied by the its nearly single-minded focus on defendant decision-making. This confusion should be put to rest. Decisional competence, or a defendant's capacity for rational decision-making in the context of her case, should be recognized as the core of "rational understanding."

Accepting a role for decisional competence requires a theory as to the necessary components of rational decision-making with reference to the particular decisions facing criminal defendants.

Some decisions — for example, strategic calls as to whether to waive indictment or demand certain forms of discovery — routinely are entrusted to the attorney, while others are the province of the defendant. These defendant-driven decisions are whether to demand a jury trial, represent oneself, testify on one's own behalf, be present at trial, or plead guilty. More broadly, the defendant is thought also to have the right to make global decisions as to the theory of her defense — for example, whether to pursue an insanity defense — and the objectives to be pursued by counsel. Thus, when we speak of decisional competence, it is the competence to make these choices, not a more general decision-making capacity, about which the law should care. The decisional capacity we demand is that which renders her capable of making critical, defendant-driven decisions in a minimally rational and self-protective manner.

Still, the content of such "rationality," a term that is far from self-defining, requires yet further explication. The vast decision-making literature yields some consensus as to the necessary building blocks of rational decisions. The model of rational human decision-making offered here incorporates four complex underlying concepts, each of which represents a site of potentially competence-threatening "irrationality." These crucial elements are perception, understanding, reasoning, and choice.

What follows is an analysis of how any one of these elements may be imperiled by severe cognitive or emotional disorder, resulting in possible incompetence. The usefulness of the model is most

clearly seen by examining the competence of persons with thought disorder — that is, dysfunction in cognitive thought processes that generally is identified by its effect on either the content or form of speech (e.g., delusional thoughts or disordered speech patterns).

Thought-disordered defendants, particularly those with schizophrenia, often are labeled “psychotic,” a label strongly associated with findings of incompetence. Indeed, many forensic examiners (wrongly) regard psychosis as the sine qua non of incompetence, starting and ending their analysis with that diagnosis. Unfortunately, why psychotic thought disorder is thought to disrupt Dusky rationality seldom is made plain. There are, however, several prominent exceptions. Those courts that have attempted to explain the relevance of psychosis generally have located decision-making defects at the stages of perception and understanding.

Perception, or the human body’s transformation of sensory stimuli into internal images, is a crucial threshold requirement, but is not as straightforward as it may seem. Because sensory stimuli are transformed into conscious perceptions by complex (and largely nonconscious) neural processes, factors ranging from stress to neurological disorder can intervene, with sometimes seriously distorting consequences, between percept and perception. Once an object is perceived, with or without prior distortion, a decider will form thoughts and beliefs — or understandings — about it. Generally accurate understandings about relevant aspects of the external world are, like perception, necessary but not sufficient for competent decision-making.

Defendants with severe psychosis frequently display perceptual and understanding processes that are so profoundly distorted as to obviate competence. Such was the conclusion in Lafferty v. Cook,⁹ an unusually thoughtful decision by a sharply split Tenth Circuit panel. Ronald Lafferty was diagnosed as suffering from a “paranoid delusional state” but deemed competent; he then attempted suicide by hanging, and four examiners opined that Lafferty’s “paranoid delusional system,” aggravated by oxygen deprivation to his brain, had rendered him incompetent by impairing “his ability to perceive and interpret reality.” Lafferty’s delusions included the belief that all those involved in his case — including his lawyer — “were part of a corrupt man-made order” against which he was required by God to rebel. Because he, like Dusky, displayed factual understanding of the proceedings, the majority recognized that its task was to determine the meaning of “rational understanding.” The Lafferty majority determined that “a defendant lacks the requisite rational understanding if his mental condition precludes him from perceiving accurately, interpreting, and/or responding appropriately to the world around him.” Thus, it concluded, “sufficient contact with reality” is the “touchstone for ascertaining the existence of a rational understanding.”

This test has been adopted by a small handful of other courts. In In re Heidnik, for example, the Third Circuit found a death row inmate incompetent to abandon appeals because his decisions were based on a flawed “perception of reality,” including “fixed false beliefs,” “all-encompassing in nature,” that his victims had killed themselves and that his execution would lead to the end of capital punishment.¹⁰ A similar approach was taken in Utah v. Mitchell, in which Brian David Mitchell was found incompetent to stand trial for the kidnapping of Salt Lake City teenager Elizabeth Smart.¹¹ After determining that Mitchell suffered from a delusional disorder characterized by fixed, false beliefs (including that God required his imprisonment in order to trigger a personal battle with the Antichrist), the court concluded that his “ability to accurately perceive and interpret external reality” was unduly impaired. The court therefore found him unable to make rational choices, which it equated with “rational understanding.” Thus, as these cases demonstrate, severe cognitive defects in perception and understanding can impede a defendant’s ability to make decisions on his own behalf.

Defects in reasoning — the process by which one draws inferences and conclusions from premises — also can defeat competence. For example, were a defendant to correctly understand (and believe) that all defense attorneys are their clients’ advocates, and perceive that the person assigned to represent her is a defense attorney, and yet conclude that her defense attorney is the state’s advocate, we would conclude that her logical reasoning is impaired. Significantly, though, such defects are seldom reflected in the cases. Reasoning does not appear to be nearly as threatened by psychosis as are perception and understanding. In the cases cited above, courts have found incompetence despite intact logical

capacity. Lafferty's reasoning was logical — his decisions, such as an effort to discharge counsel, were consistent with his premises, namely, that his lawyers were out to get him. But the court found it dispositive that delusional beliefs irredeemably distorted his premises. This makes sense: while deductive reasoning is necessary to competence, it is far from sufficient, for such reasoning maps poorly onto real-world decision-making, in which the validity of premises matters and where decisional conditions are often confusing and in flux.

The extent to which courts have identified competence-threatening defects in choice — formulating a conclusion, expressing that conclusion, and taking action accordingly — is limited. Choice is nonetheless important, as a defendant might display valid reasoning on the basis of sound premises and yet reach a conflicting or somehow irrational conclusion, lack ability to communicate her choices, or be unable to act in accordance with her choices. For example, Lafferty had chosen to discharge counsel but was unable to take action implementing that choice. For reasons that he would not explain, he refused to put his expressed desire to represent himself on the record in the required form, with the result that counsel was not discharged.

With psychosis, then, the most endangered sites within the rational decision-making process appear to be perception and understanding, though psychosis could also frustrate flexible reasoning and destabilize choice. The cited decisions represent some of the only examples of an overt attempt to define rational understanding by reference to affected stages of rational decision-making processes. This approach, though controversial, has the advantage of being transparent and principled. And this approach need not be confined to thought disorders: other, possibly less obvious, disorders — including emotional disorders — might have equivalent impact.

II. Emotional Competence and Rational Understanding

Defendants with profound impairments of emotional perception, processing, and expression may be equally unable to make self-interested rational decisions, although they may appear to be in touch with reality in a way that psychotic persons often do not.

The role of emotional disorder in adjudicative competence remains almost entirely unexplored. Indeed, it is sometimes deliberately disregarded.

Emotion has a significant influence on all four stages of decision-making. It represents an important mechanism for the perception and processing of information, one that captures different information than would cognition alone. Emotion also affects the perceived value, personal relevance, or attractiveness of the information being processed, and therefore will shape motivation and goals.

First, emotion influences which stimuli are perceived and how they are perceived. Because emotionally salient stimuli tend to be the ones of greatest significance to one's survival and thriving, they will be attended to disproportionately. Thus, one without emotion's guidance will find herself unable to sort among the nearly infinite competitors for her attention. Extremes of emotion may also influence perceptual recall. In acute cases of trauma, for instance, persons might become unable to recall the incident, or instead may recall it so vividly and frequently that other information is kept out of accessible memory. Thus, the emotional salience of stimuli can substantially affect attention to, as well as perception and memory of, both those stimuli and emotionally nonsalient stimuli.

Emotion also has a strong influence on understanding, particularly through processes called "appraisal" and "appreciation," interdependent concepts that concern awareness of personal significance. Appraisal is a lightning-fast judgment as to whether and how particular stimuli matter to one's well-being and goals, a judgment that will then shape information processing. Intact appraisal leads to emotional reactions to personally relevant stimuli. Such appraisal and the attending emotion then contribute heavily to the specific understanding, or appreciation, that information presented to (and decisions required of) a person is applicable to her and carries consequences for her personal situation. For example, a defendant may understand that the death penalty is a potential consequence of her prosecution. To say that she cannot appreciate that fact would mean that she has appraised, wrongly, that it does not apply to her —

for example, because she believes that she is immortal — or that she realizes that it applies, but does not attach to that realization any emotional significance. A person without appreciation does not have access to the fear, hope, or other emotional reactions to relevant information that normally would guide personally consequential decision-making.

Reasoning also will be influenced by emotion states. For example, one exposed to a negative feeling (e.g., fear evoked by recalling the sighting of a snake) generally will report an increased (and likely inaccurate) estimation of the likelihood of future occurrence of events that, though completely unrelated, may provoke the same negative feeling (e.g., a terrorist attack). Finally, emotion can profoundly influence choice, including its communication and implementation. The person described above, inordinately fearful of a terrorist attack, might make specific choices (e.g., engaging in increased risk avoidance) on the basis of her affectively driven reasoning. Emotion-driven choice can also be far more primal. Feeling-states predispose the actor to particular behavioral responses — anger, for example, is highly associated with risk-taking behavior and aggression, fear with risk avoidance and escape. Some emotional experiences — notably fear — are nearly automatic responses, with the result that they are experienced as involuntary. Extreme emotional instability may also cause inability to maintain a consistent choice preference.

As this brief discussion reveals, not only is emotion not the natural enemy of rationality, it is intimately connected to the perception and processing of information, appraisal of value, formation of goals, motivation of behavior, and implementation of choice. Emotion can contribute to rational thought by marking stimuli as meaningful and generating a sense of personal relevance and value that will shape goals and motivations. Thus, a lack of emotion where one normally would expect it to be present can deprive the decision-maker of vital information and guidance. Excessive or disordered emotion can also derail optimal perception, understanding, reasoning, and communication, or may override one's otherwise preferred choices. A complete account of Dusky rationality therefore demands close attention to the positive and negative contributions of emotion.

I here propose two situations in which emotion ought properly to be considered in determinations of adjudicative competence. The first is that of defendants with psychiatric illnesses, particularly severe depression, that impair accurate perception and processing of information, derail self-protective motivation, and impair stable, self-interested choice. Here we are concerned about a lack of emotional balance, as well as the influence of a surfeit of particular emotions, such as despair, and a dearth of others, such as hope. The second is that of defendants with neurological defects, usually caused by brain damage, that impair perception, processing, and expression of emotion. Here, our concern stems from a general lack of access to emotion.

The effects of severe depression on attention, perception, concentration, and memory are well-recognized. First, the severely depressed may focus so disproportionately on mood-congruent stimuli (e.g., facts indicating the situation is hopeless) as to neglect important contrary information. Further, depression may become so severe as to incorporate delusions and hallucinations. Depression may also block self-interested motivation. A severely depressed defendant may be capable of accurately grasping the facts of her situation and options but simply not care about what the correct course of action might be or how it might affect her well-being. Even if she does care, the normal direction of such caring may be reversed: she may want to take undue risks and may choose a self-harming outcome.

Bipolar (or “manic”) depression can be equally devastating. When in a manic episode, these persons are highly distractible and unable to distinguish between relevant and irrelevant stimuli and thoughts. They often will exhibit extremely fast, pressured, tangential, and even nonsensical speech, as well as grandiose delusions as to their personal power and importance. The manic reason poorly: they overestimate wildly their personal abilities and chances of success in difficult situations. Further, they are prone to impulsive and imprudent choices, often seeking immediate pleasure and gratification. Their extreme lability of affect can occasion frequent, dramatic changes of course.

The case law generally does not reflect significant examination of the effects of depression, whether unipolar or bipolar, on competence. However, because mood-disordered defendants present with some regularity, so too do these issues, though the cases reflect a highly confused attitude as to their

relevance.

On the one hand, depression is sufficiently well-recognized (and its effects potentially so devastating) that courts sometimes take note of it. In Drope v. Missouri, for example, the Supreme Court found that while a recent suicide attempt did not per se signal incompetence, it was highly relevant to whether an inquiry was required.¹² More recent cases reflect a similar acknowledgment that depression is relevant, though there is no particular consensus as to how or why.¹³

Frequently, though, courts dismiss the import of depression in a manner that reflects a strong privileging of cognition.¹⁴ For example, courts sometimes appear to believe that depressed persons could be motivated to care about their fate if they chose to be so motivated — displaying a fundamental ignorance of the impact of depression on appreciation and motivation.¹⁵

The tension between these attitudes as to the impact of depression is perhaps most clearly seen in the context of execution volunteer cases. Because competent defendants are free to decide whether to challenge a lawfully imposed punishment, death row inmates generally will be presumed able to acquiesce to execution; but because such acquiescence may spring from suicidal depression, best friends often come forward to try and prevent what they consider a suicide.

In this battle, confusion reigns supreme — but a disproportionate focus on cognition is winning. This was the case in Rumbaugh v. Proconier,¹⁶ in which the Fifth Circuit, though recognizing that Rumbaugh's severe depression could render him "irrational," noted that he had filed "an extremely coherent and well-reasoned pro se state habeas corpus petition." The court upheld the finding of competence because Rumbaugh's decision to end his life was "logical"; he was "able to feed relevant facts," such as "the intense suffering caused by his depression," into "a rational decision-making process and come to a reasoned decision."¹⁷ In other words, that depression may have warped his premises — leading to a conclusion that execution was preferable to life as a severely depressed person — was of no consequence, in contrast to the consideration rightly given to distorted premises attributable to psychosis. As the dissenting judge correctly argued, the opinion rested on a limited, cognition-driven standard of rationality, erroneously equating "'rational' with logical" and wrongly holding that "a person's cognition, his understanding, is ... tantamount to an ability to choose rationally."¹⁸

Thus, the cases reveal a real and persistent disagreement over the appropriate level of consideration to be given to depression. Unfortunately, the general resolution of that debate reflects simplistic notions of decision-making, consisting of nothing more than intact cognition plus the powers of deductive reasoning.

Another competence-relevant manifestation of emotional dysfunction stems from brain damage, particularly to regions of the frontal lobes. The emotional deficits associated with such damage are highly correlated with inability to make self-protective choices in situations of risk to one's own thriving, despite retention of cognitive capacity.

Evidence of concurrent emotion-and-reasoning deficits attending brain damage, now solidly supported by the cognitive neuroscience literature, is grounded in the story of the most famous neurological patient in history, Phineas Gage.¹⁹ In 1848, Gage survived a railroad-construction accident in which an iron rod was propelled at high speed through his head. Gage's miraculous recovery, however, was elusive. Though still intelligent and skilled, he underwent profound personality change, alienated family and friends, and became unable to keep a job; in fact, as his doctor recalled, "he was good at 'always finding something which did not suit him,'" and appeared to have become incapable of planning or forethought.²⁰

The Gage case led to a number of fundamental insights, notably that "a lesion of circumscribed areas of the brain could cause the loss of very specific mental or nervous functions in humans."²¹ Further, that the "new Gage" lacked emotional regulation and became unable to plan for (or execute action toward) a stable future suggested that such abilities might be both intertwined and dependent on the ventromedial portions of prefrontal cortex, the brain areas damaged in his accident. The insight proved true: damage to these areas has been shown to interfere with social and emotional, but not cognitive, competence. It is now widely accepted that brain damage affecting emotional perception, processing, and expression — particularly damage to the frontal cortices — is correlated with diminished rationality in the

realm of personal decision-making.

This research has three important implications. First, persons with frontal lobe damage might with some regularity become defendants, as their extreme decision-making deficits may lead to poor choices (and, in rare cases, disinhibited and aggressive behaviors) with criminal consequences. Second, they may exhibit intact cognition and yet be incapable of the kind of high-stakes, personal decision-making required of defendants. In these cases, failure to consider impaired emotional capacity might lead to an erroneous finding of competence, either because deadened emotion is not recognized as a clue leading to further inquiry that might uncover brain damage, or because of imposition of an overly cognitive test in which the emotion and decision-making deficits, even if proven, are dismissed as irrelevant. Third, other brain-damaged persons (for example, those with more diffuse injuries) may display the above-described impairments as well as cognitive and motor deficits. As competence determinations look to the combined effects of impairments, failure to take seriously those going to emotion could remove important information from the calculus.

These issues are novel, and to the limited extent that they have been addressed by courts they have met with inconsistent results. Consider North Carolina v. Shytle.²² Shytle shot herself in the head after killing family members; though her intelligence and memory were intact, the injury “impaired her emotional response[s] to situations” and led to inappropriate behavior, such as laughing at serious moments, suggesting that she failed to grasp the seriousness of her plight. One examiner testified that she was incompetent because “her affective appreciation of events ha[d] been lost,” preventing her from “understanding her legal situation and cooperating with her attorney.” The North Carolina Supreme Court was asked whether, “if an individual’s cognitive, reasoning ability is separated from basic emotional responses or affect,” she would be “competent not only to aid in [her] defense but also to proceed to trial.” The court found her competent:

[T]he defendant had an IQ within the normal range and ... knew what the charges were and what could happen to her if she was convicted. If this did not worry or upset her because of her altered medical condition, it does not mean that she did not understand those facts. ... If the defendant’s situation did not bother her it does not mean she did not comprehend it.

This analysis — in which the extreme abnormality of Shytle’s lack of emotional reaction was sanitized by the presence of factual understanding — ignores the importance of rational understanding. Though in a very different procedural context, a similar conclusion was reached in the recent clemency petition of Donald Beardslee.²³ Cognitive function simply trumped emotional dysfunction.

In contrast, consider “Jane,” who suffered from an undiagnosed defect known as an arteriovenous malformation (“AVM”) in the left frontal lobe of her brain.²⁴ Jane, previously accomplished and principled, began suddenly to engage in obviously foolish financial schemes, lost all her money, and was convicted for minor participation in a fraudulent investment scheme. At sentencing, a brain scan (obtained by new counsel seeking to determine the cause of her sharp downfall and struck by her odd emotional profile) showed the AVM and associated brain damage. Neuropsychological testing revealed that Jane retained her high intelligence and cognitive abilities, which had largely masked others’ ability to recognize her deficits. However, her affect was noticeably constricted and she was consistently unable to make self-protective choices in personal, particularly financial, matters. She appeared utterly incapable of perceiving the evident mental instability of the fraud’s ringleader and was strangely detached from the extremely serious repercussions of her conviction. A court-appointed expert, after considering the defense’s evidence and examining Jane, opined that she was incompetent to be sentenced. Jane’s case would appear to be the first in which an examiner has relied on this sort of evidence to find incompetence. Were the approach offered in this article followed, it would not be the last.

III. Measurement and Policy Considerations

Is emotional competence amenable to accurate, consistent definition and measurement? As the same question applies to all possible causes of incompetence, the real question is whether there is something about emotional disorder that makes it so different from cognitive disorder as to prevent it from being considered. While there is good reason to raise this question, the answer is no.

The search for “rational” cognition is, after all, not very different from the search for “rational” emotion; as LeDoux has pointed out, “cognition is not as logical as it was once thought and emotions are not so illogical,”²⁵ and as to both we operate with reference not to an ideal but to a rough account of the normal. People consistently exhibit non-rational decision processes and routinely make foolish choices. We are not concerned about this “everyday” irrationality; competence cares only about profoundly abnormal irrationality and assumes that we can tell the difference. This is never an easy call, even with cognitive dysfunction, but it is not significantly harder where emotional dysfunction is concerned. A defendant need not have optimal emotional health to be competent, just as she is not required to display above-average intelligence and sharp reasoning skills. But if a defendant displays extreme disorders that seriously disrupt one or more identifiable stages of minimally stable, self-protective decision-making processes, we should not care if they are cognitive or emotional in origin.

Clinical depression, in particular, is a relatively well-understood disease. What is lacking is not a strong empirical foundation for depression diagnoses; it is, rather, a strong theoretical foundation — such as that offered here — affirming that depression matters to competence, and explaining how. If courts direct examiners to make such assessments, those examiners have ready access to the diagnostic tools to comply.

The instances of brain damage discussed here are rarer and less well-understood. Still, where a strange emotional profile — particularly one of affective flatness and inability to “read” the emotional signals of others — presents together with a history of evidently self-destructive behaviors, there is good reason to suspect such disorder, raising a bona fide doubt as to competence sufficient to warrant further inquiry. Whether any resulting evidence of brain damage establishes Dusky incompetence will depend on its exact nature and the extent to which it disrupts the defendant’s ability to make sound, self-protective decisions in the context of her case.

Even if we are satisfied that we can incorporate emotion into competence determinations, we still must ask if we should. It is possible that fewer defendants will be deemed incompetent under the proposed approach, because the effort might lead examiners away from simplistic determinations — for example, de facto equation of psychosis with incompetence — but it is likely to result in more incompetence determinations, particularly of the depressed. Undue expansion of the test could both impair defendants’ autonomy and frustrate the state’s interest in public safety and law enforcement.

Structural features of the competence determination, however, largely guard against any serious threat to autonomy and public safety. In nearly every case, the consequence of an incompetence determination is not termination of proceedings: it is a delay while the defendant is evaluated and treated. Extensive delay can both curtail defendants’ freedom and weaken a prosecution case, but confinement for restoration of competence may not continue indefinitely and must be justified by treatment progress, creating incentives for timely resolution. Depression often is amenable to treatment, and in very extreme cases medical staff may administer such medication involuntarily. Evaluation and treatment also is useful for detecting malingering (which is rare). Further, even if the interest in enforcing criminal law never is vindicated, the defendant might still be incapacitated, as should she be incapable of competence restoration but dangerous to herself or others she will be subject to civil commitment. And while the potential for encroachment on autonomy is real, most defendants (particularly those with viable defenses) who truly are capable of autonomous decision-making have strong incentives to try and prove that they have been wrongly identified as incompetent, to avoid both the stigma of involuntary mental health treatment and the possibility of long-term confinement with no opportunity for a determination of guilt or innocence.

Further, to the extent that some number of defendants might escape both prosecution and confinement, that is an acceptable price to pay. This is particularly relevant to brain-damaged defendants and the treatment-resistant severely depressed, who likely will be adjudicatively incompetent for life.

Should such defendants be neither dangerous nor otherwise subject to civil commitment, they may in fact go permanently unwhipped of justice. But the number of such defendants is likely to be relatively small. They will by definition not present an imminent danger to public safety; and the ill effects of their disorders may be effectively cabined by surrogate decision-making, for example, by appointment of guardians. Such a result is far less offensive than the trial of an incompetent person in contravention of her fundamental constitutional rights.

IV. Conclusion

This article has proposed a thinking-and-feeling conception of Dusky's requirement of rational understanding. Defining and measuring the cognitive and emotional influences on defendants' decision-making processes provides a transparent, workable, theoretically sound methodology for competence determinations. Under this approach, evidence of cognitive function never should be allowed simply to trump evidence of emotional dysfunction; nor should the converse be true. Adjudicative competence doctrine and practice should strive, rather, to reflect the harmonious integration of reason and passion in the brain. This is our best hope for giving meaning to "rational understanding."

Excerpted and adapted for The Champion from an article originally published by Georgetown University and the American Criminal Law Review. Full text of the article, Emotional Competence, 'Rational Understanding,' and the Criminal Defendant, 43 Am. Crim. L. Rev. 1375 (2006), including citations, available at <http://ssrn.com/abstract=892474>.

Excerpted with the invaluable assistance of Karla Momberger, an attorney specializing in indigent defense.

Notes

1. See The MacArthur Adjudicative Competence Study, Executive Summary, <http://macarthur.virginia.edu/adjudicate.html> (2001) ("[A]djudicative competence" is a "more appropriate term than 'competence to stand trial,' given that approximately 90 percent of all criminal cases in the United States are resolved by means of guilty pleas, rather than at trial").
 2. *Dusky v. United States*, 362 U.S. 402, 402 (per curiam).
 3. Part of the universe of legal competencies (which includes capacity to consent to medical care and research, enter into a contract, execute a will, and handle one's own property and finances, as well as status-based incompetencies such as infancy), adjudicative competence includes competence to waive Miranda rights; plead guilty; dismiss counsel; stand trial and make the various decisions required during trial; pursue or abandon appeals and other avenues for post-conviction relief; and be executed. Because Miranda waiver and competence to be executed raise distinctive legal issues, they are not discussed here.
- Subsequent to this article's original publication, the Supreme Court decided *Indiana v. Edwards*, 128 S. Ct. 2379 (2008) (holding that some adjudicatively competent but mentally ill defendants may be prevented from choosing to discharge defense counsel). *Edwards* does not materially alter the analysis or conclusions herein offered. However, counsel confronted with a potentially irrational client who seeks to proceed pro se should consult that case and draw his or her own conclusions as to whether and how it applies.
4. That procedure may be summarized as follows. After a defendant is arrested and charged, any party (or the judge) may raise the issue of competence. The court will determine whether there is a bona fide doubt as to competence. If not, the case proceeds (though the process may begin again if incompetence is argued at a later point). If so, the court will order an inquiry in conformance with the law of the jurisdiction, which will almost certainly entail examination by a mental health professional in an inpatient or outpatient setting. A clinical expert (or experts) will likely submit a report and testify, and probably will opine on the ultimate issue of competence. The trial court is overwhelmingly likely to agree with the expert recommendation. If multiple experts give differing testimony, the court is likely to side with the prosecution's expert, as the burden of proof as to incompetence generally will rest with the defendant. If the defendant is found competent, trial will continue. If she is found incompetent, she will be subjected to a period of evaluation and treatment — potentially including involuntary medication should stringent requirements be met — in accordance with jurisdiction-specific timelines, bounded by an outside requirement of

“reasonableness.” Should competence at any point be restored, proceedings will resume; but should the defendant be deemed unlikely to be restored to competence within a “reasonable” time, she must be released or civil commitment proceedings must commence. During a period of indeterminate incompetence it is not clear whether the criminal charges may remain pending, or for how long.

5. Actual or suspected incompetence affects a consistently significant percentage of misdemeanor and felony defendants: it is implicated in as many as 8 percent of cases, accounts for tens of thousands of forensic examinations and admissions to inpatient medical facilities every year, and easily is the most common subject of mental health testimony in criminal cases. The consequences of an incompetence adjudication are grave: such a finding may translate into long-term confinement, particularly for those deemed dangerous to themselves or others, without opportunity for a finding of guilt or innocence.

6. *Pate v. Robinson*, 383 U.S. 375, 385-86 (1966).

7. *Godinez v. Moran*, 509 U.S. 389 (1993). *Indiana v. Edwards*, 128 S. Ct. 2379 (2008), claims not to have altered the reasoning or conclusions of *Godinez*, but they appear to be in some tension. Counsel would be well advised to consult *Edwards* in determining how to frame a *Godinez*-based argument, particularly if a client seeks to discharge counsel.

8. 509 U.S. at 394. This “reasoned choice” standard was drawn from *Rees v. Peyton*, in which the Court held that a death row inmate was competent to waive appeals only if he were shown to have “capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether he is suffering from a mental disease, disorder, or defect which may substantially affect his capacity in the premises.” 384 U.S. 312, 314 (1966) (per curiam); see also *Godinez*, 509 U.S. at 415 (Blackmun, J., dissenting) (“The standard applied by the Ninth Circuit in this case — the ‘reasoned choice’ standard — closely approximates the ‘rational choice’ standard set forth in *Rees*.”).

9. *Lafferty v. Cook*, 949 F.2d 1546, 1548 (10th Cir. 1992).

10. *In re Heidnik*, 112 F.3d 105, 109 & n.4 (3d Cir. 1997) (per curiam).

11. *Utah v. Mitchell*, No. 031901884 (Third Judicial District Court, Memorandum of Judge Judith S. Atherton, dated July 26, 2005).

12. *Drope v. Missouri*, 420 U.S. 162, 179-80 (1975).

13. See, e.g., *State v. Holland*, 921 P.2d 430, 436 (Utah 1996). See also *Liles v. Saffle*, 945 F.2d 333, 339 (10th Cir. 1991) (defendant’s history of mental illness enough to require court to hire psychiatrist for defense); *United States v. Mason*, 935 F. Supp. 745 (W.D.N.C. 1996) (denying defendant’s claim that because he attempted suicide after conviction, he had been incompetent).

14. See, e.g., *Rivers v. Turner*, 874 F.2d 771, 773-74 (11th Cir. 1989) (no inquiry by counsel warranted despite repeated and recent suicide attempts and psychiatric treatment, as defendant could communicate with counsel, understand defense strategy, and respond appropriately to questions); *United States v. Pappert*, 45 F. Supp. 2d 1231, 1235-36 (D. Kan. 1999) (history of hospitalization not sufficient to overcome impression of defendant as “lucid and rational”); *Moore v. State*, 999 S.W.2d 385, 395 (Tex. Crim. App. 1999) (hospital treatment did not per se require competency hearing); *Collier v. State*, 959 S.W.2d 621, 624-25 (Tex. Crim. App. 1997); *Myers v. State*, No. 06-04-00033-CR, 2004 Tex. App. LEXIS, at *3-5 (Tex. App. Oct. 5, 2004) (long history of bipolar disorder and hospitalization did not indicate a “severe mental illness” requiring further inquiry, in light of factual understanding of case and “rational dialogue” with counsel).

15. See *United States v. Rivera*, No. 90 CR 1001-1, 1995 U.S. Dist. LEXIS 349 (N.D. Ill. Jan. 12, 1995); see also *Commonwealth v. Goodreau*, 813 N.E.2d 465 (Mass. 2004); *United States v. Landsman*, 366 F. Supp. 1027, 1029-30 (S.D.N.Y. 1973) (depressed defendant was competent despite “expressed lack of will to assist his defense” because he had the “ability” to so choose).

16. *Rumbaugh v. Procunier*, 753 F.2d 395, 398 (5th Cir. 1985), cert. denied sub nom. *Rumbaugh v. McCotter*, 473 U.S. 919 (1985).

17. The court noted:

Rumbaugh is able to feed relevant facts into a rational decision-making process and come to a reasoned decision; ... one of the facts is that Rumbaugh is mentally ill, he has severe depression, with no hope of successful treatment, which would reduce his current mental discomfort to a tolerable level. ... [His] assessment of his legal and medical situations, and the options available to him, are reasonable[, though] if the medical situation vis-à-vis treatment were different, Rumbaugh might reach a different decision about continuing judicial proceedings. In other words, Rumbaugh’s disease influences his decision because it is the source of mental pain which contributes to his invitation of death.

Id. at 402. The court refused to conclude “as a matter of law that a person who finds his life situation intolerable and who welcomes an end to the life experience is necessarily legally incompetent to forgo further legal proceedings

which might extend that experience.” *Id.* at 403.

18. Judge Goldberg’s arguments were echoed by Justices Marshall and Brennan in a dissent from the denial of certiorari. See *Rumbaugh v. McCotter*, 473 U.S. 919, 919 (1985) (Marshall, J., dissenting). Though Judge Goldberg argued that Rees “rational choice” competence was different from Dusky “rational understanding” competence and that Rumbaugh would have been Dusky-competent, the case was decided before *Godinez*, and such comments no longer have persuasive force. See *Rumbaugh*, 753 F.2d at 411-12.

19. See Antonio Damasio, *Descartes’ Error: Emotion, reason, and the Human Brain* (1994); see also Michael S. Gazzaniga et al., *Cognitive Neuroscience: The Biology of the Mind* 537-39 (2d ed. 2002).

20. Damasio, *Descartes’ Error*, *supra*, at 9, 11 (quoting Dr. John Harlow, who memorialized his interactions with Gage in John M. Harlow, *Passage of an Iron Rod Through the Head*, 39 *Boston Med. & Surgical J.* 389 (1848-49)).

21. John T. Cacioppo & Gary G. Berntson, *Social Neuroscience*, in *The Cognitive Neurosciences III* 977 (Michael Gazzaniga et al. eds., 2004). Of course, few patients suffer brain injury because of metal rods like Gage’s tamping iron; bullets to the head, blunt trauma, and stroke are far more common.

22. *State v. Shytle*, 374 S.E.2d 573 (N.C. 1989).

23. See Pet. for Executive Clemency, Donald J. Beardslee (Dec. 30, 2004); Letter of James P. Fox, District Attorney, et al. to Arnold Schwarzenegger, Governor of California 7-8, 12 (Jan. 7, 2005); Governor Arnold Schwarzenegger, Statement of Decision: Request for Clemency by Mr. Donald J. Beardslee 3 (Jan. 18, 2005).

24. “Jane” is a former client of the author. All descriptions of Jane and her situation are based on factual statements made in publicly filed documents in her case.

25. Joseph LeDoux, *The Emotional Brain: The Mysterious Underpinnings of Emotional Life* 35 (1996).

Chapter 8
Civil Commitment
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Chapter Eight

Civil Commitment

I. MENTAL HEALTH COMMITMENTS

An individual who is mentally ill and either dangerous or gravely disabled may be involuntarily detained or committed under four statutes in Indiana.

Indiana Code Citations

- I.C. 12-26-4 outlines an immediate detention (ID). A law enforcement officer who has reasonable grounds to believe that an individual is mentally ill, dangerous and in immediate need of hospitalization and treatment has the authority to apprehend and transport a person to the nearest appropriate treatment facility. The officer must provide a written statement to the facility containing the reason(s) for the officer's decision to transport the person. The individual may be held for up to 24 hours (also known as a "24-hour hold"), unless the facility or physician files an application for an emergency detention. The person may also be charged with an offense, if appropriate.
- I.C. 12-26-5 outlines an emergency detention (ED). A petition stating the applicant's belief that the person is mentally ill, dangerous and in immediate need of restraint must be filed with the court. This statement must be supported by a physician's statement that, based on either examination of the individual or information provided to the physician, the physician believes that the patient may be mentally ill and dangerous. A judge must approve the application and subsequently issue a warrant for the person's arrest. An individual may then be detained in a mental health facility for up to 72 hours (also known as a "72-hour hold"). Before the end of the 72-hour detention period, the facility or doctor must submit a written report of the person's examination. The report must state that the person either does or does not have a mental illness that renders him/her dangerous or gravely disabled and requiring continuing treatment. If the person does not require continuing treatment, s/he shall be discharged. If the individual does require continuing treatment, a hearing must then be held to determine if continued detention is appropriate.
- I.C. 12-26-6 outlines a temporary commitment. An individual who is believed to be mentally ill and dangerous to self or others, or gravely disabled, may be committed for a period of not more than 90 days. Typically, a petition is filed with the court and supported by a physician's written statement that the physician has examined the person within the past 30 days and the doctor believes that the person is mentally ill, either dangerous to self or others or gravely disabled, and in need of custody, care or treatment in an appropriate facility. The court will schedule a hearing at which time evidence is heard as to whether the person is indeed mentally ill, dangerous and/or gravely disabled and in need of treatment. If the court finds, after consideration of the record and completion of the hearing, that the person is mentally ill and either dangerous or gravely disabled, the court may order an individual to be committed to a facility or to enter an outpatient treatment program for not more than 90 days. It is expected that the person would be discharged within 90 days. If, in the opinion of the physician, the person requires continuing treatment, a report must be filed to the court making such a

recommendation. Another court hearing is held to determine if continued treatment is needed. The commitment may be extended for an additional 90 days; if continued treatment is necessary at the end of the second 90 days, a petition for regular commitment must be filed with the court.

- I.C. 12-26-7 outlines a regular commitment for persons who are in need of treatment exceeding 90 days. This type of proceeding is initiated by filing a petition, including a physician's written statement. A hearing is held in the same manner as for a temporary commitment. A regular commitment is open-ended and does not terminate until the facility discharges the person or the court orders a termination of the commitment or a release from the therapy program. An annual report to the court must be filed which reports the person's condition and treatment plan. An individual under a regular commitment may request a hearing once a year.

Preparation for Hearing

To prepare an individual for a commitment proceeding, have someone familiar with the person give verbal notice that a commitment hearing will be held. Document the discussion in the medical record. A summons from the court will be sent to the person, too.

If the individual for whom a commitment is being sought is already in the facility, the facility may transport the person to court. An appropriate staff person should also accompany the individual. Many courts require that the person arrive before the scheduled hearing time in order to meet with the court-appointed attorney. The medical record, or a copy, may be made available to the court-appointed attorney before the hearing.

Typically, an order is issued immediately after the conclusion of the commitment hearing. It is helpful if the court-appointed attorney and facility representative both get copies and reiterate the decision and recommendations of the court to the individual.

An involuntarily committed patient may challenge a treatment they wish to refuse by filing a petition with the committing court. Annually, the individual may request a review hearing.

For re-commitment proceedings, individuals are often transported from a state operated facility back to the county in which the initial commitment order was issued. Because this transportation is often provided by the county sheriff's office, such individuals are frequently "housed" in the county jail to await the hearing or transport back to the state operated facility, even though most of such persons have no criminal charges pending. Public defenders should consider strenuously objecting to this practice as it represents a major violation of the individual's rights.

II. INFORMED CONSENT

Written, informed consent must be obtained from the client before disclosure of any confidential information. Information should be presented orally, in writing and in the terms and in a manner the individual understands.

Information presented to the individual regarding informed consent for treatment includes:

1. a diagnosis or specific signs or symptoms to be changed and how each will be monitored;

2. a description of proposed treatment, anticipated therapeutic benefits and length of treatment and the expected duration;
3. reasonable alternatives to treatment;
4. possible risks and side effects; and,
5. specific information about medication prescribed, including dose, dosage range, route of administration.

Case Scenario

John Doe is a 36 year old male. Mr. Doe was recently arrested for breaking and entering. He was very agitated and verbally aggressive with the arresting police officers. His thoughts were very confused, he was rambling and quoting biblical verses. It was extremely difficult for the police to communicate with Mr. Doe and he did not appear to understand what the officers were saying. Mr. Doe talked incessantly about needing to save the woman inside the home and protecting her from the evil spirits. While incarcerated, Mr. Doe became very agitated and began yelling for his meds. Upon inquiry, jail staff discovered that Mr. Doe is receiving mental health services from the local community mental health center and has been diagnosed with paranoid schizophrenia.

The day after his arrest, Mr. Doe was scheduled to meet with the public defender, Ms. Jones, who had been assigned to his case. Ms. Jones met with Mr. Doe in a quiet room, introduced herself, and explained to Mr. Doe what her job is. Ms. Jones asked Mr. Doe to sit down and began to ask him some very general questions in order to get to know him. She also allowed him to ask her some questions so that he could get to know her. Initially, Mr. Doe was very fearful and agitated and appeared to be very preoccupied with something in the room. It was very difficult for him to stay focused on what Ms. Jones was telling him. Ms. Jones was becoming very frustrated but recalled what was written in the arrest report and began to ask Mr. Doe some open ended questions about how he was feeling. She then proceeded to ask him if he were hearing voices and what these voices were telling him. Ms. Jones remained calm and did not rush her client and eventually learned that he was experiencing auditory hallucinations at the time that the crime was committed. In fact, Mr. Doe explained that the voices were telling him to help the elderly woman who lived next door by saving her from the evil spirits. Mr. Doe also informed Ms. Jones that he let his family borrow some money from him and he was unable to pay for his medication so he had not taken any of his antipsychotic medication for over two weeks.

Although Mr. Doe admitted that he did indeed break into the neighbor's house, the public defender was able to explain to the judge how his psychiatric disorder had effected his behavior, and asked that he be placed on diversion, where psychiatric treatment and medication compliance would be mandatory under this agreement.

Ms. Jones used the following guidelines in preparing her client for court. This seemed to be extremely helpful for both the client and public defender in reducing frustration and the amount of time spent in the legal system.

III. Assisted Outpatient Treatment

Indiana Code Citations

Ind. Code § 12-26-14-1, *et. seq.*

Under some circumstances, where an individual is mentally ill and either dangerous or gravely disabled, is likely to benefit from an outpatient therapy program (generally including medication), and is not likely to be either dangerous or gravely disabled if he or she complies with the outpatient therapy program, court-ordered outpatient treatment is an available option. Mental health facilities are also authorized to transfer committed inpatients to outpatient status based on essentially the same findings. In addition to criteria for placing an individual on AOT, these statutes also set out conditions outpatients must comply with to stay in such treatment.

Resource

Treatment Advocacy Center

AOT laws were developed in recognition that many individuals with mental illness can be stabilized on medications, but, in part as a result of their illness, are unlikely to take prescribed medication, and thus once again become dangerous or gravely disabled. The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care, including AOT, and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder. The Center can serve as a helpful resource if you believe that AOT would benefit your client.

Treatment Advocacy Center
200 N. Glebe Road, Suite 730
Arlington, VA 22203
703-294-6001 (phone)
703-294-6010 (fax)
Treatmentadvocacycenter.org

IV. Preparing a Consumer For Court

Preparation for court will familiarize the person with the proceedings and the setting. This serves to reduce fears and anxiety from being in unfamiliar places and in unfamiliar roles.

1. Introduce yourself to the person and give a short explanation of your role. Be certain the individual understands you are working for him/her, and that information shared with you is considered confidential as under the rules of attorney-client privilege.
2. Have your meeting, whenever possible, in a quiet environment with as few distractions as possible.
3. Go through legal papers which have been filed and served upon the individual and explain what these documents mean.
4. Discuss with the client what role he or she will need to play in any upcoming proceedings. If the client will need to be a witness, give the client examples of the questions that will be asked and practice having the client answer the questions.
5. Describe in detail the room where the hearing may be held. Will the client need to go to the front and sit on the witness stand, or will she be permitted to stay seated next to you? Describe where the judge and court reporter will be located and explain their roles. Do the same for other parties and witnesses who will also be present.

6. If you discover the client becomes agitated easily or is likely to be compromised by anxiety issues related to testifying, or even appearing in court, it is your duty to contact the treating staff and discuss the impact of the hearing on the client's well-being. Treatment clinicians may suggest coping skills for the stressful situation and/or review the proceedings with the client. Also, advise the Court regarding such special issues or needs. There may be ways to minimize the "formal" atmosphere of the courtroom by holding the hearing in a smaller hearing room, or even having the client appear by telephone, etc.
7. To the extent possible, do not to make or encourage disparaging remarks about the treating physicians or treatment team/facility. If, for example, you are representing your client in a commitment proceeding and the commitment is granted, the treating clinicians are the people who will be working to help the client improve functioning level and condition. It is to the client's benefit to know that the treatment team/facility are not the "bad guys."
8. Prepare your client for the type of testimony that is going to be required of other witnesses. If the treating doctor will be required to present examples of the client's "bad" behavior, or to say he or she is "dangerous" or "gravely disabled", let your client know why those words may be chosen (pursuant to the Indiana statutes) and to reiterate that the physician is under oath to tell the truth as he believes it.

The same is true of others, like family members who may be testifying. They are presumably trying to do what is in the best interest of the client, although it may be interpreted by the client as someone is "out to get them."

9. After court, meet with client, review the proceedings, and discuss next steps. Find out what remaining question the individual may have regarding the proceedings. Plan the next step.

SECTION III: MENTAL HEALTH EXPERT INVESTIGATION AND EVALUATION

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Chapter 9

Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination

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CHAPTER NINE

Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination

John Blume. Reprinted with permission from *The Advocate*, Kentucky DPA, August, 1995.

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. I 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, mitigating 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.* That is not to say, of course, that the indigent defendant has a constitutional right to choose a psychiatrist to 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.* at 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 Wye v. Murray*, 884 F.2d 765 (45th 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 mitigation

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; diagnosis 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 areas, 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 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 psychiatrist’s function, the detection of indications of somatic illness, subtle as well as striking, should 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 “[t]he 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 Filsckov & Goldstein, *Diagnostic Validity of the Halstead-Reitan Neuropsychological Battery*, 42 J. of Consulting & 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 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.

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.

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 an 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 interrelationships 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 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.

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 siblings' 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 grandparents, 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 co-defendants

- 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 clients' 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 non-existent 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 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 blameworthiness. 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 workups, 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 history 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 s/he understands the 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 anti-social 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, anti-social 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 to 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 clients' 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 cannot 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 "anti-social" 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 client's 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 anti-social 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, Posttraumatic 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 import 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 a 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 multi-step 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 multi-step process.

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Endnotes

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 not 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 psychologist, 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 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 neuroradiologist 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 scans 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 or 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, 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 is useful in convincing the court that you are not on a fishing expedition.
 14. This was also true of DSM-III-R.

Chapter 10

Decision-Rules for Integrating the Expert into the Case: A 9-Step Process

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CHAPTER TEN

Decision-Rules for Integrating the Expert into the Case: A 9-Step Process

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Deputy Public Advocate

- Step 1:**
**Assess Mental Health or
Other Expertise Needs of the Case**
- Step 2:**
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- Step 3:**
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of the Expert: Telling the Story Well**
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Cross-Examination & Improving
Cross-Examination Answers**
- Step 8:**
Revise Direct Examination
- Step 9:**
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,” 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 satisfice in order to deal with the overwhelming number of decisions and the complexity of possible alternatives. Certainly 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 paper will refer to the “mental health” expert, we believe that 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 nine-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 involve-

ment 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 recent 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. In assessing our 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, or can rebut prosecution evidence.

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;
- absent or conflicted bonding;
- 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 neglect;
- head injuries;
- poverty, homelessness, transience;
- dysfunctional family;
- attachment disturbances;
- fetal alcohol or drug syndrome;
- survivor trauma;
- rehabilitative prognosis. *Id.* at 442.

Social workers are especially skilled at methods of developing relationships and obtaining information from persons who normally would vigorously defend from disclosing themselves— 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 macrosystems 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 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 Multi-axial Inventory [MCMI]); and basic personality patterns in individuals (*e.g.*, Cattell Sixteen Personality Factors [16 PF]). A skilled forensic psychologist will 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, Fourth Edition (DSM-IV)*. 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, 80-8 1 (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: Get 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.
 6. Case law and statutes affording right to expert.
 7. Unavailability or inadequacy of available state-employed and – funded experts.
 8. 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). For help in petitioning trial court for funds to hire an expert, See IPDC’s pamphlet, *Getting Funds for Experts*, 2/07, available on IPDC website or on CD-Rom.

Step 3: 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 and *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. the 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;
15. ethical issues, including confidentiality and whether there are any conflicts with the expert, defense team, client, the case, the office or firm;
16. whether criminal defendants are amenable to treatment, rehabilitation;
17. report writing: *i.e.*, should there be a report; can a draft report be obtained; what will the report focus on;
18. timelines: when can the expert do the evaluation and report writing; when can the team give the expert the necessary information;
19. does the expert have anything to worry about on cross-examination, *e.g.*, academic difficulties, license problems, board certification, personal matters;
20. 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;
21. 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. They 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 4: 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. 94-1-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 all of my 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 5: 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, 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, and 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 6: 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 & 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 & 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. Redirect.
2. **Attorney's Leading of the Learning; 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 minimize their harm. 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 make 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); and
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, 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 7: Preparing Defense Expert for Cross-Examination & Improving Cross-Examination Answers

"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 8: 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. Role-play 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 9: 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 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 can help factfinders thoughtfully analyze a complex case and render a just decision.

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SECTION IV: DEVELOPING, PRESENTING AND CHALLENGING MENTAL HEALTH EVIDENCE AT TRIAL

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Chapter 11

Principles of Developing and Presenting Mental Health Evidence in Criminal Cases

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CHAPTER ELEVEN

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 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 addiction.)

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 of ordinary 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 Ill², 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 IssuesERROR! BOOKMARK NOT DEFINED.

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 with 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 psychosocial 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 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 be 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 psychopharmacologist (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 ERROR! BOOKMARK NOT DEFINED.

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 mischaracterization 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 un rebutted 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 neuropsychologist to perform and testify about neuropsychological 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 psychosocial 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 psychosocial 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 your 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.

Endnotes

1. John Blume, *Mental Health Issues in Criminal Cases: The Elements of a Competent and Reliable Mental Health Examination*, The Advocate, August 1995.
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.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 1994).
4. Benjamin J. Sadock & Virginia A. Sadock, eds. *Comprehensive Textbook of Psychiatry* (7th ed. 2000).
5. For an excellent article on this topic, see Deana Dorman Logan, *Learning to Observe Signs of Mental Impairment*, CACJ FORUM, v. 19, n.5-6 (1992).
6. H. J. Steadman, E. P. Mulvey, J. Monahan, et al. *Violence by People Discharged from Acute Inpatient Facilities and by Others in the Same Neighborhoods*. Archives of General Psychiatry 55:393-401, 1998.
7. See Michael Davidson, Abraham Reichenberg, et al. *Behavioral and Intellectual Markers of Schizophrenia in Apparently Healthy Male Adolescents*. American Journal of Psychiatry 156:9, September 1999.
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.
9. For more information on head injuries, see the Head Injury Hotline web site at www.headinjury.com.
10. See Ronald Conley, Ruth Luckasson and George Bouthilet. *The Criminal Justice System and Mental Retardation* (1992).
11. William J. Bowers, Marla Sandys and Benjamin Steiner, *Foreclosing Impartiality in Capital Sentencing: Jurors' Predispositions, Attitudes and Premature Decision-Making*, 83 Cornell L. Rev. 1476 (1998).
12. See *Morgan v. Illinois*, 504 U.S. 719 (1992).
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).
15. See Arlene Bowers Andrews. *Social Work Expert Testimony Regarding Mitigation in Capital Sentencing Proceedings*. Social Work 36:5, September 1991.

Chapter 12

Sources of Evidence Mental Health Issues

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CHAPTER TWELVE

Sources of Evidence/Mental Health Issues

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I. Potential Sources of Evidence

- 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.

II. Presenting and Defending Mental Health Issues

Mental Health as Mitigation

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

Direct Examination of the Defense Expert

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

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
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 – 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

Chapter 13

Sample Testimonies

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CHAPTER THIRTEEN

Sample Testimonies

DIRECT OF DR. ROBERT NOELKER by Ed Monahan
GUILT PHASE
Elzie Morton, Capital Case

THE PSYCHOLOGIST

- A. Qualifications
- B. What Have You Done With Elzie
- C. Individual Tests
- D. House/Tree/Person
- E. Bender-Gestalt
- F. Rorschach
- G. Incomplete Sentence
- H. Wide Range Achievement Test
- I. Benton
- J. WAIS-R
- K. Halstead Retin Neuropsychological Battery
- L. California Psychological Inventor (CPI)
- M. Minn Multiphasic Personality Inventory (MMPI)
- N. Results of all Your Tests
- O. Previous Tests
- P. Previous Evaluations
- Q. Interview with Elzie
- R. Diagnosis
- S. The Crimes/Mental State
- T. Bad Facts/Confessions
- U. Reemphasis of EED
- V. Stress
- W. Anger
- X. Control
- Y. His Understanding of Disorder
- Z. How Did Elzie Get This Way
- AA. Rape
- BB. Elzie's Goal
- CC. Affect/Meanness
- DD. Reemphasize Diagnosis/Mental State
- EE. Possible Questions by Prosecutor on Cross-Examination

A. 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, observation, 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

B. 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 supplied 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 test
 - Halstead neuropsychological battery
 - Benton
 - Incomplete sentences
 - 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?

C. INDIVIDUAL TESTS

1. Let's talk awhile about each individual test you administered, what it is, how administered, and results.

D. 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

E. 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

F. 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 ink-blot
 - 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

G. 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

H. 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?

I. 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

J. 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?

K. 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

L. 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?

**M. MINN MULTIPHASIC PERSONALITY INVENTORY (MMPI) (*INTRODUCE
BLOWUPS*)**

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
 - Psychopathic
 - 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

N. 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?

O. PREVIOUS TESTS (INTRODUCE BLOWUPS)

1. Has Elzie previously taken psychological tests 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?

P. PREVIOUS EVALUATIONS

1. Has Elzie been previously evaluated by mental health professionals?
2. List by who, their profession, when:
 - a. Lexington Comp Care
 - (1) Dr. Ruiz - psychiatrist
– 7/77 - 2/78
 - (1) Diane Fullenwider
– certified psychologist
 - (2) Dave Rodenheffer
 - (3) Ed McChord
– courts and jails project supervisor
 - (4) Dr. Marilyn Marx
– psychologist - 9/23/77
 - (5) Dr. Martin Gebrow
– psychiatrist - 9/15/77 & 10/13/77
 - b. VA Hospital 11/7/77 - 2/21/78
 - (1) Suzanne Dozier
– psychological nurse
 - (1) Charles Powell
– social worker
 - (2) Dr. Kenneth Moore
– psychiatrist
 - b. KCPC - 7/11/79 - 8/2/79
 - (1) Dr. Pran Ravani
– psychiatrist
 - (2) Robert Hopps
– social worker
 - (3) Dennis Wagner
– psychologist
 - c. Lagrange - 1979 - 1984
 - (1) Norb Leppert
– psychologist
 - (2) Claude Turpin
 - d. Lexington Comp Care
 - (1) Gail Trumpe-Morrow - 1984
 - e. For this Trial
 - (2) Dr. Lange, April, May 1985
3. What were their major findings?
4. How do their feelings compare to what you have found?

Q. 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)

R. 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 maladaptive 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?

S. 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?
10. 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 dissociative 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?

T. BAD FACTS (PLAY PARTS OF CONFESSION)/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?

U. REEMPHASIS OF EED

1. Explain again what Extreme Emotional Disturbance is
 - includes any psychological disturbance, 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 unpredictable 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

V. 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
 - asocial not antisocial
 - unfronted 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, decompensation
 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

W. 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?

X. 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?

Y. 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 characteristic of borderline personality disorder

Z. 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

AA. 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.

BB. 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?

CC. 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?

Testimony from some people who took confessions, that he was not bizarre, funny, unusual, strange; rather, calm, odd, flat, police, cooperative.

DD. 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 predictable and we (my profession) did nothing to reduce the chances of it happening.

MOVE TO INTRODUCE EXHIBITS**EE. 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 NOT WHAT HE DID AT THIS INCIDENT, CAN'T YOU?
 - No, see above

10. YOU CAN'T SAY HE DID NOT ACT CONTRARY TO HIS PERSONALITY DURING THIS INCIDENT, CAN YOU?
 - No, in 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 COMMITTING 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 SHORTLY BEFORE OR AFTER?
 - eyewitness accounts are scientifically unreliable total body of scientific literature in the "Psychology of Perception"
21. DON'T KNOW HOW HE APPEARED PHYSICALLY, DEMEANOR?
 - 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.

DIRECT OF DR. ROBERT LANGE by Ernie Lewis
GUILT PHASE
Elzie Morton, Capital Case

PSYCHIATRIST

- A. Introduction
- B. What is a Psychiatrist?
- C. The Personality
- D. This Case
- E. Findings out Elzie
- F. The Crime Itself
- G. Summary
- H. The Crime Itself Elzie Morton, Capital Case

A. INTRODUCTION

1. Name, present address
2. Where were you born?
3. Where were you educated?
4. What training did you receive to become a psychiatrist?
 - a. Describe the specific training you received following medical school.
5. What is a fellowship? What did you do for a fellowship?
6. What is a child psychiatrist?
7. How does that differ from someone with a traditional psychiatrists' training?
8. What are boards?
9. What does that entail?
10. Are you board certified?
11. Have you published?
12. What experience have you had in the practice of psychiatry?
13. To what professional organizations do you belong?

MOVE TO ACCEPT HIM AS AN EXPERT IN THE FIELD OF PSYCHIATRY

B. WHAT IS A PSYCHIATRIST?

1. What do psychiatrists do?
2. How is what you do different from a clinical psychologist?
3. How do you find out about a person differently from the way a clinical psychologist does?
4. In what way do you use what psychologists find out about a person?
5. What methodology do you use in order to find out about a person?
 - a. How does that differ from what a psychologist does?
 - b. Is one or the other any more or less legitimate as a way of discovering what a person is about?

C. THE PERSONALITY

1. What is it?
2. What does it develop?
3. Why is a personality important?
4. How is personality related to behavior

5. What is a personality trait?
6. What is a personality disorder?
 - a. When do personality disorders begin?
 - b. Can a personality disorder be serious?
 - c. How serious?
 - d. How debilitating can a personality disorder be?
 - e. How is this different from have a *bad personality*?

D. THIS CASE

1. How did you become involved?
2. What is the fee arrangement?
 - a. Do doctors work for free?
 - b. Does this mean we have bought your opinion in some way?
3. Of what importance is the personal interview?
 - c. How many times did you see Elzie? Was this adequate?
 - d. What do you do in such an interview?
 - e. What can you find from such an interview?
 - f. How can you evaluate someone in three interviews?
4. Other Materials
 - g. What other mental health records did you review?
 - h. Why is it important to review these?
 - i. What materials did you receive concerning the crime itself?
 - j. What else did you receive? What was the quality of the materials you received and reviewed?
5. Did you receive enough material and spend enough time with Elzie to get a psychiatric picture of him?
6. Did you do a report? Why not?
 - a. Were you available and willing to talk with the prosecution?
 - b. Would you have shared your findings with them?

E. FINDINGS ABOUT ELZIE

1. Diagnosis
 - a. Based upon this information, do you have an opinion, to a reasonable psychiatric certainty, regarding Elzie Morton's mental status? What is it?
 - b. What are the meanings of these diagnoses?
 - (1) What is a *borderline personality disorder*? Is this from the DSM-III?
 - i. How serious is this?
 - ii. Can it lead to *psychosis*? What does that mean? How is stress related to the appearance of psychosis?
 - iii. What is the most serious 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
- (2) What is a *schizotypal personality disorder*
 - i. In what way does this describe Elzie?
- (3) 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 affect feelings toward siblings? Girlfriends?
- 2. Other Diagnoses
 - a. You stated that you reviewed other diagnoses and evaluations of Elzie Morton?
 - b. Are they consistent or inconsistent with their findings with what you have stated today? Explain:
 - (1) You were aware of Dr. Ravani's analysis?
 - (2) What do you think of it?
 - c. Did you notice any progression from Elzie's first evaluation in 1977, when he was 24 years of age, and today?
 - a. The Cause
 - (1) What has caused Elzie to become this way?
 - (2) When did this develop?
 - b. 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?
- 3. How certain are you of your diagnosis?

F. THE CRIME ITSELF

1. How do you know about the crime?
2. What stress was Elzie under during the spring of 1984?
 - a. What would that stress do to Elzie?
3. What emotions were going on during the Spring of 1984?
4. What was going on with Elzie emotionally on June 8, 1984?
5. 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
6. Control
 - a. Under how much control was Elzie?

- b. Why was he unable to control himself?
- 7. Was he experiencing this personality disorder at the time of the crime?
 - a. What was the degree or intensity of his emotion that night?
 - b. What reasonable explanation or excuse was he acting upon?
 - c. What is that reasonable from his perspective?
- 8. In what way did this crime occur as a result of this personality disorder?
- 9. In your opinion did he kill her to silence her?
 - a. Why would he say that he did?
- 10. How certain are you of the opinions which you have rendered today?

G. SUMMARY (NEXT DAY OF TRIAL)

- 1. Please summarize your diagnosis of Elzie Morton.
 - a. What is your primary diagnosis?
 - b. How serious is this personality disorder?
 - c. Is this:
 - (1) A bad personality?
 - (2) A problem?
 - (3) A serious disturbance?

H. THE CRIME ITSELF

- 1. How do you know about the crime
- 2. What stress was Elzie under during the Spring of 1984?
 - a. What would that stress do to Elzie during that period of time?
 - b. Is it important to view stress from our perspective or the person's perspective
- 3. What emotions was Elzie feeling from April 6, 1984 until June 8, 1984?
 - a. What was going on emotionally at the time of the crime?
 - b. What was the degree of intensity of these emotions?
 - c. What is your analysis of the factors which contributed to the raping and killing of Lin Jung Chen?
 - d. Sexual Sadism
 - (1) Where is it in the DSM?
 - (2) This is a disorder?
 - (3) An illness?
 - (4) What does this indicate about whether he has a normal or abnormal sexual identity?
 - (5) Why is this important?
 - (6) DSM indicates that this disorder begins in childhood.
 - (7) DSM also indicates that brutality often occurs in families of individual with this disorder?
 - (8) Where does this fit with the other primary or predominant personality disorders which you have described?
 - e. How important was rage that Elzie was experience?
 - f. What is the source of the rage?
 - g. Why was Elzie enraged? At whom?
 - h. How does it make sense to kill someone you don't know due to rage at your mother, Martha Morton, and other family members?
 - i. What was the effect of the personality disorder on Elzie's behavior that evening
- 4. Control
 - a. Under how much control was Elzie on the night of June 8, 1984?
 - b. Why was he unable to control himself?
 - c. He was not insane, was he?
 - d. He was not acting, thinking, or feeling normally, was he?

5. How certain are you that Elzie was suffering from the described personality disorders, and the accompanying emotions, at the time this occurred?

Chapter 14

Sample Testimony of Forensic Social Worker

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CHAPTER FOURTEEN

Sample Testimony of Forensic Social Worker

CAROL GOOD, MSW - DIRECT EXAMINATION

by Ernie Lewis

Commonwealth v. Randy Haight, Capital Case

INTRODUCTION

Name and address.

1) Present occupation.

Associate Professor of Social Work at ECU.

2) What courses do you teach?

Introduction to social work and junior and senior field placements.

3) What other positions do you have at ECU?

- *Coordinator of Field Placement.*
- *Consultant/Trainer for the Training Resource Center Project.*
- *Consultant to Social Service Dept. at Pattie A. Clay Hospital in Richmond.*

4) Where else are you employed?

Work part-time as a social worker for Hospice.

5) What was your involvement in this particular case?

6) Why did you become involved?

7) 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 ECU 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 ECU.*
- 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 be at her shortly after they were married, and lost the pregnancy.

- 1) When did the Haight family first come to the attention of the authorities?

In 1950 the Haight family was first investigated by Social Services.

- 2) What were the issues the Haight brought before the court?

Alcohol abuse, physical abuse, and infidelity.

- 3) How did the Hights relate to their children?

They used the children to manipulate each other.

- 4) Were the Hights 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 Hight Family History, p. 10 that: “neither Mr. or Mrs. Hight will ever be able to make a home for their children. Mr. Hight is too unstable and dependent himself and is actually not interested in his boys...Mrs. Hight...is unable actually to provide a suitable emotional and physical environment for these boys.*

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?

The parents were often angry with each other and fought often both verbally and physically.

- 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?

- 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 Methodist'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 in-adequacy.

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 an 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 psychological 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 teen-age 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 birth-days?
- 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 case-worker?
- 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 appropriateness 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 15

Cross Examining the Prosecutions' Mental Health Expert

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CHAPTER FIFTEEN

Cross-Examining the Prosecution's Mental Health Expert

Kelly Gleason and 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. *See*, generally, IPDC evidence manual, Chapter 7. Some possible grounds follow:

1. **The expert is attempting to testify to the ultimate issue.** An expert may comment on the facts of the case, but must refrain from making any conclusions as to the defendant's intent, guilt, or innocence. Scisney v. State, 690 N.E.2d 342, 346 (Ind.Ct.App. 1997), summ. aff'd. on these grounds, 701 N.E.2d 847 (Ind. 1998). "Abuse of discretion has been found where an expert is placed on the witness stand, presented with a hypothetical scenario nearly identical to the case at bar, and allowed to testify as to the intent, guilt, or innocence of the 'hypothetical' individual." Id. at 345 (quoting *Ross v. State*, 516 N.E.2d 61, 63 (Ind. 1987)). This has been the rule prior to and after the adoption of the Rules of Evidence. Id.

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.”) The expert may not render an opinion beyond his area of expertise. See Clark v. State, 562 N.E.2d 11 (Ind. 1990), cert. denied, 112 S. Ct. 425 (1991).

3. **The expert may lack sufficient foundation to testify.** *See* IRE 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.** Discovery violations may also violate the accused’s rights to due process, a fair trial, confrontation, and effective assistance of counsel. See, e.g., Beauchamp v. State, 788 N.E.2d 881 (Ind.Ct.App. 2003) (State’s conduct in failing to disclose expert’s changed/augmented opinion violated both trial court’s standing discovery order and requirement under T.R.26(E)(1) that parties supplement substance of their expert’s testimony in timely fashion).

5. **The expert’s evaluation may be inadmissible as the result of a violation of the defendant’s Fifth Amendment privilege against self-incrimination.** See, e.g., Estelle v. Smith, 451 U.S. 454 (1981). A defendant who pleads insanity has no right to presence of counsel during court-ordered psychiatric examinations. Williams v. State, 555 N.E.2d 133 (Ind. 1990).

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.

* * * * *

A. 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 Judgments

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 than 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 affect 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 16

Insanity Defense Practice Aids

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CHAPTER SIXTEEN

Insanity Defense Practice Aids

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§ 44:3 Insanity practice aids

[a] Notice Of Intent To Rely On Insanity Defense

To: Assistant United States Attorney

The defendant in the above-captioned case, Louis Alzheimer, hereby serves notice, pursuant to Federal Rule of Criminal Procedure 12.2, that he intends to rely on the defense of insanity and that he will offer proof at trial that he was insane at the time of the offense with which he is charged.

Attorney for Defendant

[b] Model Questions for Expert Witnesses

The following model questions for experts in cases involving the insanity defense were prepared by Frank Jackson of Dallas, Texas. According to Jackson, if used properly these questions can gut the prosecution's cross-examination. Jackson also advises giving these questions to the expert in advance of trial in order to prepare them for trial.

Psychologist

1. Name.
2. You are a duly licensed psychologist in the State of Texas with your license to practice psychology on file with the State of Texas, as required by law?
3. Are you licensed to practice in other states?
4. Doctor, what is your education and professional background in the field of psychology?
5. You are, then, a specialist in the field of psychology, are you not?
6. Will you tell the jury what professional organizations you are a member of?
7. Doctor, I will ask you if you have examined many or few persons who were charged with criminal offenses? Have you interviewed persons accused of violent crimes or acts?
8. For the defense and prosecution?
9. What is forensic psychology?
10. Is it your professional opinion that there is a difference between evaluating a person who is charged with a serious criminal offense and one who is an outpatient and is not charged with a crime?

11. Will you tell the jury what the difference is?
12. In your practice, what is an adequate psychological assessment?
13. What importance of those assessments?
14. Now, Doctor, you have been called here to testify regarding (Defendant). Do you know him?
15. Do you see him in the courtroom today? (Let the record reflect that the witness has identified the Defendant in this cause.)
16. Doctor, I will ask you if you have, in fact, examined (caused testing to be performed on) (Defendant)?
17. Were you advised, prior to your testing of (Defendant) that he stood charged with (offense) allegedly committed on (date)?
18. When and where was it that the tests were performed?
19. What period of time did your testing cover?
20. How many hours did you spend assessing (Defendant)?
21. Will you tell us what your assessment consisted of and what the results were?
22. Doctor, did (Defendant) discuss his present difficulties with you?
23. Was he able to relate the events which led up to his present difficulty?
24. In any detail?
25. What were the important parts?
26. Now, Doctor, based on your assessment of (Defendant), do you have any opinion as to whether or not he knew right from wrong?
27. What is that opinion?
28. Does (Defendant) have a severe mental disorder?
29. Does (Defendant) have a severe disease or a defect?
30. What is your diagnosis of (Defendant)?
31. Is it consistent with your diagnosis that (Defendant) was able to discuss of the events of the offense soon after they happened?
32. Please tell the jury what a sociopath is? (explain in detail).
33. Does (Defendant) have a Sociopathic Personality Disorder?
34. What evidence leads you to that conclusion?

35. Then he is not a Sociopath?
36. Doctor, what is your prognosis in this case?
37. Doctor, does psychiatric treatment or hospitalization have anything to offer (Defendant)?
38. Then hospitalization and psychiatric treatment would be helpful in this particular case.
39. Now, Doctor, is everyone who commits the acts this defendant is charged with by definition insane?
40. You must look at the individual, I presume.
41. Do you have an opinion as to (Defendant's) present mental condition?
42. What is that opinion?
43. Doctor, how much total time have you spent assessing (Defendant) in actual interviews, reviewing background data, and in diagnostic conferences and in consultation with other psychologists?
44. Would it be possible for a psychiatrist or psychologist to make a diagnosis of (Defendant) based on one 90 minute mental status examination?
45. Is a mental status examination the very minimum that is done in a psychological evaluation?
46. What procedures would be absolutely essential to properly evaluate and diagnose (Defendant)?
47. Finally, Doctor, based on your in-depth assessment of (Defendant) and the facts of this case, tell the jury whether or not because of a mental defect of disease (Defendant) knew what he did was wrong?

(Have doctor go through above in negative.)

Psychiatrist

1. Name.
2. You are a duly licensed medical doctor in the State of Texas with your license to practice medicine on file at the Board of Registration of the State of Texas?
3. Are you licensed to practice in other states?
4. Doctor, what is your education and professional background in the field of medicine?
5. You are, then, a specialist in the field of psychiatry, are you not?
6. Will you tell the jury what professional organizations you are a member of?
7. Doctor, I will ask you if you have examined many or few persons who were charged with criminal offenses? Have you interviewed persons accused of violent crimes or acts?
8. For the defense and prosecution?

9. What is forensic psychiatry?
10. Is it your professional opinion that there is a difference between evaluating a person who is charged with a serious criminal offense and one who is an outpatient and is not charged with a crime?
11. Will you tell the jury what the difference is, please?
12. In your practice, what is an adequate psychiatric assessment?
13. What is the importance of those assessments?
14. Now, Doctor, you have been called here to testify regarding (Defendant). Do you know him?
15. Do you see him in the courtroom today? (Let the record reflect that the witness has identified the Defendant in this cause.)
16. Doctor, I will ask you if you have, in fact, examined (Defendant)?
17. Were you advised, prior to your examination of (Defendant) that he stood charged with (offense) allegedly committed on (date)?
18. When and where was it that you first performed your evaluation and examination of (Defendant)?
19. What period of time did your assessment cover?
20. How many hours did you spend assessing (Defendant)?
21. I believe you testified that you gave (Defendant) a complete mental status examination, did you not?
22. Would you have been able to form an opinion of (Defendant's) mental condition based on a mental status exam alone?
23. Will you tell us what your assessment consisted of and what the results were?
24. Doctor, did (Defendant) discuss his present difficulties with you?
25. Was he able to relate the events which led up to his present difficulty?
26. In any detail?
27. What were the important parts?
28. Now, Doctor, based on your assessment of (Defendant), do you have any opinion as to whether or not he knew right from wrong?
29. What is your diagnosis of (Defendant)?
30. Does (Defendant) have a severe mental disorder?
31. Does (Defendant) have a severe disease or a defect?

32. What is your diagnosis of (Defendant)?
33. Is it consistent with your diagnosis that (Defendant) was able to discuss of the events of the offense soon after they happened?
34. Please tell the jury what a sociopath is? (Explain in detail)
35. Does (Defendant) have a Sociopathic Personality Disorder?
36. What evidence leads you to that conclusion?
37. Then he is not a Sociopath?
38. Doctor, what is your prognosis in this case?
39. Doctor, does psychiatric treatment or hospitalization have anything to offer (Defendant)?
40. Then hospitalization and psychiatric treatment would be helpful in this particular case?
41. Now, Doctor, is everyone who commits the acts this defendant is charged with by definition insane?
42. Do you have an opinion as to (Defendant's) present mental condition?
43. What is that opinion?
44. Doctor, how much total time have you spent assessing (Defendant)-in actual interviews, reviewing background data, and in diagnostic conferences and in consultation with other psychologists?
45. Would it be possible for a psychiatrist or psychologist to make a diagnosis of (Defendant) based on one 90 minute mental status examination?
46. Is a mental status examination the very minimum that is done in a psychiatric evaluation?
47. What procedures would be absolutely essential to properly evaluate and diagnose (Defendant)?
48. Finally, Doctor, based on your in-depth assessment of (Defendant) and the facts of this case, tell the jury whether or not because of a mental defect of disease (Defendant) knew what he did was wrong?

(Have Doctor go through above in negative.)

[c] Direct Examination of Defense Psychiatrist

The following is an outline of the direct examination of Susan Fiester, called as an expert witness in Commonwealth v. Lorena Bobbitt, charging Bobbitt with the malicious wounding of her husband, John Bobbitt. The direct was conducted by Lisa Kemler, then with Moffitt, Zwerling & Kemler (now Zwerling & Kemler), Alexandria, Va. Kemler sought to have Dr. Fiester bring out background information on her client, including the nature of the Bobbitts' relationship, in an effort to show that Lorena Bobbitt was a battered spouse suffering from multiple psychiatric disorders that impaired her to the point where she

was unable to resist the impulse to commit the crime with which she was charged. The jury found Bobbitt not guilty by reason of insanity, based on irresistible impulse.

A. Expert Qualifications

1. Name/where employed
2. Specialty
 - a. What are psychiatrists trained to do?
3. Educational background/training (degrees)
4. Awards
5. Published articles
6. Published in peer review journals
7. What are peer review journals?
8. Have you ever testified in court before? (competency evaluations for the State in Mass.)
9. Have you qualified as an expert in any courts in Virginia?
 - a. Name courts
10. Have you worked with/evaluated/treated battered women? (consultant to battered woman's shelter in New Haven)
 - a. How many cases of battered women have you been involved with?
 - b. Worked forensically with battered women?
 - c. Clinically treated battered women?
11. Is there any literature and/or research on battered women?
12. Are you familiar with the literature and research on battered women? *Proffer Susan an expert in field of psychiatry and move in c.v.*
13. Based on your evaluation of Lorena Bobbitt, your review of various records and documents, your interview of various witnesses and your experience, did you arrive at any opinion as to whether Lorena Bobbitt is a battered woman?
14. What is that opinion? (put in foundation later)
15. Have you ever seen or heard of a battered woman who has severed her husband's penis?
16. Does that make this case unusual?

B. Examination-Lorena's History

1. When was your first contact with Lorena Bobbitt?

- a. What was the purpose of your examination of Lorena?
 - i. evaluate her current mental state and evaluate her for the presence of prior and current psychiatric disorders;
 - ii. take a history-why is this important?
2. How many hours did you spend interviewing Lorena?
 - a. When you interviewed Lorena were you aware that she was charged with malicious wounding?
 - b. Did you do anything different because of that?
3. In addition to interviewing Lorena, did you review any documents or records?
 - a. What were they?
4. Did you do anything to confirm things that Lorena told you? (talked to numerous individuals who knew Lorena and/or John Bobbitt and who knew of certain events or observed things)
 - a. What is the reason for talking to other people? (indep. corrob.)
 - b. Did you have an opportunity to talk with Lorena's parents?
 - c. What did you talk to them about? (her upbringing, religious and cultural values, what Lorena was like growing up, etc.)
5. Going back to your interviews of Lorena, describe how she appeared (include that she is petite, often became upset, tearful, etc.)
 - a. You described her as petite, do you know how much she weighs?
 - b. Do you know how much John Bobbitt weighs?
 - c. You mentioned that Lorena would at times become upset, can you recall what issues she became upset about?
6. Did you learn anything about Lorena's upbringing that was significant for purposes of your conclusions?
 - a. where raised
 - b. type of family:
 - i. *close knit* family, very traditional;
 - ii. *very religious-strict* Catholic, going to church was obligatory, very strong moral beliefs, very much against abortion, divorce;
 - iii. *cultural influences-if a* woman gets divorced, she is blamed ("oh what did she do wrong");

iv. lack of violence

- c. What did you learn about her values re: marriage (marriage is for life and to have children, woman is the backbone of the family, must do everything possible to keep marriage together)
7. Are these things significant with respect to Lorena?
 8. Did you learn anything that was significant regarding Lorena's relationship with her mother? (very overprotective, exerted rigid control over Lorena)
 9. What type of social life did Lorena have growing up? (dating history)
 10. When was the first time that Lorena came to the United States? (sweet fifteen)
 11. What did Lorena think about the United States?
 12. How was it that Lorena came back to the United States?
 - a. Did her parents want her to return w/them?
 - b. How was Lorena's English?
 - c. By the way, obviously, you are aware that English is not Lorena's first language, did you notice any difficulties during your interviews of Lorena due to any language problems? (nuances, some trouble accurately articulating herself, especially when upset)
 13. Who did Lorena live with after her parents returned to Venezuela? (Mrs. Castro and her daughters, Mercedes & Amaline)
 14. Were there any things that were important with respect to where she lived? (very similar environment to her own home)
 15. What was Lorena doing at that time? (school, later work)

Meeting John Bobbitt

16. When and how did Lorena meet John Bobbitt?
 - a. How old was Lorena? (19 yrs.)
17. How soon did Lorena and John start dating?
18. Was there anything significant about their dating relationship (never unchaperoned, usually he visited her at Mrs. Castro's house-Mr. and Mrs. Castro even chaperoned them to the Marine Corps ball)
19. Did Lorena describe for you her feelings about John during the time they were dating?
20. What was significant to you about her feelings? (she was completely infatuated with him-saw him as her knight in shining armor-American military man, handsome, etc.)
21. Was there any physical abuse or verbal abuse during their dating relationship? (no)

22. When did they get married? (June 18, 1989)
23. Let's talk about their marriage, where did Lorena and John live after they got married? (small, one room apartment in Manassas)
24. Where was Lorena working at that time?
 - a. What kind of hours did she work?
25. Was John still in the Marines?

History of Abuse In Marriage

26. Was there anything that occurred early on in their marriage that is significant from your point of view? (John never discussed anything w/Lorena-didn't care about her feelings, her opinions did not count, e.g. inviting his brother to move in with them without discussing w/her)
27. Why was this a problem for Lorena?
28. Was there a change in the relationship between John and Lorena? (physical abuse began)
29. Can you describe this violence?
30. When was the first episode John physically beat Lorena? (July, 1989-within one month after marriage)
31. Please describe the circumstances of this beating (driving home from D.C., zigzagging, started in car, continued at home when he yanked her into apt., drove her into the wall by the force of his kick)
32. Was there something else significant about Lorena's response to this violence? (she was shocked)
33. Why is that significant? (he was her everything)
34. What injuries did she sustain as a result of this attack?
35. Was this attack and her injuries confirmed by anyone? (yes)
36. What, if anything, did Lorena do after this attack?
37. When was the next time that John Bobbitt attacked Lorena? (1 mo. later)
38. Please describe the circumstances of this attack (Lorena complained about John's brother living w/them and Thanksgiving plans-John came home, had been drinking & threw up in closet-he slapped her in face, yelled at her to shut up, pushed her around when she tried to talk to him)
39. After this second attack against her, did Lorena's husband abuse her in other ways? (began to verbally batter her)
40. What do you mean by verbal battering? (taunted her with negative criticism, made very demeaning comments)
41. Can you give some examples of this? (couldn't speak English, she was ugly, small, not blonde,

- small breasted, didn't understand because of cultural differences, etc.)
42. You testified earlier that Lorena Bobbitt is a battered woman. In this regard, is this verbal battering significant to you?
- a. How so? (low self-esteem, poor image of herself, made her more dependent on him)
 - b. Were there things in her upbringing that made her susceptible to becoming more dependent on her husband?
43. With respect to the physical violence Lorena suffered at the hands of her husband, can you describe the kinds of things he would do to her? (slapping her on the face, striking her on the skull, grab and yank her, push and shove her around, squeeze her face, shove her into the wall, yank her hair, practice martial arts techniques he had learned from watching Jean Claude Van Dam and Bruce Lee movies, head butts, dragging her, choke her, cause rug abrasions on her legs and arms, punch and kick her, etc.)
44. Would Lorena ever try to escape from these vicious attacks?
45. Can you illustrate that for the jury? (she would try to run, retreat into the bathroom or bedroom and on one occasion, tried to make herself small enough to fit under the sink in the bathroom)
47. What, if anything would John do? (used his knowledge from Marine training to make it impossible for her to get away)
48. By that what do you mean?
49. Can you describe how often these beatings and attacks occurred? (escalating frequency)
50. What, if anything, did you do to determine whether Lorena was being truthful with you about these events? [To confirm what she told you] (reviewed medical reports, records from Marines, court records of John's assault charge, talked to witnesses, etc.)
51. Was there an escalation in the severity and frequency of the beatings? (twist arm behind her back, push her to floor, throw himself on top of her)
52. Did Lorena ever go to the hospital as a result of being beaten by her husband? (Potomac Hospital- John went with her, told the doctors she had fallen down stairs-CONTROL)

Other Stressors

53. Were there other stressors on this marriage? (they purchased a house in Spring of 1991-in Manassas-Pine Street)
- a. Large mortgage (\$1400/mo.)
 - b. John left Marines three months after purchase.
 - c. His employment became erratic-financial problems.
54. Why did Lorena agree to purchase the house?
55. What else is significant to you regarding this time period? (violence took on a much more

ominous turn)

- 56. What do you mean by ominous? (sadism)
- 57. Sadism? What do you mean?
- 58. How was it connected with sex? (forced anal sex)
- 59. What would happen if Lorena told her husband that she did not want to have sex when he wanted to? (verbally insult, physically beat, force sex)
- 60. Did he ever try to have sex with her following a beating? (after beating, he would often comfort her and then try to have sex)
- 61. Did she ever do anything to try to prevent him from forcing himself on her? (locked herself in the bedroom-he used screwdriver and knife to force door open and physically struck her, often she would try to keep her legs shut, cried, etc.)
- 62. Were there other occasions when she attempted to keep him from forcing sex on her? (she would try to run, but he chased after her from room to room, once she locked herself in the house, but he kicked down the back door)
- 63. What kinds of sex did her husband force on her? (anal sex, not only did he do this to her, but he held it out as a threat if she did not agree to have sex)
- 66. Did you learn anything about when these incidents would happen? (while or after John watched pornographic movies)
- 67. Did they ever have consensual sex? (yes, but on many occasions, Lorena would simply become submissive so as to avoid being beaten)

Pregnancy and Abortion

- 68. Was there anything else important that occurred during this period of the marriage? (pregnancy)
- 69. How did Lorena feel about being pregnant?
- 70. How did John react? (went with her to the clinic and told her that it would be extremely painful)
- 71. What effect did his reaction have on her? (frightened her even more)
- 72. Did she discuss her options with anyone? (family, friends)
 - a. Why not (shame, humiliation, embarrassment, religious and family values against abortion)
- 73. What ultimately did Lorena do? (agree to have abortion)
- 74. How did she feel following the abortion?

Separation

- 75. Did you learn anything else about events in their marriage that was significant for your purposes? (John's affair)

76. How did Lorena react?
77. What, if anything, did John do? (left for 6 wks. or 2mos. leaving her w/mortgage and large credit card bills)
78. Was there any contact between them during this separation? (telephone contact every week)
79. Why would Lorena, who had been repeatedly beaten and abused, raped and verbally attacked for 2 yrs. by this man, stay in contact with him? (typical for battered woman-continues to love husband and hope they can "work it out")
80. What ultimately happened? (reconciliation)
81. Following their reconciliation, what, if anything, did John do that is significant? (second affair)
82. Did Lorena find out about this? (John said an experiment to see which woman pleased him more sexually)
83. What, if anything, did she do? (learned other woman's id. and confronted her)
84. Did John find out about her conversation with this other woman?
85. What happened? (violent attack)
86. Did Lorena sustain any injury from this violent and brutal attack by John? (confirmed by pictures taken by Mercedes Castro and sent to Immigration)
87. Did anything else happen at that time? (separation for 1 yr.)
88. Where did Lorena live during this period of time?
89. During this separation period, what, if anything, happened to their house?
90. Did Lorena have any contact w/John during this separation period?
91. Again, given everything that had occurred, what possible reason would she have for staying in contact with this man? (he was her life, her best friend, her family-family was everything to her)
92. Did you perceive anything that indicated John still exercised control over Lorena during the separation?

Reconciliation

93. When did she next see John? (5/92-showed up unannounced)
94. What happened?
95. Did she ultimately agree to get back together w/John?
96. Where did they live?
97. What was their relationship like during this time? (He soon resumed beating her, escalation in verbal abuse)

98. Did Lorena report these incidents to anyone? (only revealed a little information)
99. Was there anything significant about how Lorena felt about her marriage and what was happening to her?
100. Did there come a time when Lorena and John moved into their own apt.?
101. By this time, how frequent were the physical and sexual attacks against her? (twice/wk.)
102. In addition to the bruising, abrasions and knots to her head, etc. that she sustained, were there other significant effects of the violence? (other physical manifestations-stomach problems, shaking, hyperventilating, etc.)
103. Did Lorena attempt to get any counseling?
104. Was there any discussion about divorce or separation?
105. How did John respond? (threatened to follow her, surprise her, force her to have any kind of sex whenever he wanted it)
106. Did Lorena express her feelings to anyone? (apt. manager, friends)

Week Before Event

107. Please describe the week just prior to June 23.
 - a. Visits to Bonnie Alexander-crying, shaking, upset
 - b. Visit to Dr. Inman for hyperventilation and cramping of fingers
108. Had she taken any steps to move out of the apt?
109. Please describe (packing, moved some things to friends)
110. What, if anything, happened on Sunday? (consensual sex to avoid a fight)
111. What else happened that day? (John's friend Robbie came to visit and stayed in the apt., argument)
112. What did Lorena do on Monday? (applied for protective order)
113. Describe what she did in the evening of Tues. June 22. (declined neighbor's offer that she stay w/her because she felt she had made the decision to leave and thought she'd be safe since Robbie was staying in apt.)
114. Please describe what Lorena told you about what happened after she returned home on the evening of June 22. (Went to sleep while John was out, awoke to find him raping her. Despite plans to move out, Lorena felt trapped because he had threatened to find her if she left. She went to the kitchen to get a glass of water to calm down, but a sudden "flood of memories" of abuse overcame her. She picked up a knife on the counter and returned to the bedroom. She doesn't remember anything else until she was in her car at a stop sign and realized John's penis was in her hand)

115. What, if anything, were you able to discern about her state of mind immediately following the rape?
116. Does Lorena have a specific recollection of what she did that night? (no)
117. Explain what you mean (hands busy)

C. Medical Diagnosis

Let's shift focus now for a bit-

1. You testified that, in your opinion, Lorena is a battered woman. What does it mean to be a battered woman?
2. Can you describe what happens in a typical battering situation? (cycle of violence)
3. What happens to women who are repeatedly battered and beaten, raped and verbally assaulted by a loved one over a long period of time?
4. Is battered woman's syndrome a mental illness?
5. How is it psychiatrically significant? (the person develops severe psychiatric disorders)
6. What kinds of disorders might a woman in such a situation develop?
7. Are you familiar with this book? (DSM III-R)?
8. What is it?
9. What are axis I disorders? (most severe)

Expert's Opinion

10. Do you have an opinion, based on your training and experience, and based on a reasonable degree of scientific certainty as to whether Lorena Bobbitt had any psychiatric disorders that she developed during the period that she was violently and brutally abused by her husband?
11. What are they? (major depressive illness, panic disorder, PTSD and Brief Reactive Psychosis)
 - a. Are these is Axis I disorders?
12. Let's take them one by one-What is major depressive illness?
 - a. is this a severe mental disorder?
13. What symptoms did Lorena have? (depressed mood, weight loss, sleeplessness, tearfulness, etc.)
14. What is PTSD? (intrusive thoughts, avoidance & arousal)
 - a. Is this a severe mental disorder?
15. When did Lorena experience PTSD?
16. Please describe

17. Is it common for people who have experienced an extremely traumatic event or events and have suffered PTSD to have difficulty remembering the event?
18. Is there literature in the field with respect to this problem?
19. Panic Disorder-what characteristics of panic disorder did Lorena exhibit? (panic attacks)
 - a. Is this a severe mental disorder?
20. How did you determine that all of these disorders were present in Lorena? (extensive interviews)
21. Is this a good way to determine whether a person has certain disorders?

Testing

22. Once you had this information, did you feel you needed to do something else to learn more in order to confirm any ideas you had about what was going on with Lorena, at the time of the incident? (psychological testing)
23. What, if anything, did the psychological testing reveal for your purposes? (borderline intellig, projective testing, MMPI-2, neuropsychological screening)
24. Based on all of the information that you had, do you have an opinion, based on a reasonable degree of scientific certainty as to whether Lorena Bobbitt was suffering from a severe mental disease or defect prior to and at the time of the incident where she cut off her husband's penis?
25. What was she suffering from? (include Brief Reactive Psychosis)
 - a. What exactly is BRP?
26. What does the word psychotic mean?
27. How does brief reactive psychosis relate to the other three disorders?
28. Was Lorena particularly vulnerable to such a mental disorder? Why?
29. What coping methods did Lorena have?
30. Is there any evidence regarding the week prior to the cutting that you find significant?
31. Given that Lorena suffered from these disorders, what, if anything, did they have to do with her ability to control her impulses on the night in question?
32. Why, after having coped for four years, having made the decision to leave, having actually packed her bags, applied for a restraining order, etc., did she do what she did? (Passover question-pushed over the edge, etc.)
33. Was Lorena angry at the time she cut off her husband's penis?
34. Does the fact that she was angry change your opinion in any way?
35. Why not?

36. Is what Lorena did immediately after the cutting in any way significant in your opinion? (bizarre behavior)
37. Is Lorena, as she sits here today, suffering from any mental disorders? (yes)
38. Do you have an opinion as to what, if any, impact this event has had on Lorena?
39. As she sits here today, is she a danger to herself or to others? (no)

[d] Cross-Examination of Government Psychiatrist (Florida)

Jerrie Baist was charged in state court in Florida with the first-degree murder of her husband, a mailman, whom she shot some 13 times in broad daylight as he was delivering mail on his route. She asserted a defense of insanity, claiming that the knowledge that custody of their nine-year-old child was to be given to her husband drove her into a "dissociative state" and that it was in that dissociative state that she killed him.

Milton Hirsch, Miami, who represented Baist, describes the case as follows: "The prosecution called two psychologists and one psychiatrist to establish Jennie Baist's sanity at the time of the offense. One of the psychologists was readily impeached on grounds of professional incompetence (after my cross-examination, the judge directed that the witness not be used by the Dade State Attorney's Office in future cases), and the other on grounds of bias (he always testifies for the prosecution). The psychiatrist, however, was a thoroughly competent, highly-respected, and fair-minded expert. His cross-examination had to be conducted with delicacy. You will see that there is no thunder and lightning in this cross; my tone was respectful, I did not argue with Dr. Miller, and I always permitted him to complete his answers. Much of what he said was not what I wanted to hear, but in the end he acknowledged that there was reasonable doubt about Mrs. Baist's sanity, which was all that I could have hoped for and more." (Ultimately, however, Baist was convicted of first-degree murder.)

- Q. You were aware, Doctor, of Mrs. Baist's history, were you not, her medical history?
- A. Yes.
- Q. You were aware that for three years or more she had been repeatedly diagnosed with symptoms like persistent and continuing anxiety, stress, depression, hypertension, insomnia. You were aware of that?
- A. I was available-that was available to me, back problems. Stress post Hurricane Andrew, difficult marital relations.
- Q. And you-did you see Doctor Silverberg's records and deposition?
- A. No. I don't believe so.
- Q. Did you take those into consideration in forming your opinion?
- A. If I didn't see them, I couldn't consider them. It doesn't ring a bell.
- Q. You were also aware that some years back Jerrie Baist had [been treated by] a psychiatrist in the Kendall area by the name of Lawrence Cohen?

- A. That's correct. She told me that.
- Q. Do you know Doctor Cohen?
- A. I do by good reputation. I have not seen him lately. I don't know what he's up to.
- Q. Did you call him and ask to consult with him regarding his records and reflection on Jerrie Baist?
- A. No, I didn't.
- Q. Did you ask him to send you his reports?
- A. I didn't contact him.
- Q. Your office is right around the corner, isn't it?
- A. It is.
- Q. With whom do you share space?
- A. My landlord is Charles B. Mutter, M.D.
- Q. Doctor Mutter was in here the other day.
- A. Yes.
- Q. Do you profess any expertise in hypnosis, Doctor?
- A. No, I don't.
- Q. You're familiar with Doctor Mutter's credentials on hypnosis?
- A. As many as I can read, but I have not read them all.
- Q. He's one of the best in the business. Correct?
- A. I consider him an expert in a field that I don't consider myself to be an expert in.
- Q. You are aware he performed hypnotic regression of Jerrie Baist. Correct?
- A. Yes.
- Q. That lasted about an hour and half, two hours in duration. Are you aware of that?
- A. I don't know the duration.
- Q. Were you aware that that was videotaped?
- A. Yes.
- Q. And that a transcript was made of the videotape?

- A. That I don't know.
- Q. Did you look at the videotape?
- A. I didn't.
- Q. Did you read the transcript?
- A. No.
- Q. You were not provided either of those things by the prosecution?
- A. No.
- Q. Do you consider the possibility that having reviewed those things you might want to rethink your conclusion?
- A. The answer is, if I have not read it or reviewed it, it would be hard to scrutinize it. I'm comfortable with the opinions that I express and the jury's to decide whose opinions are right or wrong. I just should check my opinions and base them on the conclusion that I have based on the opinions and the materials I had available to me. If they think that is insufficient, so be it. But Doctor Mutter did see her after the offense which puts her in the same category as myself. That is, doctors who did not know her before the offense and trying to draw conclusions about her sanity, so I consider ourselves equal as well as any of the other doctors who saw her after the offense.
- Q. And while Doctor Mutter employed a tool that you did not. That is hypnosis. Correct?
- A. Yes.
- Q. And did you not review the video?
- A. I did not review the video.

Dissociative State

- Q. You are well familiar, Doctor, with the phenomenon known as dissociation or dissociative state?
- A. Yes.
- Q. Would you explain to the jury in layman's terms what that means?
- A. A dissociative state or reaction is one in which a person disorganizes somewhat and demonstrates unusual behavior for them. It can be a fuge state which is wandering about. It can be other forms of minor or major amnestic episode.
- Q. Amnesia means losing your memory?
- A. Losing your memory and then coming back to where they were before at some point in time, and it's associated more in people who are not suffering with major mental illnesses.
- Q. People who are not suffering with major mental illness?
- A. Right.

- Q. Is it sometimes associated with people who are suffering from anxiety disorders?
- A. Yes. Hysteria, anxiety.
- Q. That's relatively common, is it not?
- A. Well, I don't know the common-the percentage of it. I would say that it's something that could happen to anyone. And in that respect even to a minor degree, it could be a common event. Perhaps a witnesses before trial could have a little of it.
- Q. Lawyers, too?
- A. Lawyers, too, only to a minor degree, sure. It depends on the stressors upon the person.
- Q. Would it be fair to say dissociative state is often triggered by traumatic stress?
- A. Yes, it can be. It doesn't have to be, but it can be, sure.
- Q. Could the prospect of the mother losing her child be a sufficient traumatic stress to precipitate dissociative state?
- A. I wouldn't rule it out.
- Q. Would you agree with me that amnesia is a common symptom of dissociative state?
- A. Yes, I think it would be something I would anticipate to look for in dissociative reaction.
- Q. Would you agree with me also, Doctor, in an [sic] dissociative state a person would often engage in conduct that would be out of character for them otherwise?
- A. Yes. Not necessarily, but it can happen.

Defendant's Medication

- Q. Okay. Let's take the sequence of events, Doctor. You're aware that Jerrie Baist was arrested for shooting her husband on August 5th, 1994. Correct?
- A. Yes.
- Q. And she's been continually incarcerated in jail since that time?
- A. That's right.
- Q. She was seen by the court-appointed doctors, Doctors Rose, Thomas and Oshodi, in late October or early November of 1994. Correct?
- A. I don't know the dates.
- Q. Within say, roughly, three months of her arrest?
- A. All right.
- Q. And seen by Doctor Mutter at about the same time?

- A. If you say so.
- Q. Then a year went by and you were asked to see her after she had been in jail for about 15 months. Correct?
- A. That 14 months or so.
- Q. Now, it's my understanding that during the time she was in jail, she was administered a drug called Buspar, B-u-s-p-a-r. Is that correct?
- A. Right. Buspar.
- Q. Thank you. She was given 10 milligrams twice a day?
- A. If that was what was on the order sheet.
- Q. Okay. I'm the world's worst at math, Doctor, so help me out. Ten milligrams twice a day times 14 months in jail works out to about a thousand doses of Buspar, doesn't it? 900.
- A. Your math may be better than mine.
- Q. Does that sound like I'm in the neighborhood?
- A. Let's see. About 500-anyway, it's hard for me to come up with that number.
- Q. A total of about 10,000 milligrams of Buspar?
- A. It was a thousand administrations, it would be 10,000 milligrams.
- Q. Ten thousand milligrams. I have no idea. Would that fill a wheelbarrow?
- A. Probably not.
- Q. A little less than that?
- A. It would be quite a bit less, unless it was in its plastic container.
- Q. It's a lot of Buspar?
- A. It's a lot of Buspar if you took it at once.
- Q. It would be a lot of anything if you took it at once, Doctor.
- A. You wouldn't be able to beat the wheelbarrow. That's for sure. That's for sure.
- Q. Buspar is a psychotropic drug?
- A. That's right, non-addictive psychotropic medication.
- Q. Prescription drug?
- A. Prescription, used for anxiety.

- Q. I take it that has to be prescribed by a medical doctor, particularly a psychiatrist?
- A. It would have to be a psychiatrist probably. Most of the medicine of this type is prescribed by a G.P. or psychiatrist. It just depends on where the patient goes first for treatment.

Effect of Medication

- Q. Did you, in reaching your conclusion, talk to Doctor Renosa, the jail psychiatrist?
- A. I didn't.
- Q. How about Wendy Silva, the jail psychologist?
- A. I didn't talk to her.
- Q. Did you consider the possibility that 15 months after she shot her husband, 10,000 milligrams of Buspar later, Jerrie Baist may be a slightly different person than she was on August 5th?
- A. I took into consideration that the person I'm saying was the person I'm seeing October 31st and whatever she did, however she was, I would have to go back in time and try to think into my mind what may have been going on with her back then. I don't know that necessarily it was the medication that would have made her that much different. Just being in jail for 14 months is sufficient to affect a personality.

Interview with Defendant

- Q. I take it, Doctor, that throughout your clinical interview you did not ever lie to Mrs. Baist, did you?
- A. Not purposefully. I would think not.
- Q. You didn't lie to her, did you?
- A. No, I don't think so.
- Q. She didn't lie to you, as far as you know?
- A. As far as I know, for the things that I could verify, no, she didn't.
- Q. She told you the truth as far as you were able to verify?
- A. That's right. Things like having previous doctors to see, her medications, gave correct answers to the questions of mental status, her history, all appeared to be verifiable and accurate.
- Q. She even admitted to some things that might have been embarrassing or troubling for her, didn't she?
- A. Yes, that is possible.
- Q. And you did ask her about the early years of her marriage. Do you remember that?
- A. To the best of my knowledge, yes.
- Q. Okay. And you asked her what she did in the early years and she said, "I was a mommy." Do you

remember that?

A. I don't remember specifically that as a quote, but I believe that her daughter was born very close to the time of the marriage. And she was indeed a mommy in the early years of her marriage.

Q. Would it be fair to say to a substantial extent Jerrie Baist defines herself as a mommy

A. She may have at one time. When I saw her, she seemed to be proud that she was a nurse, but that that degree came in 1985, I believe.

Goal-Oriented Conduct

Q. You described in your direct examination, Doctor, her engaging in goal-oriented conduct. Do you recall that?

A. Yes.

Q. Ms. Hoague asked you some questions and you used the phrase goal-oriented conduct?

A. It's not one of my favorite phrases, but it's-

Q. I'm not crazy about it either. Let's work with it for a minute. Let's assume for my questions that I'm getting divorced and the thing I want most in the world is to hang on to my little boy and not lose him. Okay? Would you agree with me it's an example of goal-oriented conduct for me to go out and hire the best darn divorce lawyer I could?

A. Yes.

Q. Because a good divorce lawyer might be able to help me reach my goal of hanging on to my little boy. Right?

A. That's right.

Q. Would you agree with me it would be an example of goal-oriented conduct to see to it that appropriate documents and evidence were provided to the judge who had charge of the divorce case?

A. Yes, if they were favorable to you.

Q. Yes. Because the judge presiding over the divorce case has power to see to it that I do get to keep my little boy. Correct?

A. That's correct.

Q. Would you agree with me that it's not a good example of goal-directed or goal-oriented conduct to go out and shoot my spouse in broad daylight in front of a lot of strangers if my goal is to keep custody of my little boy?

A. Right. If your goal is to keep custody of your little boy, you go back to your high priced lawyer and back to the judge and get another doctor, go about your business and fight the case in the courts.

Q. Was it your conclusion that Jerrie Baist was mentally distraught at the prospect of losing her son?

Page four of your report.

A. Yes.

Writing Reports

Q. Doctor, I take it I'm safe in assuming that you can consider the work that you do in the criminal courts to be extremely important and serious?

A. Yes, I do.

Q. And that when you do that work you bring to bear all your very considerable experience and expertise?

A. Yes, sir.

Q. And you try to be as exacting and as careful as possible?

A. I try to be.

Q. And that extends, I trust, to the writing of your report? You try to be exacting and careful in the writing of your report?

A. Yes, sir.

Q. Because the report may be reviewed by the judge himself. Correct?

A. That is correct.

Q. So I'm on safe ground in assuming that in the report that you wrote your language is carefully composed and exact and scrupulous. Correct?

A. It's my best effort.

Q. Now, in your report, you said that Jerrie Baist suffered from symptoms of anxiety disorder. Correct?

A. Yes.

Q. And anxiety disorder is a mental disorder?

A. Yes, it is.

Q. You describe her at the time of the offense as being distraught and upset? Page two of your report, Doctor.

A. I said she has been distraught and upset and I would stay with that opinion.

Q. Okay. And specifically you said mentally distraught at the prospect of losing her son, aggravated by a history of spousal abuse such as to affect her judgment. Is that correct? Page four.

A. At the bottom of the page?

- Q. Did I quote it right?
- A. Yes, you did.
- Q. Good enough. And having said all that, you concluded on page two of your report she was not necessarily insane at the time that she shot her husband. Is that the language that appears in your report?
- A. Right you said not necessarily insane but not necessarily out of contact with reality.
- Q. Same thing, no different?
- A. A little different.
- Q. A little different?
- A. Little different.
- Q. Do you leave open the possibility that she may be insane?
- A. I would leave open the possibility. I grant the jury that which they earn by right of listening to all the testimony.
- Q. I understand that. But as far as the exercise of your professional discretion, you leave open the possibility that she may have been insane?
- A. And this is - I believe she is sane within a reasonable degree of medical probability. That is the standard that I'm asked to give her. If you say, "Well, medical probability, what is that? Seventy-five percent; does that mean 25 percent is the other side?" I suppose you could argue that. But I believe her to be sane with material that I have available to me.
- Q. Is that what we call in the law a reasonable doubt?
- A. That would be- I think that would be.

[el Cross-Examination Of Government Psychiatrist (New York)

In People v. Riccardi, Joyce David, Brooklyn, represented Michael Riccardi, charged with stabbing the Rev. Al Sharpton, a prominent community activist, with a steak knife during a protest rally in a Brooklyn school yard. Riccardi was charged with attempted murder, but convicted of assault and third degree criminal weapon possession. David, speaking at a program sponsored by the New York State Association of Criminal Defense Lawyers in 1993, noted that after a defendant gives notice that he will be pleading insanity or using psychiatric testimony, the prosecution has the right to have the defendant examined by its own expert and the defense attorney is entitled to be present. In the Riccardi case, she was present for the interview by Dr. Larry Siegel, which lasted about an hour. David said the psychiatrist only took a couple pages of notes and did not write down word-for-word what the client said. He generated a report about four months later.

David said Siegel "was very hard to pin down" so she decided that "the way to pin him down was to show what he had not done, to show, for example, that he was provided with information from the D.A. and he chose to use some information and not other information." For example, David said, the

witness admitted that he always assumes that the client is lying, but chose to credit Riccardi's statement that there was nothing wrong with him. The doctor also chose to ignore statements from police witnesses that Riccardi was drunk, and did not ask him how much he had been drinking prior to the incident.

The following are excerpts from David's cross-examination of Dr. Siegel, who was called to rebut the client's insanity defense.

Report Followed Interview by Months

- Q. Dr. Siegel, what are the things you reviewed, what is the data that you reviewed to formulate your opinion that you've just testified to?
- A. I reviewed [defense psychiatrist] Dr. Teich's report, spoke with Mr. Riccardi and then I reviewed police reports, the videotapes made by Dr. Teich, some of his handwritten notes, notes of conversations he had with others, various hearing testimony, some school records.
- Q. Is that the extent of it?
- A. Huntley hearing transcript, yes.
- Q. And when you interviewed Mr. Riccardi back in October you made notes of your interview?
- A. Yes.
- Q. And between the time you made the notes of your interview and the time you drew up your report was about four months, was it not?
- A. Yes.
- Q. And during that period of time about how many other people did you evaluate or interview in some fashion?
- A. I don't know. Say maybe a hundred or so.
- Q. And when it came time to write your report in this case you had your own notes of your own interview; is that correct?
- A. Yes.
- Q. Which you made so that you could refresh your recollection at a later point in time; is that correct?
- A. I always make notes when I do forensic evaluations and I often refer to them to refresh my recollection, yes.
- Q. When you were making your notes of this interview did you take down word for word everything Mr. Riccardi said to you?
- A. No.
- Q. About how much percentage-wise would you say you got in your notes?
- A. I don't know percentage-wise. I took down past history, I did a mentality status evaluation and I

took down what he told me about the alleged offense, and his recollections.

Q. Now, part of the hour that you spent with him you spent doing certain tests like asking him to remember certain objects, you remember that?

A. Yes.

Q. Math questions?

A. Yes.

Q. Questions about the president, those kinds of standard things, right?

A. Part of the mental status examination, yes.

Q. So would it be fair to say that your discussion about his background and the incident was maybe forty-five minutes and the rest were these tests?

A. Well, the mental status examination usually takes between five and ten minutes. So yes forty-five to fifty minutes.

Experts Always Explain

Q. Let me ask it as a question this way. Isn't it a fact that you approached your evaluation from the position that the person you're interviewing is lying to you?

A. Well, I approach my evaluation as a forensic psychiatrist. If I could explain, when one is doing treatment, the individual who comes to see the psychiatrist has something that's bothering them. And the doctor and the patient collaborate in trying to find out what the doctor can do to help the person get better.

Now, in doing a forensic evaluation, child custody, competency to stand trial, criminal responsibility, it's clear at the beginning of every examination I do for the courts, I tell the person the purpose of the evaluation and that it's not confidential. In that instance the individual knows something will happen to them, that they -

Q. May I interrupt? I ask that you answer my question. That is not responsive.

I asked you, isn't it a fact that you approach your evaluation from the position that the person you are evaluating is lying to you?

A. I approach it that what they say I should not rely upon, I should always seek outside sources.

Q. Well, didn't you, in fact, indicate at that meeting I referred to, that you approached the evaluation from the position that the person you're evaluating is lying to you?

THE COURT: Asked and answered.

MS. DAVID: Actually I am impeaching his answer.

THE COURT: You see, Ms. David, psychiatrists are a special breed as you saw with Dr. Teich and as any other psychiatrist, they can't say yes or no. They have to explain. And Dr. Teich can't say yes or no and he [Dr. Siegel] apparently can't say yes or no.

MS. DAVID: I am asking Dr. Siegel if I made that statement at that meeting.

Q. Did you make the statement that you approached your evaluation from the position that the person you're evaluating is lying to you?

A. I always assume that the person can be lying, yes.

Q. Now, in order to determine whether or not the person you're evaluating is lying to you, you would try to verify the information given to you; isn't that correct?

A. That's often important, yes.

Didn't Need to Talk to Family Members

Q. And one way of verifying information is to do independent interviews; isn't that correct?

A. Yes.

Q. To interview family members?

A. Yes.

Q. Did you interview his mother?

A. No.

Q. Did you interview his father?

A. No.

Q. Did you interview his cousin?

A. No.

Q. Did you interview any of his brothers and sisters?

A. No.

Q. Did you interview anybody who knew Michael Riccardi when he was growing up?

A. No.

THE COURT: You relied on Dr. Teich's tapes as well the videotapes?

THE WITNESS: Well, I didn't need to speak to any of his family.

MS. DAVID: Objection, you Honor.

THE COURT: Just yes or no.

THE WITNESS: Yes, I relied on Dr. Teich's tapes as well, yes, I did.

Q. Now, rather than doing independent investigation, you chose to rely on interviews by somebody

else, is that what you're saying?

A. No.

Q. Well, you chose not to interview any member of his family; isn't that correct?

A. That is correct.

Q. Did you even attempt to interview any member of his family?

A. No.

Q. And the total extent of your interview of Mr. Riccardi was between forty-five minutes and an hour?

A. It's an hour.

Q. An hour?

A. Yes.

Q. Now, you didn't videotape your interview, did you?

A. No.

Q. And so when it came time to write your report, you didn't have a videotape or a replay of your entire interview, of your interview upon which to base your report; isn't that correct?

A. That's correct.

Q. Just what you put down in your notes?

A. And my recollections.

Q. Well, in-between the time you did this interview and the time you wrote your reports you had interviewed over a hundred other people?

MR. BOYAR: Asked and answered.

THE COURT: Sustained.

Items Reviewed

Q. Now, you indicated there were certain other things that you took into consideration. You reviewed certain testimony, certain police reports; isn't that correct?

A. Yes.

Q. Now, by the way, you were hired by the District Attorney's Office to make an evaluation of Mr. Riccardi; isn't that correct?

A. That's correct.

- Q. And you're being paid for your work; isn't that correct?
- A. Being paid for my time.
- Q. Okay, for your time. Now, when you reviewed your notes, your notes were what you had written down of what you felt was important of your interview of Mr. Riccardi; isn't that correct?
- A. Yes.
- Q. And this was with an eye toward writing a report for Mr. Boyar; isn't that correct?
- A. No.
- Q. Now, getting back to the other things you reviewed. You testified that part of what you based your evaluation on was the statement that supposedly came out during some testimony that a police officer claimed that he heard Mr. Riccardi after the incident respond to someone in the crowd by saying, I got him. Do you remember that?
- A. Yes.
- Q. Now, you reviewed the testimony of the entire Huntley hearing?
- A. Yes.
- Q. The officer who testified as you just reported was Officer Caban; isn't that correct?
- A. To the best of my recollection, yes.
- Q. And there was also an Officer Sham who testified about the very same events that Officer Caban testified; isn't that correct?
- A. I believe so.
- Q. And, Officer Sham, who was within feet of both Mr. Riccardi and Police Officer Caban, did not testify as to having heard Mr. Riccardi say, I got him; isn't that correct?

MR. BOYAR: Objection.

THE COURT: If he can answer it.

- A. I believe the other officer did not testify as had Officer Caban.
- Q. So you chose to take the testimony of the officer that supported your position; isn't that correct?
- A. No. I evaluated the testimony. I don't vouch for the accuracy of that, what Officer Caban said. I understand he testified here. I would assume the jury will be able to make their own decision about those facts upon which I make my opinion.

THE COURT: Sustained.

- Q. What I asked you was, you chose to, in making your evaluation, take testimony that you wanted, that would support your evaluation, the statement, I got him, right? Yes or no?

A. No.

Q. Did you make note in your report that another officer testified that he did not hear him make that statement?

A. No.

Q. I got him?

A. No.

Q. Did you make a note of that in your notes?

A. No.

Selective Inclusion?

Q. Let me be very specific with you, Dr. Siegel. You testified earlier that you generally take the position of not really accepting the information given to you by the person?

A. I don't accept what people tell me at face value, no.

Q. So it would be necessary to verify what they tell you in some way?

A. If what they tell me might have a bearing upon my ultimate opinion, yes.

Q. And the way that you went about trying to verify what you considered relevant information was to look at police reports and other information that was made available to you?

A. Yes.

Q. Correct? But, from among all that information you chose those items that would support your position and disregarded the information that would not support your position?

A. I don't think that there was information that I found that was supportive of him having been confused, disorganized, to the point that he didn't know the nature-

MS. DAVID: Your Honor, I move to strike as not responsive. It was a question capable of a yes or no answer.

THE COURT: Did you disregard things that would support his position?

THE WITNESS: No.

THE COURT: Dr. Teich's position?

THE WITNESS: No.

Q. Yet, you made no mention of the testimony of Police Officer Sham.

MR. BOYAR: Objection.

THE COURT: Asked and answered.

- Q. Now, you indicated before in response to a question by Mr. Boyar that in your professional opinion, Mr. Riccardi was not suffering from post-traumatic stress disorder, do you remember saying that?
- A. Yes.
- Q. Would it be fair to say that professionals, that psychiatrists, that forensic psychiatrists can differ, can have differing opinions about the same information?
- A. Yes.
- Q. It's not an exact science, isn't that correct?
- A. Well, it's not like adding up two plus two, but I think if things are done properly and thought out that one can come to some conclusion.
- Q. So, is that a yes, that it's not an exact science?
- A. I think one can say, yes, that's correct.

Chapter 17

Malingering 101

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CHAPTER SEVENTEEN

Malingering 101: Challenging Prosecution Expert Testimony that a Defendant is Faking Psychological Symptoms

By I. Bruce Frumkin

Defenders are well aware that when a defendant's emotional or intellectual state is raised in defense or mitigation in a criminal proceeding, the prosecution often argues that the defendant is malingering or faking psychological symptoms. It is incumbent on the defender to be aware of, and to hire experts who are aware of, recent advances in assessing for malingering and deception. An evaluation can determine whether observed emotional and cognitive deficiencies are the result of the defendant's true mental state or of attempts at dissimulation. By sorting through some of the misconceptions about malingering and deception and understanding advances in assessing for such issues, defenders can equip themselves to better select defense experts and to successfully cross-examine prosecution experts.

Definitions and Psycho-legal Issues

Malingering is generally defined as the conscious or intentional fabrication or gross exaggeration of physical or psychological symptoms for an external goal. If it is only for the purpose of assuming a patient or "sick" role, it is diagnosed as a factitious disorder. Defensiveness is the conscious or intentional minimization of physical or psychological symptoms for an external goal.

A common error is to think of deception as a dichotomy, of an individual either "faking-good" or "faking-bad." No such dichotomy truly exists. Individuals exaggerate or minimize a wide variety of symptoms, to various degrees, for a wide variety of reasons. Even in non-forensic contexts, clients engage in some impression management, minimizing or exaggerating particular aspects of behavior, symptoms, or personality characteristics for a variety of reasons. It is often not a question of whether the client is "faking-good" or "faking-bad" but what aspects of that person's self is being presented in the most realistic fashion. Thus, anytime a clinician states categorically that a defendant is "malingering" or "faking-bad" or "faking-good," the mental health expert is not acknowledging that almost everyone, to various degrees, tries to influence how others think of him or her.

Second, deception of cognitive or intellectual deficiencies is different from deception of emotional or psychopathological symptoms. These are two different areas and are assessed in different ways. A clinician should not believe that truthful responding on a personality inventory equates with valid responding on tests measuring intellectual functioning. A clinician who relies on only one measure to look at malingering should only address malingering in one area.

Third, one has to assume in a forensic context that external motivations exist for defendants to present themselves in less than forthright fashion. Yet the response style adopted may be counterintuitive for both the lawyer and the clinician. For example, an individual whose attorney may be exploring an insanity defense may minimize, rather than exaggerate psychological symptoms so others do not view the individual as "crazy."

Fourth, just because a defendant exaggerates psychopathology, it does not mean he or she may still not have a serious major mental disorder. An individual with schizophrenia can still try to exaggerate or feign various symptoms. Just because a defendant exaggerates intellectual or memory impairments, it does not mean he or she may still not be mentally retarded.

Similarly, an individual feigning psychosis at the time of the evaluation may have truly been psychotic at the time of the offense. While currently stabilized on medication, the defendant erroneously believes it is important to feign severe pathology now, to increase the chances that others would believe his true symptoms at the time of the offense.

Third-Party Data and the Clinical Interview

It is essential that the clinician have access to third-party data to assess the internal and external consistency of a defendant's self-report. This includes reviewing records and/or interviewing others who have had contact with the defendant at some point in the past. The clinician can then compare a defendant's emotional and intellectual state with background history and other's descriptions.

The clinical interview is an important feature in evaluating dissimulation. Malingerers have difficulty imitating the form, rather than the content of psychotic-type thinking. One question, for example, is whether the defendant only presents obvious symptoms of psychopathology (e.g., hallucinations, overt delusions) while not exhibiting some of the more subtle forms of major mental disorders (e.g., blunted affect, impaired relatedness).

Without getting into this area in detail, research is available on the nature of hallucinations and delusions true psychiatric patients' experience. Clinicians should be able to ask defendants the right types of questions to assess real versus feigned psychotic symptomatology. A clinician who poses only several questions to the defendant regarding hallucinations is not gathering the detailed type of information needed to assess the veracity of such claims. The attorney should know each and every question the mental health professional asked when an inquiry was made concerning the defendant's hallucinations or delusions.

Psychological Testing

Forensic clinicians should be aware of the Structured Interview of Reported Symptoms (SIRS) developed by Richard Rogers. Using a structured interview format, this 172-item test was designed to assess the feigning of psychotic symptomatology by comparing scores on a number of scales to those from honest responders (in both normal and patient samples). For example, some scales measure a) symptoms that are infrequently endorsed in genuine patient populations, b) pairing of symptom combinations that is uncommon in genuine patients, c) fantastic or atypical symptoms, d) overly specified symptoms, e) blatant symptoms, and f) disproportionate number of symptoms of extreme severity. Assessing how many of eight primary scales are elevated in the 'Probable' or 'Definite' range, one can make comparisons to how true hospitalized patients perform.

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is one of the most frequently used tests by psychologists to assess psychological functioning. While most clinicians (and some attorneys) are familiar with the traditional validity scales of L (measuring the denial of common human frailties), F (measuring infrequently endorsed items, although sometimes inaccurately referred to as the "faking-bad" scale), and K (measuring defensiveness), there have been some recent advances in MMPI interpretation of which many clinicians are unaware. Without presenting a detailed overview of common problems in test interpretation, suffice it to say that one needs to hire a psychologist consultant to check scoring and help the lawyer understand potential interpretation flaws. Nevertheless, the following four questions are important starting points in any investigation as the adequacy of a psychologist's interpretation.

First, was the MMPI scored by computer? There are more than a hundred validity, clinical, content, supplementary, and subscales which assist in test interpretation. It would take literally hours to score more than a hundred scales by hand using templates. Clinicians who do not score by computer and

who do not score all of the scales would be greatly hampered in assessing the meaning of scale elevations on the test. This is not to suggest the computer interpretation is necessarily a good thing. Second, did the clinician interpret the clinical scales by looking at both K and non-K corrected scores? When the MMPI was first developed in the 1930's, the K score was used as a correction factor added to the raw scores of many scales to rid the test of false negatives (mentally ill individuals whose scores were in the normal ranges).

Many clinicians only look at the K-corrected norms. The research has shown that on the MMPI-2, K-corrected scores lessen the scales validity, not adds to it. Third, was the Infrequency-psychopathology or Fp scale scored? This is a relatively new scale developed to examine whether a high F score is due to severe psychopathology or due to feigning or exaggerating psychological symptoms. Fourth, did a clinician erroneously assess malingering by a examining the F-K score? Based upon research, it would be difficult to defend using this score if challenged in court, particularly in regards to "faking-good" statements.

Although there is some disagreement in the field, the Rorschach Inkblots Test can provide some useful information regarding dissimulation. Unlike the MMPI-2 and portions of the SIRS, defendants find it difficult to know what is considered a good or bad response. Research results, though, have been mixed as to the ability of psychologists to detect feigned versus real psychopathology expressed on the Rorschach. There are several signs that are consistent with a malingered protocol - for example, bizarre, dramatic, or outrageous content when the subject's percept corresponds to the physical attributes of the inkblot. While the lawyer should be wary of the psychologist who relies on the Rorschach alone to look at malingering, in the context of other test results, it can supply useful information.

There are a number of procedures for examining malingering of intellectual functioning. One commonly used test is the Rey 15-Item Memory Test. The subject is told a card will be shown with 15 things on it and the card must be studied for ten seconds to try to remember everything. The card is taken away, and ten seconds later, the subject is asked to copy all that is remembered. While the test is assumed to be a difficult one, in reality it is extremely easy based upon the grouping of the 15 items. Seven or fewer correct answers suggest malingering because even very impaired individuals recall more items.

The Dot Counting Test gives the subject a series of 12 cards with dots to count as quickly as possible without using one's finger. The time it takes to count the dots and the number of dots counted are recorded. Since the last six cards have dots which are grouped, the performance should be quicker and more accurate than the first six cards.

Forced-choice testing is an effective means to look at malingering of intellectual deficits. Forced-choice testing involves presenting a large number of items in a forced-choice format where the person's performance is compared to the likelihood of success based upon chance alone. One forced-choice test is the Rey Word Recognition Test. A list of 15 words to remember are read to the subject. A list of 30 words is then read, and the subject is asked whether each word had been previously read or not. The score can range from zero to 30. Since chance or random responding would yield a score of 10-20, scores less than 10 are unlikely and are probably due to the individual purposely trying to come across as impaired.

The Validity Indicator Profile (VIP) developed by Richard Frederick is an excellent forced-choice test to look at malingering of cognitive deficits. The nonverbal subtest comprises 100 nonverbal matrices with two answer choices, one of which must be chosen. The items are essentially randomly presented, not in order of their difficulty, making it difficult for subjects to know how to consistently show poor ability on the test. A computer scores the test and items are arranged back in their order of difficulty. Individuals attempting to give their best performance will get the easy items correct, and then, as the items become

more difficult, performance will fall to chance levels (50% correct). Those actively attempting to malingering will get the easier items incorrect (because they know what is the correct answer, thus they respond incorrectly) while the more difficult ones will be answered correctly at only chance levels (since they do not know the correct answer). The verbal subtest of the VIP consists of 78 target words. The subject must pick which of two words are most similar in meaning to each of the target words. Again, the words are in random order in terms of their difficulty. Interpretation is the same as with the nonverbal portion of the VIP.

Get Help

This article sometimes oversimplifies complex concepts in the interest of brevity and comprehension. Attorneys who are serious about challenging expert testimony on malingering should consult with a forensic psychologist knowledgeable in the area. The authoritative text is the Second Edition of Richard Rogers' edited book, *Clinical Assessment of Malingering and Deception*, published by Guilford Press in 1997. While it may be too technical for lawyer non-clinicians, psychology experts should be familiar with it.

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Community Resources

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Appendix 1

Wrapping Indiana in Wellness: Community Resources to Help Consumers in Selecting Services

Welcome!

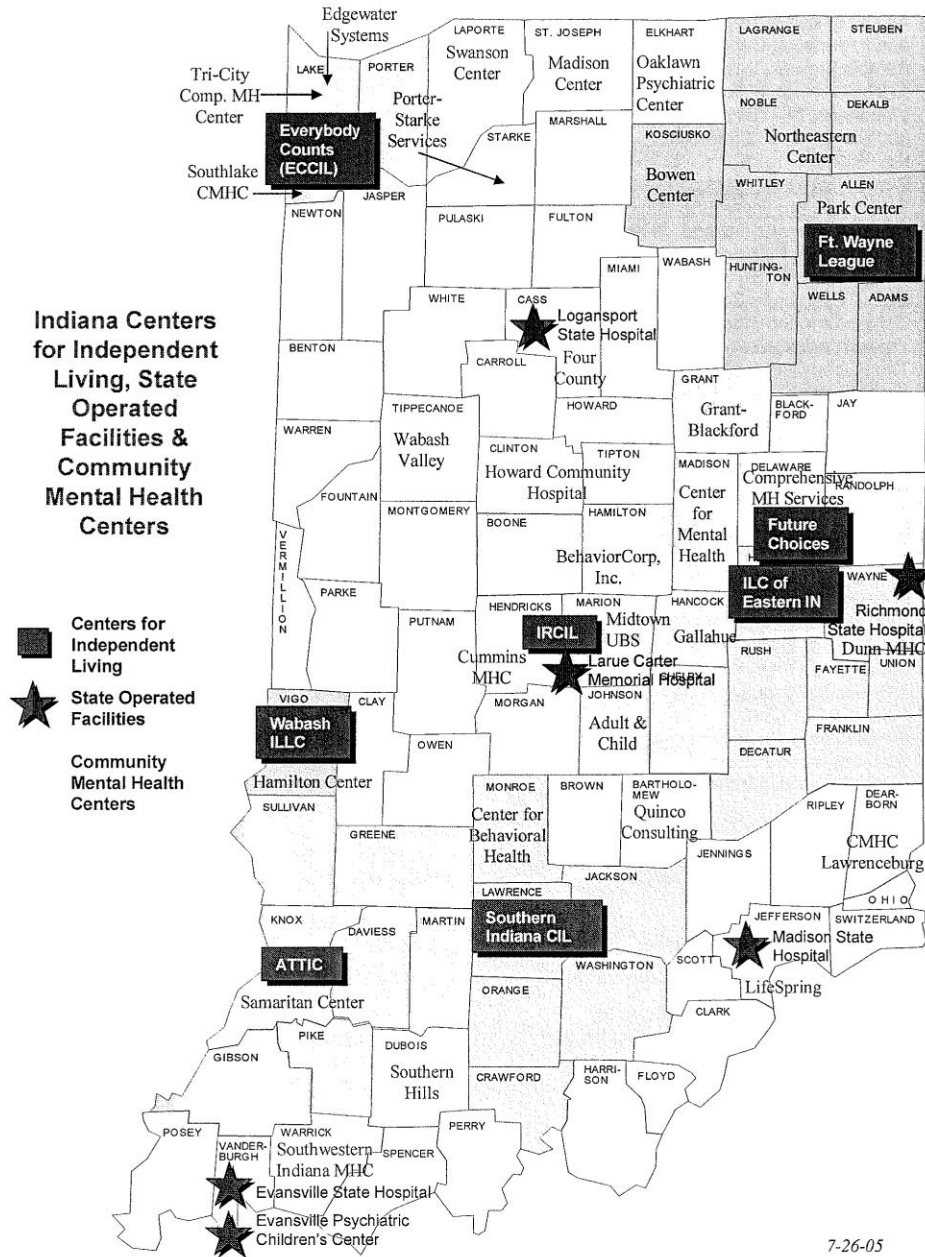
Over the past few years, organizations in Indiana have been working to develop new community resources for mental health consumers. We know that all these exciting and new services may seem overwhelming and a person may not know where to begin when exploring these organizations and programs. That's why this booklet was created especially for you, the consumer!

Inside you will find information on some of these services, including peer to peer supports, advocacy groups and formal mental health and disability organizations. We've also included a brief description and contact information for each resource. If you got this booklet at a KEY Consumer Organization event, you have already met some members of the Indiana Consumer Run Organization (CRO). One of the things that CRO's provide is connections to the community that can be valuable to you in your own journey of recovery. Don't hesitate to contact the CRO's listed in this booklet to find out how you can get involved! We hope you'll take the time to read through this information and give a call to one of the organizations listed here. Every one of them is dedicated to assuring that you have the greatest amount of choice possible over your life. They have helped many others like you make the decisions and choices they needed to create the life they wanted and deserved!

This publication was made possible by 100% funding support from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. These contents are solely the responsibility of the grantee and do not necessarily represent the official views of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

This publication is a collaboration between the Key Consumer Organization, Indiana Family and Social Services Administration Division of Mental Health and Addiction and Indiana Protection and Advocacy Services Commission. The Protection and Advocacy System for Indiana

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2506 Willowbrook Parkway Suite 199
Indianapolis, IN 46205
(317) 205-2500; 800-933-KEYS (5397)



I. CENTERS FOR INDEPENDENT LIVING (CIL's)

ATTIC Assistive Technology Training and Information Center

Patricia Stewart, Director

1721 Washington Avenue

Vincennes, IN 47591

800-96ATTIC, 812-886-0575; Fax: 812-886-1128

E-mail: INATTICI@aol.com

Web Page: <http://www.theattic.org>

Counties served: Daviess, Gibson, Greene, Knox, Martin, Pike and Sullivan

ECCIL Everybody Counts

Center for Independent Living

Teresa Torres, Executive Director

The Ruben Center

Emas Bennett, Executive Director

9111 Broadway, Suite A

Broadfield Center

Merrillville, IN 46410

888-769-3636, 219-769-5055 Fax: 219-769-5325

E-mail: ecountsnetnitco.net

Counties served: Lake and Porter

Future Choices, Inc.

Beth Quarles, Executive Director

309 N. High Street

Muncie, IN 47305

765-741-8332, 866-741-3444; Fax: 765-741-8333

E-mail: rbarnes@futurechoices.org

Counties served: Blackford, Delaware, Grant, Howard, Madison and Randolph

ILCEIN Independent Living Center of Eastern Indiana

Tom Cooney, Executive Director

201 South 5th St.

Richmond, IN 47374

877-939-9226, 765-939-9226 Fax: 765-935-2215

Web Page: www.ilcein.org

Counties served: Decatur, Fayette, Franklin, Henry, Rush, Union and Wayne

IRCIL Indianapolis Resource Center for Independent Living

1426 W. 29th Street, Suite 207 Indianapolis, IN 46208

800-860-7181, 317-926-1660 Fax: 317-926-1660

E-mail: ircil@netdirect.net

Web Page: abilityindiana.org

Counties served: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby

League for the Blind and Disabled
David Nelson, Executive Director
5821 South Anthony Blvd.
Fort Wayne, IN 46816
800-889-3443, 260-441-0551; Fax: 260-441-7760
E-mail: the.league@verizon.net
Counties served: Adams, Allen, DeKalb, Huntington, Jay, Kosciusko, LaGrange, Noble, Steuben, Wells, and Whitley

SICIL Southern Indiana
Center for Independent Living
Al Tolbert, Executive Director
Stone City Plaza
3300 W. 16th Street
Bedford, IN 47421
800-845-6914; 812-277-9626
Fax: 812- 277-9628
E-mail: sicil@tima.com
Counties served: Crawford, Jackson, Lawrence, Monroe, Orange, and Washington

WILL Wabash Independent Living and Learning Center
Teresa Mager, Executive Director
4312 S. Seventh Street Terre Haute, IN 47802
812- 298-9455
Toll free: 877-915-9455
Fax: 812-299-9061
E-mail: splash3825@aol.com
Counties served: Clay, Park, Pike, Putnam, Vermillion

II. COMMUNITY MENTAL HEALTH CENTERS

Adult & Child Mental Health Center Inc
Robert Dunbar, Executive Director
8320 Madison Ave
Indianapolis, IN 46227
317-882-5122
adultandchild.com

BehaviorCorp, Inc.
Larry Burch
697 Pro Med Lane
Carmel, IN 46032-5323 317-587-0500
lburch@behaviorcorp.org

Center for Behavioral Health Dennis P. Morrison, Ph.D.
645 S Rogers St
Bloomington, IN, 47403 812-339-1691
dennym@kiva.net

Center for Mental Health Inc
Richard DeHaven
PO Box 1258
Anderson, IN 46015
765-649-8161
<http://www.aspireindiana.org/index.html>

Community Mental Health Center Inc.,
Matt Brook, CEO
285 Bielby Rd
Lawrenceburg , IN 47025
812-537-1302
mbrooks@iccmhc.org
http://www.iccmhc.org/community_mental_health_history

Meridian Health Services 240 N. Tillotson Ave.
Muncie, IN 47304
765-288-1928
www.meridianhs.org
hank.milius@meridian.hs.org

Cummins Behavioral Health Systems
Ann Borders, CEO
6655 E US 36
Avon, IN 46123 317-272-3330
<http://cumminsbhs.com/Locations/Avon.aspx>
aborders@iquest.net

Centerstone, Suzanne Koesel
PO Box 487
Richmond, IN 47375
765-983-8000
centerstone.org

Edgewater Systems for Balanced Living Inc
Danita Johnson-Hughes, Ph.D., CEO
1100 W 6th Ave
Gary, IN 46402
219-885-4264
[http://edgewatersystems.org/ danitahughes@edgewatersystems.org](http://edgewatersystems.org/danitahughes@edgewatersystems.org)

Four County Counseling Center
C.J. Davis, CEO
1015 Michigan Ave., Logansport, IN 46947
800-552-3106
574-722-5151
<http://www.treatment-centers.net/directory/indiana/logansport/four-county-counseling-center.html>
lulrich@fourcounty.org

Gallahue Mental Health Center/Community Behavioral Health Services
Suzanne Clifford, Executive Vice President
6950 Hillsdale Ct
Indianapolis, IN, 46250
317-621-7600
<http://www.ecommunity.com/>

Cornerstone Behavioral Health Center/Grant Blackford Mental Health, Inc.
Paul G. Kuczora
505 Wabash Ave.
Marion, IN, 46952
765-662-3971
<http://www.cornerstone.org/>
paulk@cornerstone.org

Hamilton Center, Inc.
Mel Burks, CEO
William S. Shriner Corporate Building
[620 Eighth Avenue](#)
P.O. Box 4323
Terre Haute, IN 47804
[Business Calls:](#) (812) 231-8323
Access Center and 24 hour emergency [treatment:](#) (812) 231-8200 or (800) 742-0787
<http://hamiltoncenter.org/>
mburks@hamiltoncenter.org

Community Howard Regional Health Behavioral Health
James P. Alender, CEO
322 N. Main Street
Kokomo, IN 46901
765-453-8555
<http://www.ecommunity.com/howard/>
ialender@hch-kokomo-org

Lifespring, Inc.
Terry Stawar, Ed.D., President/CEO
460 Spring Street
Jeffersonville, IN, 47130
(812) 280-2080
<http://www.lifespringhealthsystems.org/>
tstawar@lifespr.com

Midtown Community Mental Health Center
Margaret Payne
850 N. Meridian St.
Indianapolis, IN 46204-1098
(317) 554-2704; (317) 554-2716; (317) 630-7791 (crisis line)
<http://www.iccmhc.org/~iccmhc/node/187>; <http://www.eskenazihealth.edu/>
Margie.Payne@wishard.edu

Northeastern Center
Jerry Hollister
220 South Main Street
PO Box 817
Kendallville, IN 46755
260-347-2453 (PH); 260-347-2456 (FAX)
After Hours Emergency: 1-800-790-0118
EAP Direct: 1-800-229-5510
<http://www.necmh.org/>
jhollister@northeastern.org

Oaklawn Psychiatric Center, Inc.
Harold Loewen, President
PO Box 809
Goshen, IN, 46527-0809
574-533-1234; 574-537-2681
<https://www.oaklawn.org/>
harold.loewen@oaklawn.org

Otis R. Bowen Center for Human Services
Kurt Carlson, CEO
PO Box 497
Warsaw, IN, 46581
800-342-5653
574-267-7169
<http://www.bowencenter.org/>
kurt.carlson@bowencenter.org

Park Center, Inc.
Paul D. Wilson, President & CEO
909 E. State Blvd.
Fort Wayne, IN 46805
866-481-2700; 260-481-2700
<http://parkcenter.org/>
pwilson@parkcenter.org

Porter Starke Services, Inc.
Rocco Schiralli, President/CEO
601 Wall St.
Valparaiso, IN 46383
219-531-3500
<http://www.porterstarke.org/>
rschiralli@porterstarke.org

Centerstone of Indiana
Suzanne Koesel
720 N Marr Rd
Columbus, IN, 47201-6660
812-348-7449 (PH); 812-376-4875 (FAX)
<https://www.centerstone.org/>

Good Samaritan Hospital
James A. Koontz, M.D. & John Manning
515 Bayou Street
Vincennes, IN 47591
Phone: 812-886-6800 or 800-824-7907 (toll free); Fax: 812-886-6809
<http://gshvin.org>
jkoontz@gshvin.org
jmanning@gshvin.org

Southern Hills Counseling Center
Don Aronoff
PO Box 769
Jasper, IN, 47547-0769
812-482-3020 (Ph); 800-883-4020 (Ph – Toll Free); 812-482-6409 (fax)
daronoff@southernhills.org

Regional Mental Health Center
Strawhun Center
Lee C. Strawhun
8555 Taft St
Merrillville, IN, 46410
219-769-4005; 219-769-2508 (fax)
<http://www.regionalmentalhealth.org/>
lee.strawhun@regionalmentalhealth.org

Southwestern Behavioral Health Care, Inc.
Dennis Moran, President/CEO
415 Mulberry St.
Evansville, IN 47713
812-423-7791 (ph); 812.422.7558 (fax)
24hr Emergency 812-423-7791
Suicide Prevention 812-422-1100
<http://www.southwestern.org/>

Swanson Center
Elizabeth Kuhn
450 St. John Rd., Ste. 501
Michigan City, IN 46360
(219) 879-0676
ekuhn@swansoncenter.org
www.swansoncenter.org

Regional Mental Health Center
Robert Krumwied, MHA, President/CEO
3903 Indianapolis Boulevard
East Chicago, IN 46312
219-398-7050 EMERGENCY HOTLINE; 219-769-4005; 888-398-7050
<http://www.regionalmentalhealth.org/>
robert.krumwied@regionalmentalhealth.org

Wabash Valley Hospital, Inc.
Rick Crawley, Chairperson
Wabash Valley Hospital, Inc.
2900 N. River Road
West Lafayette, IN 47906
(765) 463-2555; (317) 497-3960 (fax)
wvhmhc.org
rcrawley@wvhmhc.org

III. INDIANA STATE PSYCHIATRIC HOSPITALS

The state psychiatric hospitals work closely with the community mental health centers on admission and discharge planning to assure the most appropriate service for each individual. Individuals who do not respond to community-based intervention within a reasonable time-frame will be referred to the appropriate state psychiatric hospital for longer-term care. Individuals may voluntarily enter a state psychiatric hospital **only** through a community mental health center. Involuntary commitment may be sought through the community mental health center by a friend, relative, or law enforcement representative. No one is denied admission because of lack of financial resources.

1. Larue D. Carter Memorial Hospital
2601 Cold Springs Road
Indianapolis, IN 46222
(317) 941-4000
Affiliated with Indiana University as a teaching/research site. Inpatient treatment for seriously mentally ill adults and seriously emotionally disturbed children and adolescents. Adult outpatient services available.
2. Evansville Psychiatric Children's Center
3300 East Morgan Avenue
Evansville, IN 47715
(812) 477-6436
Serves children ages 4-12. Special education classes provided on-site.
3. Evansville State Hospital
3400 Lincoln Avenue
Evansville, IN 47714
(812) 469-6800
Inpatient care for adults with serious mental illness. Special units for older persons and persons with mental illness, mental retardation and developmental disabilities.
4. Logansport State Hospital
1098 South State Road 25
Logansport, IN 46947
(574) 722-4141
Inpatient care for adults with serious mental illness. Special units for persons with mental illness who are involved in the criminal justice system, persons who have mental retardation and developmental disabilities.

5. Madison State Hospital/Southeast Regional Center
711 Green Road
Madison, IN 47250
(812) 265-2611
Inpatient care for adults with serious mental illness, including geriatrics. Special unit for persons who are mentally retarded and have developmental disabilities.
6. Richmond State Hospital
498 N.W. 18th Street
Richmond, IN 47374
(765) 966-0511
Inpatient treatment for seriously mentally ill adults. Special units for persons who are chemically addicted, persons who are dually diagnosed with mental illness and chemical addictions, and male adolescents with conduct or adjustment disorders.

How Can MEDICAID Help?

Indiana Medicaid pays for the following Mental Health services for most Medicaid Recipients:

Assessment and Counseling/ Psychotherapy for an Individual, a Group, or a Family.

For those adults who are diagnosed as Seriously Mentally Ill, or children who are diagnosed as Seriously Emotionally Disturbed, Medicaid will also pay for the services offered by the

Mental Health Rehabilitation Option - MRO

MRO services are clinical mental health services provided to individuals, families, or groups of persons who are living in the community. They are designed to assist the individual in developing his or her optimum functional ability in daily living activities. Medicaid will pay for the following MRO services provided by the certified Community Mental Health Centers in Indiana (a description of these services can be found at www.indianamedicaid.com. Click on **Manuals**, click on **MRO manual**.):

1. Diagnostic assessment
2. Individual counseling or psychotherapy
3. Group counseling/psychotherapy
4. Family counseling or psychotherapy
5. Crisis intervention
6. Medication Monitoring and assistance
7. Training in activities in daily living (individual)
8. Training in activities in daily living (group)
9. Partial Hospitalization
10. Case management services
11. Second Case Manager
12. ACT - Assertive Community Treatment

Indiana's Medicaid Waiver for Children with Serious Emotional Disturbance (SED Waiver)

The purpose of the SED Waiver is to offer families the choice of intensive community based services as an alternative to a State Psychiatric Hospital for children who have serious emotional disturbances that

result in serious or extreme functional impairments. Application is made at the Community Mental Health Center in the child's county of residence.

To qualify for the SED Waiver, a child must:

- o be at risk of placement in a state psychiatric hospital or be a resident of a state psychiatric hospital;
- o be a U.S. citizen and a resident of Marion, Randolph, Knox, Daviess, Martin, Pike, Elkhart, St Joseph, Lake, or Vigo County; (this may be extended to other counties in the future)
- o be at least 4 years of age and under age 21;
- o have a primary diagnosis of serious emotional disturbance;
- o not have community service costs that are greater than the cost of hospitalization; and meet the income requirements. (If otherwise eligible, parents' income is not counted in the Medicaid eligibility decision)
- o meet the eligibility criteria for Disability Medicaid

IV. CONSUMER-RUN ORGANIZATIONS (CRO's)

Consumer-run organizations are defined as organizations in which consumers make up the majority of the staff and the board of the organization.

KEY (Knowledge Empowers You) Consumer Organization

Key Consumer Organization is a service organization for mental health consumers, their families, friends and treatment providers. Indiana consumers began organizing in 1984 and KEY was formally started in 1988 with support from the Mental Health Association. Non-profit status was obtained in mid-1990 under the guidance of an all-consumer Board of Directors. KEY is run by and for consumers of mental health services and promotes consumer empowerment. KEY members advocate individually and collectively in order to improve services, promote understanding, end discrimination against persons with mental illness and to change the stigma of mental illness from shame, isolation and despair to a stance of hope, dignity and courage.

The Key Peer Support Training Group offers:

- The Wellness Recovery Action Plan (WRAP)
- The Freedom Self-Advocacy Curriculum
- The Indiana Leadership Academy
- The "Inside/Outside: Building a Meaningful Life Outside of the Hospital" presentation

Statewide consumer organizations are run by and for consumers of mental health services and promote consumer empowerment. These organizations provide information for mental health and other support services at the State level and are active in addressing and advocating for mental health system issues. For information about consumer activities in your area, contact:

Ronda Ames, Executive Director
KEY (Knowledge Empowers You) Consumer
Organization
2506 Willowbrook Parkway, Suite 199
Indianapolis, IN 46205
Phone: 317-205-2500; Fax: 317-205-2510
Toll-free: 800-933-KEYS (5397)

Division of Mental Health and Addiction**Office of Consumer and Family Affairs**

The purpose of the Office of Consumer and Family Affairs (OCFA) is to empower consumers and family members by assuring their interests are represented and their input is considered in DMHA planning and policy development.

The goals of OCFA are summed up in four objectives:

1. Providing an internal voice for consumers and family members within DMHA through participation in DMHA planning and policy development activities.
2. Active liaison work with national, state, and local consumer and family organizations the broader disability community in order to establish ongoing communications, disseminate information, identify major issues and provide consultation, technical assistance, and ongoing support.
3. Development, implementation, and monitoring of special projects, including State Coordinator of the Olmstead Mental Health grant solicit consumer input on Olmstead planning and implementation. Identification, training and involvement of consumers in DMHA planning activities.
4. Maintain a Consumer Council to advise Division of Mental Health and Addiction. This council is composed of consumers and family members of consumers of mental health and addiction services. The council's purpose is to provide the consumer perspective for DMHA planning and policy development. The Consumer Council meets seven times per year. The Consumer Council is also a sub-committee of the state Mental health Planning Council, which is required in order for the state to receive the annual federal Mental Health Block Grant.

Jill Fuqua, Bureau Chief
Office of Consumer and Family Affairs
Division of Mental Health and Addiction
402 W. Washington St. Room W353
Indianapolis IN
46204
Phone: 317-232-7912
FAX: 317-233-3472
TDD: 317-232-7844
Website: <https://secure.in.gov/fssa/dmha/4339.htm>
E-mail: jill.fuqua@fssa.in.gov

V. FAMILY / CONSUMER ORGANIZATIONS:***Indiana Federation of Families for Children's Mental Health*****Family Support**

The Center for Mental Health Services awards grants to statewide, family-run networks to provide support and information to families of children and adolescents with serious emotional, behavioral, or mental disorders. For more information, contact:

Brenda Hamilton, Director
Indiana Federation of Families for Children's Mental Health
2205 Castella Dr.

Anderson, IN 46011

(765) 643-4357

<http://indianafamilies.org/page1.php>

E-mail: indianafedfam@comcast.net

<https://www.facebook.com/pages/Indiana-Federation-of-Families-for-Childrens-Mental-Health/142675742409968> (Facebook page)

About Special Kids (“ASK”)

Joe Brubaker, Executive Director

7122 Graham Road, Suite 100

Indianapolis, IN 46250

317-257-8683; 800-964-4746; 317-251-7488 (fax)

<http://www.aboutspecialkids.org/>

ASK describes its mission as follows:

“The mission of About Special Kids is: [Helping children](#) with special needs live better lives by educating, empowering and connecting their families.

We define children with special needs as children with:

- Physical, mental, emotional disabilities
- Developmental delays
- Chronic illnesses
- Mental health concerns
- Behavioral disorders
- Learning disabilities and educational delays
- Children who have risk factors or who are showing signs of a suspected disability

Indianapolis Bipolar Parents Organization

IBPO is a group of parents and family members that are dedicated to the rights of children and their family members with Bipolar and similar mood disorders. The organization is a merge of efforts between Parents of BP children and Indpls BP parents. The purpose of this organization is to build partnerships between the existing entities/persons serving children with mental illness and the parents/family members of the community seeking support and assistance. We will strive to seek adequate resources for family members and advocate for the rights of each individual.

Indianapolis, IN 46219-1843

Jami Perkins

317-797-4402

<http://www.indplsbpparents.org>

jami@indplsbpparents.org

National Alliance on Mental Illness (NAMI)

NAMI Indiana is a non-profit grassroots organization dedicated to improving the lives of people afflicted by serious and persistent mental illness. NAMI Indiana consists of families, consumers, and professionals. NAMI is dedicated to helping families through a network of support, education, advocacy, and promotion of research. NAMI coordinates 30 local affiliates/support groups throughout the state, promotes public education, participates in boards, task forces, and committees at state and local levels, advocates for legislation to improve the system of care of persons with mental illness, and testifies in related public hearings.

Note: Planning For/Responding To Mental Health Crisis

To prepare for a future mental health crisis, or to seek guidance on how to handle such a crisis as it unfolds, we recommend the pamphlet at the following link:
<https://www.dropbox.com/s/dkve4b56tdcqda0/Crisis%20Booklet%203rd%20Edition%20%281%29.pdf>.

This pamphlet, “Planning for and Responding to a Mental Health Crisis,” is published by NAMI Indiana (National Alliance on Mental Illness). Among other things, it: 1) advises whom to call in an emergency, 2) discusses the legal basis for detention and commitment; 3) provides alternatives to involuntary commitment; and 4) explains the urgent need to immediately contact the Social Security Administration to begin the process to obtain disability benefits.

NAMI Indiana also coordinates a number of programs that have originated at the national level. For further information on these programs, contact Joshua G. Sprunger, Executive Director, at 800-677-6442; 317-925-9398 (Fax); P.O. 22697, Indianapolis, IN 46222
jsprunger@namiindiana.org
[Email](mailto:info@namiindiana.org) Address: info@namiindiana.org

The Family-to-Family Education Program is a 12-week course directed towards those who have a loved one with a mental illness. The course is taught by trained family members. All course materials are furnished at absolutely no cost to students. The curriculum focuses on schizophrenia, bipolar disorder (manic depression), clinical depression, panic disorder, and obsessive-compulsive disorder (OCD).

Support Groups are led by nationally trained and certified family member facilitators. They tend to meet weekly, bi-weekly, or monthly. These groups provide an atmosphere in which family members can feel "safe" and "supported/nurtured" as they are free to share with other family members at levels of emotional disclosure which are more "in depth" than other NAMI settings and/or programs.

In Our Own Voice: Living With A Mental Illness is an informational outreach program on recovery presented by consumers to other consumers, families, students, professionals, and all people wanting to learn about mental illness. It is designed to offer insight into how people with serious mental illnesses cope with the realities of their disorders while recovering and reclaiming meaningful and productive lives.

Visions for Tomorrow is an educational program written for direct (primary) caregivers of children and adolescents with brain or mental disorders. The course is designed for the parents/caregivers of children/adolescents diagnosed with a brain or mental disorder, as well as those who exhibit behaviors that strongly suggest such a diagnosis.

The Peer-to-Peer Education Program is a 9-week education course on recovery for any person with serious mental illness who is interested in establishing and maintaining wellness. The course is similar to NAMI's Family-to-Family Education Course, in that it is based upon the idea that living with serious mental illness is, among many other things, an experience of trauma, and the recovery path occurs in predictable stages.

The NAMI Indiana Consumer Council is new to NAMI Indiana. It is an organization of consumers within NAMI acting as advocates and support for those who have experienced a serious mental illness. It received formally approved structure and status at the October 5, 2002 annual meeting of NAMI Indiana. A set of by-laws for our Consumer Council and proposed changes to the NAMI Indiana By-laws providing for the selection of a NAMI Indiana director chosen by this Consumer Council are available now.

All NAMI consumer members in good standing are automatically a member of the Consumer Council. Each affiliate can have two voting representatives. If the affiliate has a consumer membership of more than thirty, three voting representatives can represent the affiliate. Voting representatives must be nominated by their affiliate leader. If you or a consumer you know would like to be considered as a Voting Council Member, contact your affiliate leader.

VI. ADVOCACY ORGANIZATIONS:

Mental Health Association in Indiana

Local chapters of the National Mental Health Association have information about community services and engage in national and State level advocacy. For more information about the association, write or call:

Mental Health Association of Indiana
14341 North Delaware
Indianapolis, IN 6202
Phone: 317-638-3501
Toll-Free: 1-800-555-MHAI (6424)
Fax: 317-638-3540
<http://mhai.net/>
E-mail: mha@mentalhealthassociation.com

Depression and Bipolar Support Alliance
730 N. Franklin Street, Suite 501
Chicago, Illinois 60654-7225
Toll-free: (800) 826-3632
Fax: (312) 642-7243
<http://www.dbsalliance.org/site/PageServer?pagename=home>

Indiana

DBSA Indiana
Contact 1: Dayna L. Switzer
Phone: (317) 638-3501 x240
Contact 2: Stephen C. McCaffrey
Additional Phone: (317) 638-3501 x222 or smccaffrey@mhai.net
Fax: (317) 638-3540
Email: dswitzer@mhai.net
Website: <http://mhai.net/index.php/subsidiary/depression-and-bipolar-support-alliance-indiana-inc>

Mission:

To educate patients, families, professionals and the public concerning the nature of depressive and manic-depressive illness as a medical disease; to foster self-help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses.

Governor's Planning Council for People with Disabilities

The Indiana Governor's Council is an independent state agency that facilitates change. Our mission is to promote public policy which leads to the independence, productivity and inclusion of people with disabilities in all aspects of society. This mission is accomplished through planning, evaluation, collaboration, education, research and advocacy.

The Council is consumer-driven and is charged with determining how the service delivery system in both the public and private sectors can be most responsive to people with disabilities. The Council receives and disseminates federal funds to support innovative programs that are visionary, influence public policy, empower individuals and families and advocate systems change.

Board members of the Council are appointed by the Governor and 60% must be people with disabilities or their family members.

Governor's Council for People with Disabilities offers the Partners in Policymaking. The Partners in Policymaking Academy (PIP) offers eight weekends of intensive training designed to educate participants to be active partners with those who make policy. Each year 35 people with disabilities and family members are selected. PIP curriculum utilizes national presenters and promotes the values of integration/ inclusion, and the belief that all people with disabilities should be respected and contributing members of their communities.

Applications are distributed throughout the year and must be postmarked by the first Friday in June. Sessions are monthly beginning in October and ending with graduation in May.

Governor's Council for People with Disabilities

Indiana Government Center South, Room E145
402 West Washington Street
Indianapolis, Indiana 46204
Phone: (317) 232-7770
Fax: (317) 233-3712
<http://www.in.gov/gpcpd/>

Indiana Protection and Advocacy Services Commission (IPAS)

IPAS was established "To protect and promote the rights of individuals with disabilities, through empowerment and advocacy."

IPAS may be able to assist citizens of Indiana who have a disability and are either being denied a right or are being discriminated against because of that disability. IPAS is an Independent State Agency which receives no state funding and is Independent from all service providers. Governed by the 13-member IPAS Commission which sets the agency's Priorities, IPAS is advised on Mental Illness matters by a 10-member Advisory Council (MIAC).

To request services, contact an Intake Specialist.

For services in Indianapolis and South, contact Dann Ward at 1-800-622-4845 ext. 234, or email him at dward@ipas.state.in.us.

For services in Northern Indiana, contact Debbie Dulla at 1-800-622-4845 ext. 236, or email her at ddullaipas.state.in.us.

For general information about IPAS, contact Karen Pedevilla, Education and Training Director, at 1-800-622-4845, ext. 232, or email her at kpdevillaipas.state.in.us

Each State has a protection and advocacy agency that receives funding from the Federal Center for Mental Health Services. Agencies are mandated to protect and advocate for the rights of people with mental illnesses and to investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illnesses. These facilities, which may be public or private, include hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails, and prisons. Agencies provide advocacy services or conduct investigations to address issues that arise during transportation or admission to such facilities, during residency in them, or within 90 days after discharge from them. Contact:

Indiana Protection and Advocacy Services
4701 North Keystone, Suite 222
Indianapolis, IN 46205
Toll-free: 800-622-4845
Internet: www.in.gov/ipas/

VII. OTHER CONSUMER RESOURCES

Choices, Inc. is a dynamic nonprofit that creates and guides supportive care programs for community members in need of help. We rejuvenate lives and strengthen communities through compassion, creativity and respect.

<http://www.choicesteam.org/>
Choices@ChoicesTeam.org

Choices - Central Indiana
4701 N. Keystone Ave.
Suite 150
Indianapolis, IN 46205
888.543.9727
317.726.2121

Choices - Merrillville
7895 Broadway
Suite G
Merrillville, IN 46410
888.543.9727

Choices - Fort Wayne
7233 W. Jefferson Blvd.
Fort Wayne, IN 46804
888.543.9727

On Our Own, Together: Peer Programs for People with Mental Illness

Edited by Sally Clay with Bonnie Schell, Patrick W. Corrigan, and Ruth O. Ralph Nashville:
Vanderbilt University Press 2005 <http://www.sallyclay.net/z.together/ooo.html>

This book began as part of the Consumer-Operated Service Programs COSP four year research study funded by SAMHSA, and describes much of it. In particular, it includes and gives results from the qualitative fidelity study that was conducted.

"Positive Partnerships: How Consumer and Nonconsumers Can Work Together as Service Providers"

You can order it through the National Research and Training Center on Psychiatric Disability at the University of Illinois at Chicago,
104 South Michigan Ave, Suite 900 Chicago, Illinois 60603-5901
Phone: (312) 422-8180

The National Mental Health Consumers' Self-Help Clearinghouse is proud to announce the launch of the new Directory of Consumer-Driven Services (CDS) at <http://www.cdirectory.org>.

VIII. GETTING INVOLVED!

Join the new ICAN list serve!!

The Indiana Consumer Advocacy Network (ICAN) is a group of mental health consumers who have joined together to advocate for improving mental health services in Indiana. The ICAN_Indiana yahoo group is an opportunity for all who are consumers interested in advocacy to share support and ideas about how to advocate in Indiana. Anyone may join in discussing advocacy who is willing to show respect for each person who is a member of this group.

E-mail address to Subscribe: ICANIndiana-subscribe@yahoogroups.com

Join the new WRAP list serve!

WRAP_Indiana is a group for anyone interested in learning about, giving and/or getting support in following Mary Ellen Copeland's Wellness Recovery Action Plan. Persons in Indiana who are using WRAP, training others to use WRAP, or wanting to know more about WRAP are invited to participate. Subscribe: WRAPIndiansubscribe@yahoogroups.com

IX. CONSUMER TECHNICAL ASSISTANCE CENTERS FUNDED BY THE FEDERAL GOVERNMENT:

National Mental Health Consumers' Self-Help Clearinghouse
1211 Chestnut Street 10th Floor
Philadelphia, Pennsylvania 19107
Phone: (800) 553-4539
FAX: (215) 636-6310
E-mail: info@hselfhelp.org
URL: <http://www.mhselfhelp.org>

Consumer Organization And Networking Technical Assistance Center (CONTAC)

W. Virginia Mental Health Consumers Association

1036 Quarrier Street Suite 208A Charleston, West Virginia 25301

Phone: (888) 825-TECH (8324) (304) 346-9992

FAX: 304-345-7303

E-mail: contac@contac.org

URL: <http://www.contac.org>

National Empowerment Center

599 Canal Street

Lawrence, Massachusetts 01840

Phone: (800) 769-3728

FAX: (978) 681-6426

URL: <http://www.Power2u.org>

National Mental Health Association's National Consumer Supporter Technical Assistance Center:

2000 N. Beauregard Street, 6th Floor

Alexandria, VA 22311

Tel. (866) 439-9465

Fax. (703) 684-5968

<http://www.ncstac.org/>

E-mail: ConsumerTA@nmha.org

National Alliance for the Mentally Ill (NAMI) -- NAMI Support, Technical Assistance, and Resource Center (STAR):

STAR Center

3803 N. Fairfax Dr., Suite 100

Arlington, VA 22203

Toll-Free: (866) 537-STAR (7827)

Fax: (703) 600-1112

<http://www.consumerstar.org/star@nami.org>

National Consumer Conference: <http://www.power2u.org/alternatives2005.html>

In addition to the above sites for consumers, the Substance Abuse and Mental Health Administration (SAMHSA) provides many links to helpful sites for persons wanting information about mental illness treatment and recovery. These sites can be accessed through the link below.

<http://store.samhsa.gov/facet/Treatment-Prevention-Recovery>

Technical Assistance Centers - Indiana

Several universities and other organizations have contributed extensively to the promotion of knowledge about mental illness and addiction. The following sites have been established to provide technical assistance regarding a specific area of knowledge. Some of the sites are in Indiana and others are located throughout the United States.

The ACT Center of Indiana provides technical assistance regarding implementation of Assertive Community Treatment, Illness Management and Recovery, Integrated Dual Diagnosis Treatment, and other Evidence-based Practices in the field of mental health.

<http://psych.iupui.edu/ACT/index.html>

The Supported Employment Consultation and Training Center in Indiana provides information about Supported Employment and Supported Education programs and offers consultation and training about these practices to mental health centers. <http://w.sectcenter.org/>

The Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children is located in Indiana. This Center offers consultation, training, coaching, and other assistance to groups establishing a System of Care for children.

<http://www.choicesteam.org/page/program/alias/TACenter&article=317&prog=317>

The National Association of Mental Health Planning and Advisory Councils (NAMHPAC) is a network of people involved with State mental health planning and advisory councils, which are required by federal statute to assist states in developing and implementing state mental health plans.

<http://www.namhpac.org>

Toolkits for Evidence-Based Practices in Mental Health including Assertive Community Treatment (ACT), Illness Management and Recovery (IMR), Medication Management, Supported Employment, Integrated Dual Disorder Treatment (IDDT), and Family Psychoeducation: <http://www.occmha.org/> (National Consumer Organization)

Treatment Advocacy Center

The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to timely and effective treatment of severe mental illness.

200 N. Glebe Road, Suite 730
Arlington, VA 22203
703-294-6001 (phone)
703-294-6010 (fax)
Treatmentadvocacycenter.org

Other Web-Sites of Interest:

Indiana Institute on Disability and Community:

<http://www.iidc.indiana.edu/>

Program: <http://www.insource.org/>

Information and Referral Network: <http://www.connect2help.org/>

About Special Kids: <http://www.aboutspecialkids.org/>

Indiana Consortium for Mental Health Services Research: <http://www.indiana.edu/~icmhsr/>

Legislative Codes: <http://www.state.in.us/legislative/iac/title440.html>

Great Lakes ADA and Accessible IT Center, A Disability and Business Technical Assistance Center:
<http://www.adagreatlakes.org/>

DisabilityInfo.gov provides federal government information and resources for persons interested in disability-related issues: <https://www.disability.gov/>

National Council on Disability (NCD): <http://www.ncd.gov/>

Handling your Psychiatric Disability in Work and School: <http://cpr.bu.edu/resources/reasonable-accommodations/jobschool>

The Resource Center to Address Discrimination and Stigma (ADS Center):
http://www.nami.org/Template.cfm?Section=Top_Story&template=/contentmanagement/contentdisplay.cfm&ContentID=21217

Mary Ellen Copeland: <http://www.mentalhealthrecovery.com/>

Empowerment /Self-Determination Resources: http://www.psych.uic.edu/mhsrp/empowrmnt_res.htm;
http://www.tucollaborative.org/comm_inclusion/self_determination.html

An overview of Systems of Care: <http://www.tapartnership.org/SOC/SOCoverview.php> ;
<http://www.tapartnership.org/SOC/SOCoverview.php?id=topic1>

KEY Peer Support Training Team offers these consumer training opportunities: Mental Health Recovery Including Wellness Recovery Action Planning (WRAP)

Researcher, author, and educator Mary Ellen Copeland has written the Wellness Recovery Action Plan (WRAP) based on 12 years of studying how people who have various mental health issues help themselves to feel better and how they recover. "WRAP is used widely across the United States and around the world and is considered an exemplary practice by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. WRAP has helped numerous people who experience difficult psychiatric symptoms, some for many years, take charge of their lives and move on with recovery."

Recovery & Rehabilitation (volume 3, number 1), Center for Psychiatric Rehabilitation, Boston University, December 2003.

"WRAP is a structured system for keeping well and for responding to difficult symptoms or troubling things that happen when a person is not feeling well. WRAP does not tell you what to do, but rather WRAP helps each person figure out what to do for him/herself in a totally self-determined approach. In order to arrest symptoms and hasten remission and recovery, participants both learn and share personal strategies for dealing with each level of relapse."

Freedom Self-Advocacy Curriculum

The Freedom Self-Advocacy Curriculum is a tool to help teach self-advocacy skills to mental health consumers. The National Mental Health Consumers' Self-Help Clearinghouse, working in conjunction with the National Mental Health Association (NMHA), the National Association of Protection and Advocacy Systems (NAPAS), and other organizations, has developed the Freedom Self-Advocacy Curriculum. The original curriculum can be found on the Clearinghouse web site at <http://www.mhselfhelp.org/storage/training/freedom-self-advocacy-curriculum/intro.pdf>

Overview of the Freedom Self-Advocacy Curriculum: Workshop one "Attitudes" teaches how to keep feelings from getting in the way of what you need. Workshop two "Skills" teaches planning and

communication skills that will help you to get people to listen. Workshop three "Knowledge" will increase your knowledge of the mental health system and to learn resources to turn to when things are not working. We can come to any location in Indiana to present the self-advocacy training. There is no cost for this training. A minimum of three hours is needed to cover the curriculum.

Indiana Leadership Academy

The Leadership Academy is an exemplary self-help program with consistently applied methodology utilized to improve outcomes for adults with mental illness. The curriculum promotes empowerment, leadership, organizational skill-development, citizenship rights, and collective advocacy. Evidence of the significance of the Leadership Academy has been validated through formal research, (Hess, Clapper & Hekstra, 2001; Sabin, 2002; Stringfellow and Muscari, 2002).

The Leadership Academy has proven successful for adults with mental health and/or co-occurring concerns because it emphasizes the importance of peer-support, responsibility, empowerment and recovery-oriented strategies. It is beneficial to the community-at-large by supporting collective advocacy, increasing networking and greater civic involvement, and improving awareness of and action on local issues and concerns.

Inside / Outside: Building a Meaningful Life Outside of the Hospital:

This is a work of hope created by ex-patient film-makers Pat Deegan and Terry Strecker. Inside Outside tells the story of how eight people with very significant histories of institutionalization made the transition to recovery and community living. In the spirit of the New Freedom Initiative and the Supreme Court's Olmstead Decision, the film carries the message that recovery and life in the community are possibilities even for people who are viewed as the most chronic or impaired.

Appendix 2

Motion to Suppress

DAUGHERTY'S STATEMENTS GIVEN TO OFFICERS WEST AND ELIOT ON OCTOBER 30, 2000
ARE INVOLUNTARY AND SHOULD BE SUPPRESSED.....2-1

Appendix 2

STATE OF INDIANA	)	IN THE MARION SUPERIOR COURT
	) SS:	CRIMINAL DIVISION, ROOM NO.4
COUNTY OF MARION	)	CAUSE NO.G040011CF196823

STATE OF INDIANA,	)
	)
Plaintiff,	)
	)
vs.	)
	)
	)
CHARLES DAUGHERTY	)
Defendant.	)

DAUGHERTY’S STATEMENTS GIVEN TO OFFICERS WEST AND ELIOT ON OCTOBER 30, 2000 ARE INVOLUNTARY AND SHOULD BE SUPPRESSED

Establishing a valid waiver of ones’ *Miranda* warnings and the voluntariness of a defendant's statement require the same analysis under the Due Process Clause of the U.S. Constitution. Each employs the totality of the circumstances test. *Crain v. State*, 726 N.E.2d 1223,1230-1232 (Ind.2000); *Ashby v. State*, 265 Ind.316, 321, 354 N.E.2d 192, 195 (1976); *Malloy v. Hogan*, 378 U.S.1, 84 S.Ct.1489, 12 L.Ed.2d 653 (1964). The requirement that *Miranda* warnings be given does not, alone, dispense with the voluntariness inquiry. *Id*; *Allen v. State*, 686 N.E.2d 760,770 (Ind.1997). The court looks at the totality of the circumstances to ensure that a defendant's self-incriminating statement was not induced by violence, threats, or other improper influences that overcame the defendant's free will. *Crain*, 726 N.E.2d at 1230; *Wilcoxon v. State*, 619 N.E.2d 574, 577 (Ind.1993).

Although coercive police activity is a necessary prerequisite to finding a confession involuntary within the meaning of the Due Process Clause of the Fourteenth Amendment, *Crain*, 736 N.E.2d 1223,1232; *Colorado v. Connelly*, 479 U.S. 157, 167, 107 S.Ct. 515, 522, 93 L. Ed.2d 473, 484 (1986), the court need not find proof of police coercion to render a defendant's confession involuntary under the Indiana Constitution. The proper standard under the Indiana Constitution is whether the confession was “freely self-determined and

the product of a rational intellect and a free will." *Hurt v. State*, 694 N.E.2d 1212, 1218 (Ind.Ct.App.1998); *Linthicum v. State*, 511 N.E.2d 1026,1031 (Ind.1987). The burden is on the State to prove that the statement was given voluntarily by a preponderance of the evidence. *Smith v. State*, 689 N.E.2d 1238, overruling *Houchin v. State*, 581 N.E.2d 1228 (Ind.1991).

The analysis focuses on the effect of the totality of the circumstances on the defendant's will. Although it matters not whether the statement was true or false or even if there is ample evidence aside from the confession to support the verdict, *Light v. State*, 547 N.E.2d 1073, 1077 (Ind. 1989), citing *Rogers v. Richmond*, 365 U.S. 534, 81 S.Ct. 735, 5 L.Ed.2d 760 (1961), the court nonetheless looks at a multitude of factors. The court examines not only police coercion, but the length of the interrogation, its location, its continuity, the defendant's maturity, education, physical condition, mental health, and whether the defendant was given *Miranda* warnings. *Withrow v. Williams*, 507 U.S. 680 (1993). The court also examines whether the defendant was under the influence of drugs or alcohol. *Battles v. State*, 688 N.E.2d 1230, 1233 (Ind.1997). The court examines the lack of experience with police procedure, coercive psychological techniques, and false legal advice. *Light*, 547 N.E.2d 1073,1079. The court examines police deception in the form of falsehoods expressed to the defendant. *Kahlenbeck v. State*, 719 N.E.2d 1213, 1218 (Ind.1999). The court also considers inconsistencies in the defendant's statement.¹ *Davies v. State*, 730 N.E.2d 726, 732-735 (Ind.Ct.App.2000);

¹According to *Crane v. Kentucky*, 476 U.S. 683; 106 S.Ct. 2142, 90 L.Ed.2d 636, (1986) the Supreme Court has never questioned that evidence surrounding the making of a confession bears on its credibility, as well as its voluntariness. Because questions of credibility are for the jury, the requirement that the court make a pretrial voluntariness determination does not undercut the defendant's traditional prerogative to challenge the confessions reliability during the course of trial. Evidence about the manner in which a confession was secured will often be germane to its probative weight, a matter that is exclusively for the jury to assess. The circumstances surrounding the taking of a confession can be highly relevant to two separate inquiries, one legal and one factual. The manner in which a statement was extracted is relevant to the purely legal question of its voluntariness, a question most states assign to the trial judge alone. *Id.* The *Crane* Court further explains that the physical and psychological environment that yielded the confessing can also be of substantial relevance to the ultimate factual issue of the defendant's guilt or innocence. The *Crane* court opined that a confession, even those that have been found to be voluntary, are not conclusive of guilt. A confession may be shown to be insufficiently corroborated or otherwise unworthy of belief, citing *Lego v. Twomey*, 404 U.S. 477, 488-89, 92 S.Ct. 619, 30 L.Ed.2d 618 (1972). Although the court at this time need not pass on the truth or falsity of Daugherty's statement, the inconsistencies contained therein are a factor to consider in applying the totality of the circumstances analysis. As pointed out by the Supreme Court in *Crane*, the analyses overlap.

Patterson v. State, 563 N.E.2d 653, 655 (Ind.Ct.App.1990).

The finding of police coercion need not depend upon actual violence by a government agent. *Arizona v. Fulminante*, 499 U.S. 279 (1991), *dissenting opinion*. A credible threat is sufficient. Coercion can be mental as well as physical. *Id.* When analyzing promises of leniency or inducements, the crucial element is whether the confession was compelled or extracted as a result of promises of leniency. *Drew v. State*, 503 N.E.2d 613,617 (Ind.1987). A confession is inadmissible when obtained by a promise of immunity or mitigation of punishment. *Id.* The relevant inquiry is whether the challenged police conduct induced a confession which was not freely self-determined. *Id.*

A “mild promise of leniency” is deemed sufficient to bar a confession “given by a defendant in custody, alone and unrepresented by counsel.” *Brady v. United States*, 397 U.S. 742,754, 90 S.Ct.1463, 1372, 25 L.Ed.2d 747,759 (1970). A coerced confession claim, whether founded on a promise of immunity or otherwise, always involves the question of whether the government conduct complained of brought about a confession that was not freely self-determined. *Shotwell Manufacturing Co. v. United States*, 371 U.S.341, 348, 83 S.Ct. 448, 453, 9 L.Ed.2d 357 (1963).

By all doctors' accounts, Charles is mentally retarded. As a component of his mental deficiencies, Charles is incapable of appreciating the complexities of abstract thought. Charles understands only the most concrete and immediate implications of any given statement. The undisputed testimony established that Charles was told that if he gave a statement, he could go home. In fact, West testified that he felt compelled to honor this promise because of the conditions under which the promise was made and Charles' statement was given. Clearly, it was an offer of leniency and mitigation that induced Charles to give a statement incriminating himself. According to the doctors, Charles would have been incapable of appreciating the duplicitous nature of the deception: that Charles would be taken home as promised, but kept under surveillance and arrested in the morning. In fact, West testified that he and the prosecutor had reached the conclusion that Charles would be arrested, but such was not communicated to Charles.

Charles was unrepresented by counsel, was alone, and in the custody² of police at the time. As acknowledged by *Brady v. United States* referenced above, a “mild promise of leniency” is deemed sufficient to bar a confession given by a defendant who was in custody, alone, and unrepresented by counsel. Charles was intentionally led to believe that the only immediate consequences of his statement would be his release from the custody of West on that day, October 30, 2000, a promise of leniency that overcame his will.

Although Charles was given *Miranda* warnings several times on the October 30, 2000, Dr. Olvera testified that Charles did not have the mental capacity to understand the nature of the rights and the ability to appreciate the consequences of incriminating himself. His ignorance and confusion of the potential harm in giving an incriminating statement were compounded by the offers of leniency and mitigation extended to him by West.

In *A.A. v. State*, 706 N.E.2d 259 (Ind.Ct.App.1999), the Court of Appeals analyzed the voluntariness of a statement given in exchange for a promise made by the officer that the defendant’s case against another person would be prosecuted if he proved himself to be a credible witness by incriminating himself in the matter at hand. Although the court could have held that the officer’s nebulous assurance that giving a statement might bolster his credibility, the court reasoned otherwise. The Court stated the officer’s conduct indicated an “undeviating intent” to obtain the defendant’s confession. Even though the defendant was not in custody and both he and his mother had signed the written confession, the court held there was “substantial evidence of police pressure” and the statement was leveraged by an improper *quid pro quo*. As such, the Court of Appeals held that the admission of the statement violated Due Process and should have been suppressed by the trial court.

The Supreme Court in *Smith v. State*, 689 N.E.2d 1238, 1248 (Ind.1997) acknowledged that under the

² The court need not resolve the legal conclusion as to whether Charles was “in custody” because he was in fact given *Miranda* warnings. As a factual matter, West testified that Charles had no mode of transportation other than that provided by West, who picked Charles up in the morning and took him home late in the evening. For the purpose of analyzing the impact of the police tactics on Charles’ ability to withstand the pressure, it suffices to understand that Charles could not have left the station on his own volition. West had Charles under his complete control.

federal standard, the mere examination of the confessor's state of mind, even where the defendant is delusional, can never conclude the due process inquiry, *unless the police knew* of the defendant's mental state and susceptibility to police coercion at the time of the interrogation. The Court stated that suppressing the confession would serve no purpose in enforcing constitutional guarantees. In other words, the defendant's mental state is not enough to render a confession inadmissible in the absence of coercive police activity. In *Smith*, the defendant's argument failed because he had made no claim that the police who interrogated the defendant *knew* that he was slow or unusually susceptible to pressure. *Id.*

Such is not the case here. The police were aware that Charles was retarded. Defendant's Exhibit A, the inter-department memo from IPD, identified Charles as a retarded person who found the body. Roy West, the detective who ultimately elicited the statements in question received that information and was at least informed that the department considered Charles to be retarded. In the statement Charles gave to Phillips on September 25, 2000, Phillips asked him about special classes he had taken in school, page 5. Charles indicated he was a slow learner, page 5. Charles also indicated that he did not comprehend well. Page 6. Charles indicated that he has problems reading "big words" in the newspaper. Charles also indicated in that statement that he had problems in math with "times and take away." Page 7. Phillips asked Charles if "the social security people send you money" and Charles indicated that they did. His difficulties emerged in the course of the interview again on page 23 when Charles indicated that he was having a hard time recalling, or "catching on to stuff" and "understanding what people are saying." Phillips questioned Charles extensively in that statement as to whether he knew the body was a boy or a girl when he found it and Charles indicated he did not know for certain, but thought it might be a girl because of the small hands and feet and because the shoes appeared to be those of a girl. He indicated that he did not know for certain the body was a girl until he was later told by police. Pages 27-30.

Charles' statement to Phillips was given less than a week before Charles was questioned for the third time by Roy West. Although West stated he did not know that Charles was mentally challenged, his position belies the information received from Captain Snow and the statement Charles had just recently given Phillips.

Furthermore, Masbaum and Schuster both reached the conclusion that Charles was mentally retarded after having given him no formal testing and after having spent less than two hours with him. Each testified that Charles' deficiencies were apparent even from a layman's perspective. West's notes indicated that Charles could not understand big words. West stated that he read the *Miranda* warnings to Charles, indicating that he was at least aware Charles could not even attempt to read and understand the waiver without assistance. Eliot testified that he had been informed by Detective Guthier that Charles was mentally challenged. Eliot was with West on October 30, 2000 when the statements were elicited.³

The record establishes that the detectives who questioned Charles knew of his mental state and susceptibility to police coercion at the time of the interrogation in question. Holding him from early in the morning until late at night and promising him they would take him home if he gave a statement clearly suggests that they intended to take full advantage of his vulnerabilities.

Charles had already been questioned numerous times in the past:

April 6, 1994 by Jesse Beavers, (Defendant's Exhibit 1)

April 8, 1994 by Larry Smith, polygrapher

September 25, 2000 by Phillips, (Defendant's Exhibit 2)

September 26, 2000, another polygraph exam by Larry Smith

October 16, 2000 by Roy West

October 17, 2000 by Roy West

and then on October 30, 2000 by both Roy West and Eliot. The lengthy period of time Charles was held on the 30th must be viewed in the context of repeated and unrelenting efforts to elicit an incriminating statement from Charles. The intensity of the questioning had increased in October of 2000. The clear message was that the questioning would not stop until Charles said he killed Lashonna Bates. As in *AA v. State*, the officer's conduct indicated an "undeviating intent" to obtain the defendant's confession. The atmosphere of pressure

³Eliot administered a polygraph to Charles on the 30th. He stated that all the statements Charles made to him were during the polygraph exam, which included the follow up questions after the actual testing.

and coercion, coupled with the promises made by the police, renders the statement involuntary under both Indiana and federal Due Process jurisprudence.

CONCLUSION

If Charles is convicted of murder, his case will be appealed, like most other convictions for serious offenses. The gravity of the decision to admit his statements will be reviewed in light of what other evidence of guilt there may be. Various standards will be employed at the different levels of review. For instance, on appeal the court may employ the analysis under the “Incredible Dubiosity” doctrine, which applies when a sole witness presents inherently contradictory testimony that is equivocal or the result of coercion, combined with a complete lack of circumstantial evidence of the appellant’s guilt. *West v. State*, 755 N.E.2d 173 (Ind.2001). In so doing, the court will look to the presence of corroborating evidence of the State’s theory of the case, as the Indiana Supreme Court did in *Lee v. State*, 735 N.E.2d 1169 1169,1173 (Ind.2000). A properly admitted statement of the defendant that is inconsistent and improbable will sustain a conviction on appeal if there is other evidence in the record to support the verdict. *Davenport v. State*, 749 N.E.2d 1144, 1152 (Ind.2001). An improperly admitted statement will be deemed harmless error if there is substantial independent evidence of guilt. *Morales v. State* 749 N.E.2d 1260,1267 (Ind.Ct.App. 2001). On post conviction relief, this court’s decision to admit Charles statements may not be deemed clearly erroneous, as was the case in *Conner v. State*, 711 N.E.2d 1238, 1247-8 (Ind. 1999), where the “principle facts” in the confession are corroborated by other facts. Similarly, on habeas review, the federal court will conduct a plenary review of the record and render a *de novo* decision as to whether the error is “harmless beyond a reasonable doubt.” *Chapman v. California*, 386 U.S. 18, 24, 87 S.Ct.824,17 L.Ed.2d 705 (1967).

Charles was induced to provide a statement of guilt that will be the only piece of evidence linking him to the death of Lashonna Bates, other than the undisputed fact that he found the body. At trial, there will be no eye witnesses, no videotape from the Village Pantry, no pubic hairs, head hairs or sperm linking Charles to his alleged multiple acts of sexual intercourse, no fingerprints, and no property of the victim found in his possession. In his first statement to the police given shortly after the body was reported, Charles asked

Detective Beavers if the body was a boy or a girl. Six years later, upon the detectives' promise to return Charles home if he gave a statement, Charles stated he killed her, raped her numerous times, drove her all around town, then hit her over the head with a rock and left her where she lay.

If Charles' statements are admitted at trial and he is convicted, it is unlikely any error in the admission of such statements would be deemed harmless error. For all the reasons set forth above, Charles Daugherty respectfully requests that the court consider all relevant factors, including the incredulous nature of the uncorroborated statements at issue and conclude that the statements given to Detective West and Detective Eliot on October 30, 2000 were the product of aggressive police tactics that were inappropriate under the circumstances of this case for the compromised mental capacity possessed by Charles Daugherty. Daugherty respectfully requests that the court suppress the statements given to Eliot and West on October 30, 2000 and for all other just and proper relief.

CERTIFICATE OF SERVICE

I, Jane Ruemmele, hereby certify that I have on the _____, served a true and accurate copy of the above and foregoing via United States mail, first class, postage pre-paid, or delivery to the mail box in court 4 to:

Judi Johnson-Shock

Marion County Prosecutor's Office
E415 City-County Building
200 East Washington Street
Indianapolis, IN 46204

JANE RUEMMELE

Appendix 3

Competency to Stand Trial

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Appendix 3

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	1	2	3	4	5	6
4. Planning of legal strategy, including guilty plea to lesser charges where pertinent	1	2	3	4	5	6
5. Appraisal of role of:	1	2	3	4	5	6
a. Defense counsel						
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 do 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 within 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?

DEFENDANT: _____

7. APPRECIATION OF CHARGES:

- a. What are you charged with?
- b. Is that a major or a minor charge?
- 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.

DEFENDANT: _____

- 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?

- 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?

DEFENDANT: _____

Appendix 4

The Goals of Mitigation Interviews

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Appendix 4

The Goals of Mitigation Interviews

by Lee Norton

Introduction

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, 990).

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 de-scribing the event (details are critical to an adequate psycho-social 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 some-time 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 re-main 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 compromised. 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 psycho-dynamics 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 de-scribing 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 re-duce 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. (Orthmer, 1994). For witnesses with cognitive deficits, open-ended questions are confusing and overwhelming; 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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Appendix 5

Social Histories and Forensic Mental Health Evaluations

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Appendix 5

Social Histories and Forensic Mental Health Evaluations in Forensic Cases

©by Robert Walker

Introduction

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 court-room 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 worthwhile 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:

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.

- 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 vogue "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."

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 bounded 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 genetic pattern while sensitivity to comorbidities 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 commonalities 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 foster care 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 is 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' viewpoints. 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 stereotyping; 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 "non-traumatic" 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 incapacities, 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 than 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 pernicious 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 is 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 questions 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 antisocial acts that are most influenced by social environment versus those that predate 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 preoccupations 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 antisocial 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 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 as 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 memorial capacity for short term, intermediate term and long term functions. All memorial 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. Memorial 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 memorial 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.)

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

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 memorial 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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Appendix 6

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."	6/6/58		Randy committed by court to Child Welfare Board (CWB), but remains at Mercurios, his grandparents
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. Thornton and Betty Conley have a child.	11/58		
24.	1959	6	Randy begins year at MCH.
25.	1959	6	Randy repeats the first grade.

FACTS IN RANDY'S LIFE	DATE	RANDY'S AGE	RANDY'S LIFE
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	
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" according 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	

FACTS IN RANDY'S LIFE	DATE	RANDY'S AGE	RANDY'S LIFE
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."
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.
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.

FACTS IN RANDY'S LIFE	DATE	RANDY'S AGE	RANDY'S LIFE
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	

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Overview of New DSM-5

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Appendix 7

Overview of New DSM-5

INTRODUCTION

Many of the changes in the new DSM-5¹ were made to better characterize symptoms and behaviors of groups of people who are currently seeking clinical help but whose symptoms are not well-defined by DSM-IV, which means they are less likely to seek treatment.

To provide an overview of the new DSM-5, this appendix reproduces three documents from DSM-5: 1) the new DSM-5 table of contents, 2) highlights of changes from DSM-IV to DSM-5, and 3) an overview of the DSM-5 discussion of personality disorders.

Key DSM-5 Links:

Home website: <http://www.dsm5.org/Pages/Default.aspx>.

Other DSM-5 related documents: <http://www.dsm5.org/Documents/Forms/AllItems.aspx>. These include documents on ADHD, schizophrenia, autism spectrum disorder, intellectual disabilities, obsessive-compulsive disorder, social anxiety disorder, and substance abuse.

¹ Beginning with the DSM-5, new versions of the DSM will be identified with Arabic rather than Roman numerals.

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Unspecified Hypersomnolence Disorder
Other Specified Sleep-Wake Disorder
Unspecified Sleep-Wake Disorder

Sexual Dysfunctions

Delayed Ejaculation
Erectile Disorder
Female Orgasmic Disorder
Female Sexual Interest/Arousal Disorder
Genito-Pelvic Pain/Penetration Disorder
Male Hypoactive Sexual Desire Disorder
Premature (Early) Ejaculation
Substance/Medication-Induced Sexual Dysfunction
Other Specified Sexual Dysfunction
Unspecified Sexual Dysfunction

Gender Dysphoria

Gender Dysphoria
Other Specified Gender Dysphoria
Unspecified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder
Intermittent Explosive Disorder
Conduct Disorder
Antisocial Personality Disorder
Pyromania
Kleptomania
Other Specified Disruptive, Impulse-Control, and Conduct Disorder
Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders**Substance-Related Disorders**

Substance Use Disorders
Substance-Induced Disorders
Substance Intoxication and Withdrawal

Substance/Medication-Induced Mental Disorders

Alcohol-Related Disorders

Alcohol Use Disorder
Alcohol Intoxication
Alcohol Withdrawal
Other Alcohol-Induced Disorders
Unspecified Alcohol-Related Disorder

Caffeine-Related Disorders

Caffeine Intoxication
Caffeine Withdrawal
Other Caffeine-Induced Disorders
Unspecified Caffeine-Related Disorder

Cannabis-Related Disorders

Cannabis Use Disorder
Cannabis Intoxication
Cannabis Withdrawal
Other Cannabis-Induced Disorders
Unspecified Cannabis-Related Disorder

Hallucinogen-Related Disorders

Phencyclidine Use Disorder
Other Hallucinogen Use Disorder
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Other Phencyclidine-Induced Disorders
Other Hallucinogen-Induced Disorders
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder

Inhalant-Related Disorders

Inhalant Use Disorder
Inhalant Intoxication
Other Inhalant-Induced Disorders
Unspecified Inhalant-Related Disorder

Opioid-Related Disorders

Opioid Use Disorder
Opioid Intoxication
Opioid Withdrawal
Other Opioid-Induced Disorders
Unspecified Opioid-Related Disorder

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

Sedative, Hypnotic, or Anxiolytic Use Disorder
Sedative, Hypnotic, or Anxiolytic Intoxication
Sedative, Hypnotic, or Anxiolytic Withdrawal
Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

Stimulant-Related Disorders

Stimulant Use Disorder

Stimulant Intoxication

Stimulant Withdrawal

Other Stimulant-Induced Disorders

Unspecified Stimulant-Related Disorder

Tobacco-Related Disorders

Tobacco Use Disorder

Tobacco Withdrawal

Other Tobacco-Induced Disorders

Unspecified Tobacco-Related Disorder

Other (or Unknown) Substance-Related Disorders

Other (or Unknown) Substance Use Disorder

Other (or Unknown) Substance Intoxication

Other (or Unknown) Substance Withdrawal

Other (or Unknown) Substance-Induced Disorders

Unspecified Other (or Unknown) Substance-Related Disorder

Non-Substance-Related Disorders

Gambling Disorder

Neurocognitive Disorders

Delirium

Other Specified Delirium

Unspecified Delirium

Major and Mild Neurocognitive Disorders

Major Neurocognitive Disorder

Mild Neurocognitive Disorder

Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease

Major or Mild Frontotemporal Neurocognitive Disorder

Major or Mild Neurocognitive Disorder With Lewy Bodies

Major or Mild Vascular Neurocognitive Disorder

Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

Substance/Medication-Induced Major or Mild Neurocognitive Disorder

Major or Mild Neurocognitive Disorder Due to HIV Infection

Major or Mild Neurocognitive Disorder Due to Prion Disease

Major or Mild Neurocognitive Disorder Due to Parkinson's Disease

Major or Mild Neurocognitive Disorder Due to Huntington's Disease

Major or Mild Neurocognitive Disorder Due to Another Medical Condition

Major or Mild Neurocognitive Disorder Due to Multiple Etiologies

Unspecified Neurocognitive Disorder

Personality Disorders

General Personality Disorder

Cluster A Personality Disorders

Paranoid Personality Disorder

Schizoid Personality Disorder
Schizotypal Personality Disorder

Cluster B Personality Disorders

Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder

Cluster C Personality Disorders

Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder

Other Personality Disorders

Personality Change Due to Another Medical Condition
Other Specified Personality Disorder
Unspecified Personality Disorder

Paraphilic Disorders

Voyeuristic Disorder
Exhibitionistic Disorder
Frotteuristic Disorder
Sexual Masochism Disorder
Sexual Sadism Disorder
Pedophilic Disorder
Fetishistic Disorder
Transvestic Disorder
Other Specified Paraphilic Disorder
Unspecified Paraphilic Disorder

Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition
Unspecified Mental Disorder Due to Another Medical Condition
Other Specified Mental Disorder
Unspecified Mental Disorder

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Other Conditions That May Be a Focus of Clinical Attention

Section III: Emerging Measures and Models

Assessment Measures

Cross-Cutting Symptom Measures DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult
Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure—Child Age 6–17
Clinician-Rated Dimensions of Psychosis Symptom Severity
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

Cultural Formulation

Cultural Formulation Interview (CFI)
Cultural Formulation Interview (CFI)—Informant Version

Alternative DSM-5 Model for Personality Disorders**Conditions for Further Study**

Attenuated Psychosis Syndrome
Depressive Episodes With Short-Duration Hypomania
Persistent Complex Bereavement Disorder
Caffeine Use Disorder
Internet Gaming Disorder
Neurobehavioral Disorder Associated With Prenatal Alcohol Exposure
Suicidal Behavior Disorder
Nonsuicidal Self-Injury

Appendix

Highlights of Changes From DSM-IV to DSM-5
Glossary of Technical Terms
Glossary of Cultural Concepts of Distress
Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM)
Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM)
Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM)
DSM-5 Advisors and Other Contributors

HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5

Changes made to the DSM-5 diagnostic criteria and texts are outlined in this chapter in the same order in which they appear in the DSM-5 classification. This is not an exhaustive guide; minor changes in text or wording made for clarity are not described here. It should also be noted that Section I of DSM-5 contains a description of changes pertaining to the chapter organization in DSM-5, the multiaxial system, and the introduction of dimensional assessments (in Section III).

Terminology

The phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.

Neurodevelopmental Disorders

Intellectual Disability (Intellectual Developmental Disorder)

Diagnostic criteria for intellectual disability (intellectual developmental disorder) emphasize the need for an assessment of both cognitive capacity (IQ) and adaptive functioning. Severity is determined by adaptive functioning rather than IQ score. The term mental retardation was used in DSM-IV. However, intellectual disability is the term that has come into common use over the past two decades among medical, educational, and other professionals, and by the lay public and advocacy groups. Moreover, a federal statute in the United States (Public Law 111-256, Rosa’s Law) replaces the term “mental retardation with intellectual disability. Despite the name change, the deficits in cognitive capacity beginning in the developmental period, with the accompanying diagnostic criteria, are considered to constitute a mental disorder. The term intellectual developmental disorder was placed in parentheses to reflect the World Health Organization’s classification system, which lists “disorders” in the International Classification of Diseases (ICD; ICD-11 to be released in 2015) and bases all “disabilities” on the International Classification of Functioning, Disability, and Health (ICF). Because the ICD-11 will not be adopted for several years, intellectual disability was chosen as the current preferred term with the bridge term for the future in parentheses.

Communication Disorders

The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorder.

Autism Spectrum Disorder

Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus that four previously separate disorders are actually a single condition with different levels of symptom severity in two core domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive

behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present.

Attention-Deficit/Hyperactivity Disorder

The diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) in DSM-5 are similar to those in DSM-IV. The same 18 symptoms are used as in DSM-IV, and continue to be divided into two symptom domains (inattention and hyperactivity/impulsivity), of which at least six symptoms in one domain are required for diagnosis. However, several changes have been made in DSM-5: 1) examples have been added to the criterion items to facilitate application across the life span; 2) the cross-situational requirement has been strengthened to “several” symptoms in each setting; 3) the onset criterion has been changed from “symptoms that caused impairment were present before age 7 years” to “several inattentive or hyperactive-impulsive symptoms were present prior to age 12”; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. Finally, ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM-5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood, or adolescence.

Specific Learning Disorder

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Because learning deficits in the areas of reading, written expression, and mathematics commonly occur together, coded specifiers for the deficit types in each area are included. The text acknowledges that specific types of reading deficits are described internationally in various ways as dyslexia and specific types of mathematics deficits as dyscalculia.

Motor Disorders

The following motor disorders are included in the DSM-5 neurodevelopmental disorders chapter: developmental coordination disorder, stereotypic movement disorder, Tourette’s disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. The tic criteria have been standardized across all of these disorders in this chapter. Stereotypic movement disorder has been more clearly differentiated from body-focused repetitive behavior disorders that are in the DSM-5 obsessive-compulsive disorder chapter.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was Highlights of Changes from DSM-IV-TR to DSM-5 removed due to the nonspecificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions. Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.

Schizophrenia subtypes

The DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

Schizoaffective Disorder

The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met. This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different points in their illness, has been a clinical challenge.

Delusional Disorder

Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs. DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

Catatonia

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as another specified diagnosis.

Bipolar and Related Disorders**Bipolar Disorders**

To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, “with mixed features,” has been added that can be applied to episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present.

Other Specified Bipolar and Related Disorder

DSM-5 allows the specification of particular conditions for other specified bipolar and related disorder, including categorization for individuals with a past history of a major depressive disorder who meet all

criteria for hypomania except the duration criterion (i.e., at least 4 consecutive days). A second condition constituting another specified bipolar and related disorder is that too few symptoms of hypomania are present to meet criteria for the full bipolar II syndrome, although the duration is sufficient at 4 or more days.

Anxious Distress Specifier

In the chapter on bipolar and related disorders and the chapter on depressive disorders, a specifier for anxious distress is delineated. This specifier is intended to identify patients with anxiety symptoms that are not part of the bipolar diagnostic criteria.

Depressive Disorders

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scientific evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study,” to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modified way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to find scientifically meaningful differences between these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV.

Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier “with mixed features.” The presence of mixed features in an episode of major depressive disorder increases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained.

Bereavement Exclusion

In DSM-IV, there was an exclusion criterion for a major depressive episode that was applied to depressive symptoms lasting less than 2 months following the death of a loved one (i.e., the bereavement exclusion). This exclusion is omitted in DSM-5 for several reasons. The first is to remove the implication that bereavement typically lasts only 2 months when both physicians and grief counselors recognize that the duration is more commonly 1–2 years. Second, bereavement is recognized as a severe psychosocial stressor that can precipitate a major depressive episode in a vulnerable individual, generally beginning soon after the loss. When major depressive disorder occurs in the context of bereavement, it adds an additional risk for suffering, feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder, which is now described with explicit criteria in Conditions for Further Study in DSM-5 Section III. Third, bereavement-related major depression is most likely to occur in individuals with past personal and family histories of major depressive episodes. It is genetically influenced and is associated with similar personality characteristics, patterns of comorbidity, and risks of chronicity and/or recurrence as non-bereavement-related major depressive episodes. Finally, the depressive symptoms associated with bereavement-related depression respond to the same psychosocial and medication treatments as non-

bereavement-related depression. In the criteria for major depressive disorder, a detailed footnote has replaced the more simplistic DSM-IV exclusion to aid clinicians in making the critical distinction between the symptoms characteristic of bereavement and those of a major depressive episode. Thus, although most people experiencing the loss of a loved one experience bereavement without developing a major depressive episode, evidence does not support the separation of loss of a loved one from other stressors in terms of its likelihood of precipitating a major depressive episode or the relative likelihood that the symptoms will remit spontaneously.

Specifiers for Depressive Disorders

Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to make a determination of the prominence of suicide prevention in treatment planning for a given individual. A new specifier to indicate the presence of mixed symptoms has been added across both the bipolar and the depressive disorders, allowing for the possibility of manic features in individuals with a diagnosis of unipolar depression. A substantial body of research conducted over the last two decades points to the importance of anxiety as relevant to prognosis and treatment decision making. The “with anxious distress” specifier gives the clinician an opportunity to rate the severity of anxious distress in all individuals with bipolar or depressive disorders.

Anxiety Disorders

The DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder (which is included with the obsessive-compulsive and related disorders) or posttraumatic stress disorder and acute stress disorder (which is included with the trauma- and stressor-related disorders). However, the sequential order of these chapters in DSM-5 reflects the close relationships among them.

Agoraphobia, Specific Phobia, and Social Anxiety Disorder (Social Phobia)

Changes in criteria for agoraphobia, specific phobia, and social anxiety disorder (social phobia) include deletion of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in “phobic” situations and that older individuals often misattribute “phobic” fears to aging. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after taking cultural contextual factors into account. In addition, the 6-month duration, which was limited to individuals under age 18 in DSM-IV, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears.

Panic Attack

The essential features of panic attacks remain unchanged, although the complicated DSM-IV terminology for describing different types of panic attacks (i.e., situationally bound/cued, situationally predisposed, and unexpected/uncued) is replaced with the terms unexpected and expected panic attacks. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including but not limited to anxiety disorders. Hence, panic attack can be listed as a specifier that is applicable to all DSM-5 disorders.

Panic Disorder and Agoraphobia

Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria. The co-occurrence of panic disorder and agoraphobia is now coded with two diagnoses. This change recognizes that a substantial number of individuals with agoraphobia do not experience panic symptoms. The diagnostic criteria for agoraphobia are derived from the DSM-IV descriptors for agoraphobia, although endorsement of fears from two or more agoraphobia situations is now required, because this is a

robust means for distinguishing agoraphobia from specific phobias. Also, the criteria for agoraphobia are extended to be consistent with criteria sets for other anxiety disorders (e.g., clinician judgment of the fears as being out of proportion to the actual danger in the situation, with a typical duration of 6 months or more).

Specific Phobia

The core features of specific phobia remain the same, but there is no longer a requirement that individuals over age 18 years must recognize that their fear and anxiety are excessive or unreasonable, and the duration requirement (“typically lasting for 6 months or more”) now applies to all ages. Although they are now referred to as specifiers, the different types of specific phobia have essentially remained unchanged.

Social Anxiety Disorder (Social Phobia)

The essential features of social anxiety disorder (social phobia) (formerly called social phobia) remain the same. However, a number of changes have been made, including deletion of the requirement that individuals over age 18 years must recognize that their fear or anxiety is excessive or unreasonable, and duration criterion of “typically lasting for 6 months or more” is now required for all ages. A more significant change is that the “generalized” specifier has been deleted and replaced with a “performance only” specifier. The DSM-IV generalized specifier was problematic in that “fears include most social situations” was difficult to operationalize. Individuals who fear only performance situations (i.e., speaking or performing in front of an audience) appear to represent a distinct subset of social anxiety disorder in terms of etiology, age at onset, physiological response, and treatment response.

Separation Anxiety Disorder

Although in DSM-IV, separation anxiety disorder was classified in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence,” it is now classified as an anxiety disorder. The core features remain mostly unchanged, although the wording of the criteria has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. For example, attachment figures may include the children of adults with separation anxiety disorder, and avoidance behaviors may occur in the workplace as well as at school. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that age at onset must be before 18 years, because a substantial number of adults report onset of separation anxiety after age 18. Also, a duration criterion—“typically lasting for 6 months or more”—has been added for adults to minimize overdiagnosis of transient fears.

Selective Mutism

In DSM-IV, selective mutism was classified in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged from DSM-IV.

Obsessive-Compulsive and Related Disorders

The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV diagnosis of trichotillomania is now termed trichotillomania (hair-pulling disorder) and has been moved from a DSM-IV classification of impulse-control disorders not elsewhere classified to obsessive-compulsive and related disorders in DSM-5.

Specifiers for Obsessive-Compulsive and Related Disorders

The “with poor insight” specifier for obsessive-compulsive disorder has been refined in DSM-5 to allow a distinction between individuals with good or fair insight, poor insight, and “absent insight/delusional”

obsessive-compulsive disorder beliefs (i.e., complete conviction that obsessive-compulsive disorder beliefs are true). Analogous “insight” specifiers have been included for body dysmorphic disorder and hoarding disorder. These specifiers are intended to improve differential diagnosis by emphasizing that individuals with these two disorders may present with a range of insight into their disorder-related beliefs, including absent insight/delusional symptoms. This change also emphasizes that the presence of absent insight/delusional beliefs warrants a diagnosis of the relevant obsessive-compulsive or related disorder, rather than a schizophrenia spectrum and other psychotic disorder. The “tic-related” specifier for obsessive-compulsive disorder reflects a growing literature on the diagnostic validity and clinical utility of identifying individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications.

Body Dysmorphic Disorder

For DSM-5 body dysmorphic disorder, a diagnostic criterion describing repetitive behaviors or mental acts in response to preoccupations with perceived defects or flaws in physical appearance has been added, consistent with data indicating the prevalence and importance of this symptom. A “with muscle dysmorphia” specifier has been added to reflect a growing literature on the diagnostic validity and clinical utility of making this distinction in individuals with body dysmorphic disorder. The delusional variant of body dysmorphic disorder (which identifies individuals who are completely convinced that their perceived defects or flaws are truly abnormal appearing) is no longer coded as both delusional disorder, somatic type, and body dysmorphic disorder; in DSM-5 this presentation is designated only as body dysmorphic disorder with the absent insight/delusional beliefs specifier.

Hoarding Disorder

Hoarding disorder is a new diagnosis in DSM-5. DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder. However, available data do not indicate that hoarding is a variant of obsessive-compulsive disorder or another mental disorder. Instead, there is evidence for the diagnostic validity and clinical utility of a separate diagnosis of hoarding disorder, which reflects persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them. Hoarding disorder may have unique neurobiological correlates, is associated with significant impairment, and may respond to clinical intervention.

Trichotillomania (Hair-Pulling Disorder)

Trichotillomania was included in DSM-IV, although “hair-pulling disorder” has been added parenthetically to the disorder’s name in DSM-5.

Excoriation (Skin-Picking) Disorder

Excoriation (skin-picking) disorder is newly added to DSM-5, with strong evidence for its diagnostic validity and clinical utility.

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder and Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

DSM-IV included a specifier “with obsessive-compulsive symptoms” in the diagnoses of anxiety disorders due to a general medical condition and substance-induced anxiety disorders. Given that obsessive-compulsive and related disorders are now a distinct category, DSM-5 includes new categories for substance-/medication-induced obsessive-compulsive and related disorder and for obsessive-compulsive and related disorder due to another medical condition. This change is consistent with the intent of DSM-IV, and it reflects the recognition that substances, medications, and medical conditions can present with symptoms similar to primary obsessive-compulsive and related disorders.

Other Specified and Unspecified Obsessive-Compulsive and Related Disorders

DSM-5 includes the diagnoses other specified obsessive-compulsive and related disorder, which can include conditions such as body-focused repetitive behavior disorder and obsessional jealousy, or unspecified obsessive-compulsive and related disorder. Body-focused repetitive behavior disorder is characterized by recurrent behaviors other than hair pulling and skin picking (e.g., nail biting, lip biting, cheek chewing) and repeated attempts to decrease or stop the behaviors. Obsessional jealousy is characterized by nondelusional preoccupation with a partner's perceived infidelity.

Trauma- and Stressor-Related Disorders**Acute Stress Disorder**

In DSM-5, the stressor criterion (Criterion A) for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly. Also, the DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event (e.g., "the person's response involved intense fear, helplessness, or horror") has been eliminated. Based on evidence that acute posttraumatic reactions are very heterogeneous and that DSM-IV's emphasis on dissociative symptoms is overly restrictive, individuals may meet diagnostic criteria in DSM-5 for acute stress disorder if they exhibit any 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.

Adjustment Disorders

In DSM-5, adjustment disorders are reconceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or nontraumatic) event, rather than as a residual category for individuals who exhibit clinically significant distress without meeting criteria for a more discrete disorder (as in DSM-IV). DSM-IV subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct have been retained, unchanged.

Posttraumatic Stress Disorder

DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced "traumatic" events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior. Posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

Reactive Attachment Disorder

The DSM-IV childhood diagnosis reactive attachment disorder had two subtypes: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. In DSM-5, these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder. Both of these disorders are the result of social neglect or other situations that limit a young child's opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have

established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders.

Dissociative Disorders

Major changes in dissociative disorders in DSM-5 include the following: 1) derealization is included in the name and symptom structure of what previously was called depersonalization disorder and is now called depersonalization/derealization disorder, 2) dissociative fugue is now a specifier of dissociative amnesia rather than a separate diagnosis, and 3) the criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

Dissociative Identity Disorder

Several changes to the criteria for dissociative identity disorder have been made in DSM-5. First, Criterion A has been expanded to include certain possession-form phenomena and functional neurological symptoms to account for more diverse presentations of the disorder. Second, Criterion A now specifically states that transitions in identity may be observable by others or self-reported. Third, according to Criterion B, individuals with dissociative identity disorder may have recurrent gaps in recall for everyday events, not just for traumatic experiences. Other text modifications clarify the nature and course of identity disruptions.

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. In DSM-IV, there was significant overlap across the somatoform disorders and a lack of clarity about their boundaries. These disorders are primarily seen in medical settings, and nonpsychiatric physicians found the DSM-IV somatoform diagnoses problematic to use. The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom Disorder

DSM-5 better recognizes the complexity of the interface between psychiatry and medicine. Individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors may or may not have a diagnosed medical condition. The relationship between somatic symptoms and psychopathology exists along a spectrum, and the arbitrarily high symptom count required for DSM-IV somatization disorder did not accommodate this spectrum. The diagnosis of somatization disorder was essentially based on a long and complex symptom count of medically unexplained symptoms. Individuals previously diagnosed with somatization disorder will usually meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.

In DSM-IV, the diagnosis undifferentiated somatoform disorder had been created in recognition that somatization disorder would only describe a small minority of “somatizing” individuals, but this disorder did not prove to be a useful clinical diagnosis. Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Medically Unexplained Symptoms

DSM-IV criteria overemphasized the importance of an absence of a medical explanation for the somatic symptoms. Unexplained symptoms are present to various degrees, particularly in conversion disorder, but somatic symptom disorders can also accompany diagnosed medical disorders. The reliability of medically unexplained symptoms is limited, and grounding a diagnosis on the absence of an explanation is

problematic and reinforces mind-body dualism. The DSM-5 classification defines disorders on the basis of positive symptoms (i.e., distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). Medically unexplained symptoms do remain a key feature in conversion disorder and pseudocyesis because it is possible to demonstrate definitively in such disorders that the symptoms are not consistent with medical pathophysiology.

Hypochondriasis and Illness Anxiety Disorder

Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Pain Disorder

DSM-5 takes a different approach to the important clinical realm of individuals with pain. In DSM-IV, the pain disorder diagnoses assume that some pains are associated solely with psychological factors, some with medical diseases or injuries, and some with both. There is a lack of evidence that such distinctions can be made with reliability and validity, and a large body of research has demonstrated that psychological factors influence all forms of pain. Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological Factors Affecting Other Medical Conditions and Factitious Disorder

Psychological factors affecting other medical conditions is a new mental disorder in DSM-5, having formerly been included in the DSM-IV chapter “Other Conditions That May Be a Focus of Clinical Attention.” This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings. The variants of psychological factors affecting other medical conditions are removed in favor of the stem diagnosis.

Conversion Disorder (Functional Neurological Symptom Disorder)

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

Feeding and Eating Disorders

In DSM-5, the feeding and eating disorders include several disorders included in DSM-IV as feeding and eating disorders of infancy or early childhood in the chapter “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” In addition, brief descriptions and preliminary diagnostic criteria are provided for several conditions under other specified feeding and eating disorder; insufficient information about these conditions is currently available to document their clinical characteristics and validity or to provide definitive diagnostic criteria.

Pica and Rumination Disorder

The DSM-IV criteria for pica and for rumination disorder have been revised for clarity and to indicate that the diagnoses can be made for individuals of any age.

Avoidant/Restrictive Food Intake Disorder

DSM-IV feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder, and the criteria have been significantly expanded. The DSM-IV disorder was rarely used, and limited information is available on the characteristics, course, and outcome of children with this disorder. Additionally, a large number of individuals, primarily but not exclusively children and adolescents, substantially restrict their food intake and experience significant associated physiological or psychosocial problems but do not meet criteria for any DSM-IV eating disorder. Avoidant/restrictive food intake disorder is a broad category intended to capture this range of presentations.

Anorexia Nervosa

The core diagnostic criteria for anorexia nervosa are conceptually unchanged from DSM-IV with one exception: the requirement for amenorrhea has been eliminated. In DSM-IV, this requirement was waived in a number of situations (e.g., for males, for females taking contraceptives). In addition, the clinical characteristics and course of females meeting all DSM-IV criteria for anorexia nervosa except amenorrhea closely resemble those of females meeting all DSM-IV criteria. As in DSM-IV, individuals with this disorder are required by Criterion A to be at a significantly low body weight for their developmental stage. The wording of the criterion has been changed for clarity, and guidance regarding how to judge whether an individual is at or below a significantly low weight is now provided in the text. In DSM-5, Criterion B is expanded to include not only overtly expressed fear of weight gain but also persistent behavior that interferes with weight gain.

Bulimia Nervosa

The only change to the DSM-IV criteria for bulimia nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behavior frequency from twice to once weekly. The clinical characteristics and outcome of individuals meeting this slightly lower threshold are similar to those meeting the DSM-IV criterion.

Binge-Eating Disorder

Extensive research followed the promulgation of preliminary criteria for binge eating disorder in Appendix B of DSM-IV, and findings supported the clinical utility and validity of binge-eating disorder. The only significant difference from the preliminary DSM-IV criteria is that the minimum average frequency of binge eating required for diagnosis has been changed from at least twice weekly for 6 months to at least once weekly over the last 3 months, which is identical to the DSM-5 frequency criterion for bulimia nervosa.

Elimination Disorders

No significant changes have been made to the elimination disorders diagnostic class from DSM-IV to DSM-5. The disorders in this chapter were previously classified under disorders usually first diagnosed in infancy, childhood, or adolescence in DSM-IV and exist now as an independent classification in DSM-5.

Sleep-Wake Disorders

Because of the DSM-5 mandate for concurrent specification of coexisting conditions (medical and mental), sleep disorders related to another mental disorder and sleep disorder related to a general medical condition have been removed from DSM-5, and greater specification of coexisting conditions is provided for each sleep-wake disorder. This change underscores that the individual has a sleep disorder warranting independent clinical attention, in addition to any medical and mental disorders that are also present, and acknowledges the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders. This reconceptualization reflects a paradigm shift that is widely accepted in the field of sleep disorders medicine. It moves away from making causal attributions between coexisting disorders. Any additional relevant information from the prior diagnostic categories of sleep disorder related to another mental disorder and sleep disorder related to another medical condition has been integrated into

the other sleep-wake disorders where appropriate. Consequently, in DSM-5, the diagnosis of primary insomnia has been renamed insomnia disorder to avoid the differentiation of primary and secondary insomnia. DSM-5 also distinguishes narcolepsy, which is now known to be associated with hypocretin deficiency, from other forms of hypersomnolence. These changes are warranted by neurobiological and genetic evidence validating this reorganization. Finally, throughout the DSM-5 classification of sleep-wake disorders, pediatric and developmental criteria and text are integrated where existing science and considerations of clinical utility support such integration. This developmental perspective encompasses age-dependent variations in clinical presentation.

Breathing-Related Sleep Disorders

In DSM-5, breathing-related sleep disorders are divided into three relatively distinct disorders: obstructive sleep apnea hypopnea, central sleep apnea, and sleep-related hypoventilation. This change reflects the growing understanding of pathophysiology in the genesis of these disorders and, furthermore, has relevance to treatment planning.

Circadian Rhythm Sleep-Wake Disorders

The subtypes of circadian rhythm sleep-wake disorders have been expanded to include advanced sleep phase syndrome, irregular sleep-wake type, and non-24-hour sleep-wake type, whereas the jet lag type has been removed.

Rapid Eye Movement Sleep Behavior Disorder and Restless Legs Syndrome

The use of DSM-IV “not otherwise specified” diagnoses has been reduced by designating rapid eye movement sleep behavior disorder and restless legs syndrome as independent disorders. In DSM-IV, both were included under dyssomnia not otherwise specified. Their full diagnostic status is supported by research evidence.

Sexual Dysfunctions

In DSM-IV, sexual dysfunctions referred to sexual pain or to a disturbance in one or more phases of the sexual response cycle. Research suggests that sexual response is not always a linear, uniform process and that the distinction between certain phases (e.g., desire and arousal) may be artificial. In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder. To improve precision regarding duration and severity criteria and to reduce the likelihood of overdiagnosis, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.

Genito-Pelvic Pain/Penetration Disorder

Genito-pelvic pain/penetration disorder is new in DSM-5 and represents a merging of the DSM-IV categories of vaginismus and dyspareunia, which were highly comorbid and difficult to distinguish. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research.

Subtypes

DSM-IV included the following subtypes for all sexual disorders: lifelong versus acquired, generalized versus situational, and due to psychological factors versus due to combined factors. DSM-5 includes only lifelong versus acquired and generalized versus situational subtypes. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors have been deleted due to findings that the most frequent clinical presentation is one in which both psychological and biological factors contribute. To indicate the presence and degree of medical and other nonmedical correlates, the

following associated features are described in the accompanying text: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors.

Gender Dysphoria

Gender dysphoria is a new diagnostic class in DSM-5 and reflects a change in conceptualization of the disorder's defining features by emphasizing the phenomenon of "gender incongruence" rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder. In DSM-IV, the chapter "Sexual and Gender Identity Disorders" included three relatively disparate diagnostic classes: gender identity disorders, sexual dysfunctions, and paraphilias. Gender identity disorder, however, is neither a sexual dysfunction nor a paraphilia. Gender dysphoria is a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical (at least for some adolescents and most adults). In contrast to the dichotomized DSM-IV gender identity disorder diagnosis, the type and severity of gender dysphoria can be inferred from the number and type of indicators and from the severity measures. The experienced gender incongruence and resulting gender dysphoria may take many forms. Gender dysphoria thus is considered to be a multicategory concept rather than a dichotomy, and DSM-5 acknowledges the wide variation of gender - incongruent conditions. Separate criteria sets are provided for gender dysphoria in children and in adolescents and adults. The adolescent and adult criteria include a more detailed and specific set of polythetic symptoms. The previous Criterion A (cross-gender identification) and Criterion B (aversion toward one's gender) have been merged, because no supporting evidence from factor analytic studies supported keeping the two separate. In the wording of the criteria, "the other sex" is replaced by "some alternative gender." Gender instead of sex is used systematically because the concept "sex" is inadequate when referring to individuals with a disorder of sex development. In the child criteria, "strong desire to be of the other gender" replaces the previous "repeatedly stated desire" to capture the situation of some children who, in a coercive environment, may not verbalize the desire to be of another gender. For children, Criterion A1 ("a strong desire to be of the other gender or Highlights of Changes from DSM-IV-TR to DSM-5 an insistence that he or she is the other gender . . .") is now necessary (but not sufficient), which makes the diagnosis more restrictive and conservative.

Subtypes and Specifiers

The subtyping on the basis of sexual orientation has been removed because the distinction is not considered clinically useful. A posttransition specifier has been added because many individuals, after transition, no longer meet criteria for gender dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.

Disruptive, Impulse-Control, and Conduct Disorders

The chapter on disruptive, impulse-control, and conduct disorders is new to DSM-5. It brings together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). These disorders are all characterized by problems in emotional and behavioral self-control. Because of its close association with conduct disorder, antisocial personality disorder has dual listing in this chapter and in the chapter on personality disorders. Of note, ADHD is frequently comorbid with the disorders in this chapter but is listed with the neurodevelopmental disorders.

Oppositional Defiant Disorder

Four refinements have been made to the criteria for oppositional defiant disorder. First, symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that the disorder reflects both emotional and behavioral symptomatology. Second, the exclusion criterion for conduct disorder has been removed. Third, given that many behaviors associated with symptoms of oppositional defiant disorder occur commonly in normally developing children and adolescents, a note has been added to the criteria to provide guidance on the frequency typically needed for a behavior to be considered symptomatic of the disorder. Fourth, a severity rating has been added to the criteria to reflect research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

Conduct Disorder

The criteria for conduct disorder are largely unchanged from DSM-IV. A descriptive features specifier has been added for individuals who meet full criteria for the disorder but also present with limited pro-social emotions. This specifier applies to those with conduct disorder who show a callous and unemotional interpersonal style across multiple settings and relationships. The specifier is based on research showing that individuals with conduct disorder who meet criteria for the specifier tend to have a relatively more severe form of the disorder and a different treatment response.

Intermittent Explosive Disorder

The primary change in DSM-5 intermittent explosive disorder is the type of aggressive outbursts that should be considered: physical aggression was required in DSM-IV, whereas verbal aggression and non-destructive/noninjurious physical aggression also meet criteria in DSM-5. DSM-5 also provides more specific criteria defining frequency needed to meet criteria and specifies that the aggressive outbursts are impulsive and/or anger based in nature, and must cause marked distress, cause impairment in occupational or interpersonal functioning, or be associated with negative financial or legal consequences. Furthermore, because of the paucity of research on this disorder in young children and the potential difficulty of distinguishing these outbursts from normal temper tantrums in young children, a minimum age of 6 years (or equivalent developmental level) is now required. Finally, especially for youth, the relationship of this disorder to other disorders (e.g., ADHD, disruptive mood dysregulation disorder) has been further clarified.

Substance-Related and Addictive Disorders**Gambling Disorder**

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

Criteria and Terminology

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study”). Of note, the criteria for DSM-5 tobacco use

disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as the situation warrants.

Neurocognitive Disorders

Delirium

The criteria for delirium have been updated and clarified on the basis of currently available evidence.

Major and Mild Neurocognitive Disorder

The DSM-IV diagnoses of dementia and amnesic disorder are subsumed under the newly named entity major neurocognitive disorder (NCD). The term dementia is not precluded from use in the etiological subtypes where that term is standard. Furthermore, DSM-5 now recognizes a less severe level of cognitive impairment, mild NCD, which is a new disorder that permits the diagnosis of less disabling syndromes that may nonetheless be the focus of concern and treatment. Diagnostic criteria are provided for both major NCD and mild NCD, followed by diagnostic criteria for the different etiological subtypes. An updated listing of neurocognitive domains is also provided in DSM-5, as these are necessary for establishing the presence of NCD, distinguishing between the major and mild levels of impairment, and differentiating among etiological subtypes. Although the threshold between mild NCD and major NCD is inherently arbitrary, there are important reasons to consider these two levels of impairment separately. The major NCD syndrome provides consistency with the rest of medicine and with prior DSM editions and necessarily remains distinct to capture the care needs for this group. Although the mild NCD syndrome is new to DSM-5, its presence is consistent with its use in other fields of medicine, where it is a significant focus of care and research, notably in individuals with Alzheimer’s disease, cerebrovascular disorders, HIV, and traumatic brain injury.

Etiological Subtypes

In DSM-IV, individual criteria sets were designated for dementia of the Alzheimer’s type, vascular dementia, and substance-induced dementia, whereas the other neurodegenerative disorders were classified as dementia due to another medical condition, with HIV, head trauma, Parkinson’s disease, Huntington’s disease, Pick’s disease, Creutzfeldt-Jakob disease, and other medical conditions specified. In DSM-5, major or mild vascular NCD and major or mild NCD due to Alzheimer’s disease have been retained, whereas new separate criteria are now presented for major or mild NCD due to frontotemporal NCD, Lewy bodies, traumatic brain injury, Parkinson’s disease, HIV infection, Huntington’s disease, prion disease, another medical condition, and multiple etiologies. Substance/medication-induced NCD and unspecified NCD are also included as diagnoses.

Personality Disorders

The criteria for personality disorders in Section II of DSM-5 have not changed from those in DSM-IV. An alternative approach to the diagnosis of personality disorders was developed for DSM-5 for further study and can be found in Section III. For the general criteria for personality disorder presented in Section III, a revised personality functioning criterion (Criterion A) has been developed based on a literature review of reliable clinical measures of core impairments central to personality pathology. Furthermore, the moderate level of impairment in personality functioning required for a personality disorder diagnosis in DSM-5 Section III was set empirically to maximize the ability of clinicians to identify personality

disorder pathology accurately and efficiently. With a single assessment of level of personality functioning, a clinician can determine whether a full assessment for personality disorder is necessary. The diagnostic criteria for specific DSM-5 personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and by characteristic pathological personality traits that have been empirically determined to be related to the personality disorders they represent. Diagnostic thresholds for both Criterion A and Criterion B have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder—trait specified, based on moderate or greater impairment in personality functioning and the presence of pathological personality traits, replaces personality disorder not otherwise specified and provides a much more informative diagnosis for patients who are not optimally described as having a specific personality disorder. A greater emphasis on personality functioning and trait-based criteria increases the stability and empirical bases of the disorders. Personality functioning and personality traits also can be assessed whether or not an individual has a personality disorder, providing clinically useful information about all patients. The DSM-5 Section III approach provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

Paraphilic Disorders Specifiers

An overarching change from DSM-IV is the addition of the course specifiers “in a controlled environment” and “in remission” to the diagnostic criteria sets for all the paraphilic disorders. These specifiers are added to indicate important changes in an individual’s status. There is no expert consensus about whether a long-standing paraphilia can entirely remit, but there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be reduced to acceptable levels. Therefore, the “in remission” specifier has been added to indicate remission from a paraphilic disorder. The specifier is silent with regard to changes in the presence of the paraphilic interest per se. The other course specifier, “in a controlled environment,” is included because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges.

Change to Diagnostic Names

In DSM-5, paraphilias are not ipso facto mental disorders. There is a distinction between paraphilias and paraphilic disorders. A paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention. The distinction between paraphilias and paraphilic disorders was implemented without making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm—or risk of harm—to others). The change for DSM-5 is that individuals who meet both Criterion A and Criterion B would now be diagnosed as having a paraphilic disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B—that is, to those individuals who have a paraphilia but not a paraphilic disorder. The distinction between paraphilias and paraphilic disorders is one of the changes from DSM-IV that applies to all atypical erotic interests. This approach leaves intact the distinction between normative and nonnormative sexual behavior, which could be important to researchers or to persons who have nonnormative sexual preferences, but without automatically labeling nonnormative sexual behavior as psychopathological. This change in viewpoint is reflected in the diagnostic criteria sets by the addition of the word disorder to all the paraphilias. Thus, for example, DSM-IV pedophilia has become DSM-5 pedophilic disorder.

PERSONALITY DISORDERS

Personality disorders are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. They fall within 10 distinct types: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder.

During the development process of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), several proposed revisions were drafted that would have significantly changed the method by which individuals with these disorders are diagnosed. Based on feedback from a multilevel review of proposed revisions, the American Psychiatric Association Board of Trustees ultimately decided to retain the DSM-IV categorical approach with the same 10 personality disorders.

The proposed revisions that were not accepted for the main body of the manual were approved as an alternative hybrid dimensional-categorical model that will be included in a separate chapter in Section III of DSM-5. This alternative model is included to encourage further study on how this new methodology could be used to assess personality and diagnose personality disorders in clinical practice. DSM-5 moves from the multiaxial system to a new assessment that removes the arbitrary boundaries between personality disorders and other mental disorders.

Assessing on a Single Axis

Until now, DSM has organized clinical assessment into five areas, or axes, addressing the different aspects and impact of disorders. This multiaxial system was introduced in part to solve a problem that no longer exists: Certain disorders, like personality disorders, received inadequate clinical and research focus. As a consequence, these disorders were designated to Axis II to ensure they received greater attention. However, the axis system was seen by some clinicians as burdensome and time consuming. Given that there is no fundamental difference between disorders described on DSM-IV's Axis I and Axis II, DSM-5 has shifted to a single axis system.

This system combines the first three axes outlined in past editions of DSM into one axis with all mental and other medical diagnoses. Doing so removes artificial distinctions among conditions, benefitting both clinical practice and research use. Evolving the Diagnosis of Personality Disorders

Evolving the Diagnosis of Personality Disorders

The Personality Disorders Work Group began its efforts on DSM-5 by reviewing recent research on these disorders and considering general feedback from the field about the categorical approach. The Work Group's first revision represented a significantly different approach to diagnosis. It attempted to break down the concise models of personality disorders, which sometimes are too rigid to fit patients' symptoms, and replaced them with a trait-specific method. Using this model, clinicians would 2 • Personality Disorders have determined if their patients had a personality disorder by looking at the traits suggested by their symptoms and ranking each trait by severity.

As evidenced by the field's reaction, this new model was too complex for clinical practice. After considering that response and additional research, the Work Group evolved the diagnostic criteria for personality disorders to marry the most useful aspects of DSM-IV criteria with features from the first

revision's trait-based approach. The result was reflected in a second proposal, a hybrid model that included evaluation of impairments in personality functioning (how an individual typically experiences himself or herself as well as others) plus five broad areas of pathological personality traits.

Although this hybrid proposal was not accepted for DSM-5's main manual, it is included in Section III for further study. Using this alternate methodology, clinicians would assess personality and diagnose a personality disorder based on an individual's particular difficulties in personality functioning and on specific patterns of those pathological traits.

The hybrid methodology retains six personality disorder types:

- Borderline Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Avoidant Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Narcissistic Personality Disorder

Each type is defined by a specific pattern of impairments and traits. This approach also includes a diagnosis of Personality Disorder—Trait Specified (PD-TS) that could be made when a Personality Disorder is considered present, but the criteria for a specific personality disorder are not fully met. For this diagnosis, the clinician would note the severity of impairment in personality functioning and the problematic personality trait(s).

This hybrid dimensional-categorical model and its components seek to address existing issues with the categorical approach to personality disorders. APA hopes that inclusion of the new methodology in Section III of DSM-5 will encourage research that might support this model in the diagnosis and care of patients, as well as contribute to greater understanding of the causes and treatments of personality disorders.

Appendix 8

Global Assessment of Functioning (GAF) Scale

by Lynn Geurin, MSW, CSW Pathways, Inc.

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.)

- 91 – 100 **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.**
- 81 – 90 **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).
- 71 – 80 **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).
- 61 – 70 **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.**
- 51 - 60 **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).
- 41 - 50 **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).
- 31 - 40 **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).
- 21 - 30 **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)
- 11 - 20 **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).
- 1 - 10 **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.

Appendix 9

Neuropsychological Evidence in Criminal Defense: Rationale and Guidelines for Enlisting an Expert

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Appendix 9

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 psychologists 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 neuropsychologist'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.

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Appendix 10

PTSD in the Forensic Setting

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Appendix 10

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-I)*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 injury², 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 or 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 for-warded 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 abusing 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-I*, 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 3/4¹² 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 associates¹⁶ 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 others⁹ 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 veterans¹² and civilians²² 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

Erlinder¹⁸ suggests that the language in *DSM-I* 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 witnesses) 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 amnesic 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 achieved, 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 child-hood 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 de-signed and administered to groups suspected of having the diagnosis in efforts to develop some objectivity and reproducibility (for reviews see Watson²⁷ and

Keane²⁸). 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 increase diagnostic reliability, and
2. Most of the instruments are obvious and easy to manipulate.

Keane²⁹ 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, and 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

Pitman³⁵ 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 clonidine.^{11,36,37}

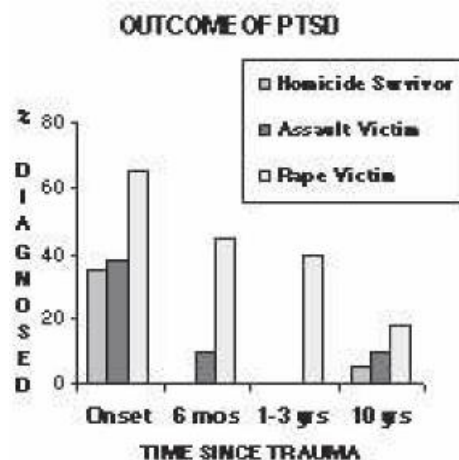
In addition to relieving anxiety, panic, depression, and insomnia and other sleep pathology, the anti-depressant drugs can relieve the core intrusive symptoms such as sleep disturbance, re-experiencing, and flashbacks independent of any anti-depressant effect. Their impact might not be seen for up to 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 inter-action 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 hyperarousal symptoms 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 per-cent 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 1986¹². 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 ob-

scure. 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 treat-able, 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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Appendix 11

Understanding Severe Traumatization

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Appendix 11

Understanding Severe Traumatization

by Elizabeth 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 naïve 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 over-stated, 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 consistent 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, catecholamines 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 sabertooth 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 catecholamines (*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 over time, 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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Appendix 12

Improving Responses to People with Mental Illnesses *The Essential Elements of a Specialized Law Enforcement–Based Program*

A report prepared by the
Council of State Governments Justice Center
in partnership with the Police Executive Research Forum
for the

Bureau of Justice Assistance
Office of Justice Programs
U.S. Department of Justice

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Acknowledgments

This report could not have been written without the leadership of the Bureau of Justice Assistance (BJA), Office of Justice Programs, U.S. Department of Justice, particularly from Domingo S. Herraiz, Director; A. Elizabeth Griffith, Deputy Director for Planning; Robert Hendricks, former Policy Advisor; and Michael Guerriere, former Senior Policy Advisor for Mental Health and Substance Abuse. Additional support was provided by Ruby Qazilbash, Senior Policy Advisor for Substance Abuse and Mental Health, and Rebecca Rose, Policy Advisor for Substance Abuse and Mental Health, during the final review and approval process.

Thanks are also due to members of a project advisory group, listed alphabetically below.¹ A subset of the group (indicated by an asterisk) met in October 2005 and February 2006 to review earlier drafts of this document, and the entire advisory group convened in September 2006 to provide their insights on a more recent version of the document.

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1. Advisory Board members' titles and agency affiliations reflect the positions they held at the time of their involvement with the project.

- Lieutenant Richard Wall, *Los Angeles (Calif.) Police Department*
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A special thanks must be given to Council of State Governments Justice Center Director Mike Thompson and Health Systems and Services Policy Director Fred Osher for their insights in helping shape the scope and direction of this publication. In

addition, the authors appreciate the ongoing support that the Police Executive Research Forum's Executive Director, Chuck Wexler, has provided.

Finally, the authors wish to express their gratitude to the nearly two hundred contributors who provided feedback in an August 2006 online Web forum. Far too many to name individually, these practitioners, policymakers, and advocates offered insights and suggestions that informed the authors and can be seen throughout these pages.

Introduction

Law enforcement officers throughout the country regularly respond to calls for service that involve people with mental illnesses—often without needed supports, resources, or specialized training.² These encounters can have significant consequences for the officers, people with mental illnesses and their loved ones, the community, and the criminal justice system.³ Although these encounters may constitute a relatively small number of an agency's total calls for service, they are among the most complex and time-consuming calls officers must address.⁴ At these scenes, frontline officers must stabilize a potentially volatile situation, determine whether the person poses a danger to him- or herself or others, and effect an appropriate disposition that may require a wide range of community supports.

In the interests of safety and justice, officers typically take approximately 30 percent of people with mental illnesses they encounter into custody—for transport to either an emergency room, a mental health facility, or jail.⁵ Officers resolve the remaining incidents informally, often only able to

provide a short-term solution to a person's long-term needs. As a consequence, many law enforcement personnel respond to the same group of people with mental illnesses and the same locations repeatedly, straining limited resources and fostering a collective sense of frustration at the inability to prevent future encounters.⁶

In response, jurisdictions across the country are exploring strategies to improve the outcomes of these encounters and to provide a compassionate response that prioritizes treatment over incarceration when appropriate. These efforts took root in the late 1980s, when the crisis intervention team (CIT) and law enforcement–mental health co-response models, described in more detail below, first emerged. Since that time, hundreds of communities have implemented these programs; some have replicated the models, and others have adapted features to meet their jurisdiction's unique needs. Although this number represents only a small fraction of all U.S. communities, there are many indications that the level of interest in criminal justice–mental health collaborative initiatives is surging.⁷

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2. For the purposes of this document, "officer" refers to any law enforcement personnel with direct contact with the community; this includes sheriffs' deputies, state troopers, and other individuals with arrest powers.
 3. The nation's prisons and jails hold unprecedented numbers of people with mental illnesses—many of whom came into contact with law enforcement as a result of behaviors related to their illness. For example, in 1999 the Los Angeles County Jail and New York's Rikers Island jail each held more people with mental illnesses than any psychiatric inpatient facility in the United States. The most recent data from the Bureau of Justice Statistics, U.S. Department of Justice, reveals that more than half of all prison and jail inmates reported that they had any one of a number of mental health symptoms. E. Fuller Torrey, "Reinventing Mental Health Care," *City Journal* 9 (1999):4; Doris J. James and Laura E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Bureau of Justice Statistics, NCJ-213600 (Washington, D.C.: Bureau of Justice Statistics, 2006).
 4. Recent data indicate that behaviors that appear to be the result of a mental illness are a factor in approximately 3–7 percent of all law enforcement calls for service. See Martha W. Deane, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph P. Morrissey, "Emerging Partnerships between Mental Health and Law Enforcement," *Psychiatric Services* 50 (1) (1999): 99–101; Lodestar, *Los Angeles Police Department Consent Decree Mental Illness Project Final Report* (Los Angeles: Lodestar, 2002); Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls,"

- Psychiatric Services* 57 (2006): 232–37; William Terrill and Stephen Mastrofski, "Situational and Officer-Based Determinants of Police Coercion," *Justice Quarterly* 19 (2002): 215–48.
5. Linda Teplin, "Managing Disorder: Police Handling of the Mentally Ill," in *Mental Health and the Criminal Justice System*, ed. Linda Teplin. (Beverly Hills, CA: Sage Publications, 1984); Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37.
6. Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series*, 40, U.S. Department of Justice (Washington, D.C.: Office of Community Oriented Policing Services, 2006).
7. Federal interest in criminal justice–mental health initiatives is perhaps best illustrated by the broad bipartisan support for the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) and its subsequent appropriations. MIOTCRA facilitates collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals to treatment when appropriate. Among its allowable uses, MIOTCRA funds can support law enforcement training. For more information on MIOTCRA, see www.consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA.

Specialized Law Enforcement–Based Response Programs

This document focuses on specialized law enforcement–based response programs that meet three criteria: (1) they enhance traditional law enforcement roles to provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illnesses; (2) when appropriate, they establish a link for these individuals to services in the community; and (3) they are based in law enforcement agencies with strong collaborative ties to mental health partners, other criminal justice agencies, and community members.⁸

Specialized law enforcement–based response programs include both the CIT and law enforcement–mental health co-responder models.

- The CIT model originated in the Memphis (Tenn.) Police Department and is therefore often called the Memphis Model. It was developed in response to a tragic incident in which a law enforcement officer used lethal force against a person with a mental illness. This model is designed to de-escalate tensions at the scene and to reduce the need for use of force during these types of encounters. To improve the likelihood of a safe and effective outcome, the CIT model includes training and deployment of self-selected officers to provide a first-response to the majority of incidents involving people with mental illnesses.
- The co-responder model was developed in Los Angeles County and implemented soon after in San Diego (Calif.). Leaders in those jurisdictions were concerned that they were unable to link people with mental illnesses to appropriate services

or provide other effective and efficient responses. They identified limitations on officers' time and lack of awareness about both community mental health resources and the characteristics of individuals who need access to those services as major obstacles. They then developed an approach that pairs specially trained officers with mental health professionals to provide a joint secondary response to the scene.

About the Elements

As the growing number of interested communities grapple with implementing specialized law enforcement–based programs at the local level, there is a commensurate demand for more information on the key elements of promising programs. Several communities have tried to identify critical program elements, particularly for CIT initiatives, to promote consistency and quality.⁹ Until this BJA-supported effort, however, there had been limited debate or agreement at the national level about which elements were essential to successfully implement any specialized law enforcement–based response program—regardless of the specific model.

This report articulates 10 essential elements for any specialized law enforcement–based response program. The elements are derived from recommendations made by a broad range of practitioners and other related experts to ensure they are practical and valuable (see the “Document Development” section, p. ix). They provide practitioners and policymakers with a common framework for program design and implementation that will promote positive outcomes while being sensitive to every jurisdiction's distinct needs and resources. Each element contains a short

8. Many communities also have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. While these models are undoubtedly a valuable resource for many communities and departments, they are not law enforcement–based and thus are not within the scope of this document. For further discussion of how law enforcement have collaborated with mental health mobile crisis teams, see www.uc.edu/criminaljustice/ProjectReports/MCT_Report.pdf. For more on how mental health agencies have tailored assertive community treatment teams to work with a justice-involved population, see www.gainscenter.samhsa.gov/text/ebp/Papers/ExtendingACTPaper.asp.

9. Most notably, promoters of the CIT model have recently formed a national group, the CIT National Organization (www.cit.memphis.edu/cno.html), to provide leadership and guidance to jurisdictions implementing CIT programs. Several members of the CIT National Organization also serve on the advisory board that has guided the development of this publication, to ensure complementary products. The National CIT Organization's guide describes critical elements of the CIT model using three categories: operational, ongoing, and sustaining elements. A draft of the guide is available at www.cit.memphis.edu/~cjus/dw.php?id=cjuscitdw01. In contrast, this document provides a framework for developing or enhancing elements of a specialized law enforcement–based response of any type.

statement (in italics) describing criteria that specialized law enforcement–based response programs should meet to be effective, followed by several paragraphs explaining the element’s importance and how its principles can be achieved.

The document reflects two key assumptions: First, each element depends on meaningful collaboration among professionals in the criminal justice and mental health systems. Although achieving the requisite level of collaboration is often difficult—particularly when faced with long-standing system barriers—successful partnerships are needed to carry out any of the elements. Second, law enforcement represents only the first of several criminal justice agencies with which people with mental illnesses may come in contact. Addressing problems raised by the large numbers of people with mental illnesses in the criminal justice system requires a comprehensive community- and systemwide strategy in which the law enforcement–based program plays only one part. The impact of a specialized law enforcement–based response program on jails, courts, the community-based mental health system, and the larger community must therefore be considered when planning and implementing the program.

The elements are meant to help guide individuals in communities that are interested in developing a law enforcement–based program or improving the organization and functions of an existing program. This document can be used as a practical planning tool for a specialized response at each stage of the process (e.g., designing the program, developing or enhancing policies and procedures, monitoring practices, and conducting evaluations). This report is meant to be a “living, breathing document” and thus will be updated or supplemented as specialized law enforcement–based programs mature, and to address new research studies that can provide a stronger base of knowledge about how these programs can best operate, their impact on the community and various affected systems, and the relative importance of the elements that form them.¹⁰

Document Development and Related Materials

The essential elements are based on information from a variety of sources, including interviews with law enforcement executives and officers, mental health professionals, advocates, and mental health consumers who have been engaged in these programs for many years, as well as a review of the scholarly literature. A panel of national experts guided early drafts of this document. It was then posted on a Web-based discussion forum through which hundreds of stakeholders reviewed it and provided feedback.¹¹ An advisory group of leading executives, practitioners, researchers, and other experts subsequently reviewed and discussed the comments and suggested revisions.

The Bureau of Justice Assistance (BJA), U.S. Department of Justice, is developing a series of resources for law enforcement practitioners and their community partners as part of BJA’s Law Enforcement/Mental Health Partnership Program. This report serves as the centerpiece of this series. The *Improving Responses to People with Mental Illnesses* series includes a collection of resources that will complement the essential elements: a practical handbook on implementing effective training strategies; a monograph on tailoring law enforcement responses to the unique needs of the jurisdiction, which will include specific examples from the field; and Web-based information on statewide efforts to coordinate these law enforcement responses. Also available is an online database, the Criminal Justice/Mental Health Information Network, which includes profiles of local law enforcement responses to people with mental illnesses. This project is coordinated by the Council of State Governments Justice Center in partnership with the Police Executive Research Forum.

10. Updates to this document will be available at www.consensusproject.org/issue-areas/law-enforcement.

11. Throughout this document, the term “stakeholders” is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such

as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as “consumers”) and their loved ones; crime victims; and other community representatives.

Ten Essential Elements

Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Specialized responses to people with mental illnesses are an outgrowth of community policing and as such should reflect a partnership between a law enforcement agency and other stakeholder groups and individuals. Partners for the lead law enforcement agency should include mental health service providers, people with mental illnesses and their family members and loved ones, and mental health advocates. Based on the nature of the problem, additional partners could include other area law enforcement professionals; health and substance abuse treatment providers; housing officials and other service providers; hospital and emergency room administrators; crime victims; other criminal justice personnel such as prosecutors and jail administrators; elected officials; state, local, and private funders; and community representatives. Any stakeholder may initiate the planning for the specialized response, but to take root, the lead law enforcement agency must fully embrace the effort.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives should come together as a multidisciplinary *planning committee*. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design (see Element 2, Program Design), taking into consideration how the committee will relate to other criminal justice–mental health boards that may be in place or are in the process of being established. The

planning committee also should provide a forum for developing grant applications and working with local and state officials. Although focused primarily on planning decisions, members should remain engaged during the implementation phase to provide ongoing leadership and support problem solving and design modifications throughout the life of the program.

Agency leaders on the planning committee also should designate appropriate staff to make up a *program coordination group* responsible for overseeing day-to-day activities. (In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.) This coordination group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness. The group also should serve to keep agency leaders and other policymakers informed of program costs, developments, and progress. Both groups' members should reflect the community's demographic composition.

To overcome challenges inherent in multidisciplinary collaboration, including staff turnover and changes in leadership, partnership and program policies should be institutionalized to the extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as how each organization will commit resources and what information can be shared through identified mechanisms.

Program Design

The planning committee designs a specialized law enforcement–based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

As a critical first step in the design process, the planning committee should develop a detailed understanding of the problems in its jurisdiction and identify all contributing factors. In this analysis, it is important to understand the driving force(s) behind current efforts to improve the law enforcement response. In some jurisdictions, law enforcement executives may become aware of the problem because of a tragic incident. In others, executives may realize there are operational challenges presented by particularly complex field encounters, such as the inordinate amount of time officers spend waiting for medical clearance in emergency rooms or the frequency with which officers repeatedly come in contact with the same individuals without an effective resolution.

The committee must examine the reasons why these incidents occur and other aspects of the problem that may not have been raised by the single high-profile incident. It should look at law enforcement data on calls for service, beat boundaries, feedback from officers, community survey data, and other sources of information. To enhance their understanding of root causes and available resources, committee members also should examine factors such as the community's inpatient and outpatient treatment options, crisis response services, ancillary services such as housing and substance abuse treatment, population, and geography. They also may want to talk to people in other jurisdictions who have grappled with limited community resources to see what alternatives are available to increase the reach of existing services.

The analysis of the problems and assessment of available and potential resources to address them should drive the short- and long-term goals of the program. For example, if the analysis reveals that a significant barrier to improving the law enforcement response is that officers lack the training to safely de-escalate situations involving people with mental

illnesses, one program goal would be to correct this deficiency. If officers cannot efficiently link people to mental health treatments, another goal may be to revise and streamline processes for connecting to these services.

Once the program's purpose is defined, the committee must address personnel assignments and related considerations. The planning committee must decide whether some or all officers should be trained to stabilize and de-escalate situations involving people with mental illnesses in immediate response to the call for service. Should all officers receive some baseline training and others receive more extensive training? Should a subset of officers be trained to respond with a mental health professional? When considering the answers to questions like these, the committee should explore the practical implications of different staffing options and present them to the chief law enforcement executive or his or her designee on the committee. The committee also must help interpret the criteria for emergency mental health evaluation and decide how officers will access that service. These decisions will help the committee determine which additional skills and information the identified group of responders should receive in training.

If committee members, including representatives from policing, conclude that a subset of officers will respond to incidents involving people with mental illnesses, they should help the law enforcement executive determine how many officers are needed to cover all shifts and geographic districts. The committee also should develop personnel selection criteria and a process for identifying officers best suited for the challenges of this new role. In particular, planners should consider officers' ability to reorient from the more traditional method of gaining control by using an authoritative approach during a field contact to a non-adversarial, crisis-intervention style. To the extent possible, the selection process should be voluntary, yet selective.

Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.

Training must be provided to improve officers' responses to people with mental illnesses. Agencies may differ in the amount of training they offer: some will provide comprehensive training to all officers, some will provide this training only to a subset, and some will provide basic training to everyone in combination with more comprehensive training to a subset. At a minimum, a group of officers sufficient to cover all time shifts and geographic districts should receive extensive skills and knowledge training that builds on the more cursory information routinely given on this topic at recruit and in-service trainings.¹² The chief law enforcement executive should ensure that training is also provided to supervisory and support personnel, such as midlevel managers, field training officers, call takers, and dispatchers, who advance the specialized program's operations.

Planning and implementing a training initiative that supports the specialized program should be a collaborative effort between the law enforcement agency and stakeholders represented on the program coordination group. The coordination group should help guide training decisions, which include selecting content and techniques, ensuring the instruction is culturally competent, identifying and preparing trainers, and evaluating effectiveness. The group's multidisciplinary/multisystem composition helps make certain that the training initiative reflects an appropriate range of perspectives; members can identify mental health practitioners, consumers, and family members to provide some of the training instruction. Likewise, the

group helps ensure quality by establishing a process for consistently reviewing and evaluating training and then modifying the curriculum based on the findings. The group can be particularly helpful in identifying resources to defray law enforcement agency costs.

Specialized training should, at a minimum, provide officers with an improved understanding of the following: mental illnesses and their impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; disposition options; community resources; and legal issues. Trainers should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem-solving exercises.

Training should address issues specific to the community in which it is being given. Mental health personnel and other stakeholders should be invited to participate in the specialized training to help improve cross-system understanding of agencies' roles and responsibilities, as well as to convey any requirements for accessing community-based services. Planners should brief any trainers outside law enforcement about effective techniques, language, and sensitivities to the law enforcement culture that will improve their connection with this audience. When possible, additional cross-training should be provided to improve the mental health professionals' understanding of law enforcement issues, such as ride-alongs and other opportunities to see policies translated into action.

12. For more information on various types of training opportunities for law enforcement personnel, see Council of State Governments, *Criminal Justice/Mental Health Consensus Project Report*

(New York, N.Y.: Council of State Governments, 2002), www.consensusproject.org.

Call-Taker and Dispatcher Protocols

Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

When 911 or other call takers receive a request for service they suspect involves a person with a mental illness, they should gather descriptive information on the person's behavior; determine whether the individual appears to pose a danger to him- or herself or others; ascertain whether the person possesses or has access to weapons; and ask the caller about the person's history of mental health or substance abuse treatment, violence, or victimization. All call takers should receive training on how to collect the most useful information quickly. To supplement this training, members of the coordinating group with mental health backgrounds should develop a concise list of questions for call takers to have on hand when answering service requests that seem to involve someone with a mental illness.

Call takers and dispatchers must have an understanding of the purpose of the specialized program and how it works—particularly what types of calls for service should be directed to particular officers or teams. Dispatchers must be provided with up-to-date information on staffing patterns during all shifts and over all geographic areas that identify law enforcement or mental health responders designated to respond to calls that appear to involve a person with a mental illness.

The coordinating group should also provide these personnel with specific guidance on how to record information in the dispatch database about calls in which mental illness may be a factor. The information should be used for assessing procedures, informing future responses, and evaluating program outcomes (see Element 10 for more on how evaluations promote sustainability). Locations of repeat calls for service involving individuals with mental illnesses can be coded to help ensure that specially trained officers will be dispatched to respond to those locations in the future. Coding can help agencies ultimately reduce call and transport time, as well as potential injuries to all involved, by dispatching experienced officers. To protect community members' privacy, the notes made on these locations must never identify specific individuals and must be reviewed periodically to ensure accuracy (see Element 7 for more on confidentiality concerns). Responding officers should also validate and update this information when they clear a call to that location. All communications personnel and responding officers should be instructed to avoid using slang and pejorative language when describing individuals thought to have a mental illness.

Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Specialized law enforcement–based response programs are designed to resolve officers’ encounters with people with mental illnesses safely and, when appropriate, link these individuals to mental health supports and services that reduce the chances for future interactions with the criminal justice system. The success of these programs is contingent on officers’ using tactics that safely de-escalate situations involving someone who is behaving erratically or is in crisis. The high prevalence of trauma histories in this population requires the use of trauma-informed responses. In addition to de-escalating the incident, responding officers should assess whether a crime has been committed and observe the person’s behavior within the given circumstances to determine if mental illness may be a factor. Officers should draw upon expertise acquired in specialized training and from their experiences to identify signs and symptoms of mental illness. Officers must ascertain whether the person appears to present a danger to him- or herself or others. To assist in this determination, officers may gather information from knowledgeable individuals at the scene, including mental health co-responders.

Officers must make disposition decisions based on their observations, information they gather at the scene, and their knowledge of community services and legal mandates. To assist officers in their decision making, the planning committee should develop clear guidelines that are consistent with the program’s goals and governing authorities. For example, such programs might promote alternatives to incarceration for eligible individuals. If a person has come to the attention of law enforcement because of behaviors that appear to result from a mental illness and no serious crime has been committed, guidelines and protocols consistent with existing law should enable officers to

divert the individual to mental health supports and services. When a serious crime has been committed, the person should be arrested.

To make these decisions, officers must be familiar with available community resources—particularly any 24-hour center that can receive individuals in mental health crises. Officers also must understand their state’s criteria for involuntary emergency evaluation to make appropriate decisions regarding whether to detain and transport the person to a facility where he or she can undergo an emergency mental health evaluation. Officers must take into consideration both the individual’s treatment needs and civil liberties and should pursue voluntary compliance with treatment whenever possible.

In the rare case when an incident involves barricaded individuals or de-escalation fails, responding officers will require additional support. Some agencies may equip officers who most frequently encounter people with mental illnesses with less-lethal weapons, so as to minimize injuries that could occur if there is a threat to safety and some use of force becomes necessary. Agencies should provide officers with additional training on the safe and appropriate deployment of these weapons and should establish protocols to guide officers in their decisions to use them. The planning committee also should develop protocols to make certain there is effective coordination during such incidents among specialized law enforcement responders, SWAT teams, and mental health professionals. Although agencies often are under pressure to resolve these situations quickly, it may be best, when there is no imminent threat of danger, to allow time for mental health personnel with expertise in crisis negotiation and law enforcement operations to communicate with the individual.

Transportation and Custodial Transfer

Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

Law enforcement is authorized to provide transportation for people who are under arrest or who they believe meet the criteria for emergency evaluation (whether the evaluation is voluntary or involuntary). These individuals are in law enforcement custody, and rules and regulations regarding restraints in custodial situations apply.¹³ Given the frequent history of traumatic experiences among people with mental illnesses, custodial restraints may create acute stress, which in turn may escalate their degree of agitation. Law enforcement executives, with input from other program planners, should review policies regarding restraints in custodial situations and balance considerations of officer and citizen safety with the impact of these controls on people with mental illnesses.

The planning committee should identify facilities that are capable of assuming custodial responsibility, are available at all times, and have personnel qualified to conduct a mental health evaluation.¹⁴ Speedy custodial transfer is critical to the overall success of law enforcement responses. To enable officers to return quickly to their duties, staff

in the receiving facility should efficiently and accurately obtain relevant law enforcement information. Protocols should ensure that medical clearance is achieved in a timely manner and that people brought by law enforcement are never turned away. If law enforcement responders determine that the person with a mental illness should be arrested and officers take the person to jail or lockup, then qualified staff should be available to screen the arrestee at intake for mental health status, medication needs, and suicide risk.

In noncustodial situations in which the person does not meet the criteria for emergency evaluation and is not under arrest—but officers determine he or she would benefit from services and support—officers should try to connect the individual with a friend or family member, peer support group, or treatment crisis center. Similarly, officers should seek to engage the services of the individual's current mental health provider or a mobile crisis team. In some jurisdictions, law enforcement may also collaborate with mental health professionals to help transport individuals to evaluation or treatment facilities.

13. Law enforcement agencies generally define custody using a case law standard that can be described as whether or not a “reasonable person” would feel free to leave.

14. H. Steadman and colleagues have used the term “specialized crisis response site” (SCRS) to refer to such a facility. SCRSs are defined as “sites where officers can drop off individuals in psychiatric crisis and return to their regular patrol duties. These [pre-booking diversion] programs identify detainees with mental

disorders and work with diversion staff, community-based providers, and the courts to produce a mental health disposition in lieu of jail.” They also can link individuals to substance abuse and other treatment. See H. Steadman, K. Stainbrook, P. Griffin, J. Draine, R. Dupont, and C. Horey, “A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs,” *Psychiatric Services* 52 (2001): 219–222.

Information Exchange and Confidentiality

Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons: foremost among them, information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs, reduce injury, and enhance their ability to determine next steps. To facilitate an appropriate disposition decision, law enforcement officers should collaborate with mental health professionals to better understand the individual's mental health needs. Similarly, mental health providers working at receiving facilities can conduct a more effective mental health evaluation if law enforcement officers share their observations regarding the person's behavior at the scene. In addition to improving the outcomes of specific incidents, sharing information across systems will help program planners as they develop the program and its outcome measures.

The program's planning committee should carefully consider the type of information needed and existing barriers to its exchange and then develop procedures (and in some cases MOUs) to ensure that essential information is shared in an appropriate manner. These protocols should be reviewed during cross-training sessions, which will provide law enforcement and mental health professionals an opportunity to develop relationships with their counterparts and learn why they need certain information. Agency leaders also can explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.¹⁵

Information should be shared in a way that protects individuals' confidentiality rights as mental health consumers and constitutional rights as potential defendants. The planning committee should

determine which personnel have the authority to request and provide information about an individual's mental health and criminal history. In general, mental health records should be maintained by mental health professionals. Information exchanges should be limited strictly to what is needed to inform an appropriate incident response or disposition, and officers should focus on documenting observable behaviors only. All communications must, of course, comply with state and federal laws requiring the confidentiality of mental health records, such as the Health Insurance Portability and Accountability Act.¹⁶ Cross-training should ensure that program staff understand relevant state and federal regulations about issues such as how medical information is released, secured, and retained.

Individuals with mental illnesses who have been in contact with a mental health agency should be offered an opportunity to provide consent in advance for mental health providers to share specified information with law enforcement authorities if an incident occurs (sometimes called an advance directive).¹⁷ Individuals should be asked if an advance directive exists, and if so what the instructions are and who should be contacted to verify this information.

Officers can play an important role in exchanging information with family members and crime victims by providing explanations about criminal proceedings or diversion programs. They may inform the person with a mental illness and his or her family members about mental health treatment linkages and how to access other services or support groups, such as those related to substance use disorders. Law enforcement officers also can assist victims of crimes committed by people with mental illnesses by providing information about protective orders, victim support groups, and other services.

15. The Bureau of Justice Assistance has supported groundbreaking advances that facilitate the electronic exchange of information between agencies. To learn more about efforts involving the development of national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.

16. For more information, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal

Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007).

17. For more information on psychiatric advance directives, see the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at www.nrc-pad.org. NRC-PAD provides an overview, forms to complete psychiatric advance directives, links to state statutes, educational Web casts and discussion forums, and other resources.

Treatment, Supports, and Services

Specialized law enforcement–based response programs connect individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services.

Law enforcement officers often are called to respond to incidents that are the manifestation of an untreated or inadequately treated mental illness. Specialized law enforcement–based responses provide an opportunity to link these individuals to community mental health supports and services that promote long-term wellness and reduce the chance of future negative encounters with officers.

When law enforcement responders bring individuals who are not under arrest to licensed mental health professionals at a receiving facility, staff there should be qualified to conduct a mental health evaluation; assess the contributions of mental illness, substance abuse, and other medical conditions to current behavior; and manage crisis situations. With their knowledge of available community-based treatment resources, mental health professionals can then link the individual to needed supports and services.

Individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment,

income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the specialized response program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to better ensure these needs can be met and coordinated.

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, follow-up services will be most effective when delivered by providers with the capacity to integrate treatment approaches. Accordingly, the planning committee should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.¹⁸ Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

18. For our purposes here, evidence-based practices (EBPs) refer to mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R.E. Drake, H.H. Goldman, H.S. Leff, A.F. Lehman, L. Dixon, K.T. Mueser, and W.C. Torrey, “Implementing Evidence-Based Practices in Routine Mental Health Service Settings,”

Psychiatric Services 52 (2001): 179–182. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management. For more information on the application of EBPs in forensic settings, see materials produced by the National GAINS Center at www.gainscenter.samhsa.gov/html/.

Organizational Support

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals.

Law enforcement leaders who recognize the value of a specialized response program to reduce repeat calls for service and produce better outcomes for people with mental illnesses must create an organizational structure to support it. Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing that the response program is a high priority for the agency is essential and is best demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.

Specifically, leaders should embrace new partners and foster a supportive culture through frequent messages about the value of this type of “real” policing work. Communications with officers at every level of the agency should stress the benefits of the response program. Officers should be encouraged to volunteer for the program’s assignments when possible, rather than receive mandatory reassignment. Enlisting the support of supervisors and field training officers is critical to transforming how the program will be viewed by others in the agency. A program “champion” in a position of authority within the agency and with a demonstrated commitment to the specialized program should be identified to serve as the agency’s representative on the coordination group and the program’s representative within the agency.

Leaders should modify officers’ performance evaluations to take into account the initiative’s unique objectives. As a program designed to improve the safety of all those involved in an incident and to reduce the number of people inappropriately taken into custody, success should not be measured by the number of arrests. As with other successful law enforcement problem-solving efforts, personnel performance should be evaluated and rewarded based on officers’ success collaborating with and making referrals to community partners, addressing the underlying causes of calls for service, and taking measures that reduce the need for force.¹⁹ The law enforcement agency and planning committee should acknowledge these professionals’ hard work through commendation ceremonies and other forms of recognition.

Agency leaders may need to adjust officers’ schedules, obtain grants, or devote funds to specialized program training, create new positions dedicated to coordinating program activities and recruiting and screening responding officers, and revise deployment strategies to maximize the availability of trained law enforcement responders across shifts and geographic areas. Agencies may find it beneficial to develop a standard operating procedure to enumerate specific processes and roles and responsibilities within the program. In some jurisdictions, these issues will require close cooperation with labor unions.

19. For more information on innovative personnel performance measures for community policing initiatives, see Mary Ann Wycoff and Timothy N. Oettmeier, *Evaluating Patrol Officer*

Performance under Community Policing: The Houston Experience, U.S. Department of Justice (Washington, D.C.: National Institute of Justice, 1993).

Program Evaluation and Sustainability

Data are collected and analyzed to help demonstrate the impact of and inform modifications to the program. Support for the program is continuously cultivated in the community and the law enforcement agency.

The planning committee should take steps early in the design process to ensure the program's long-term sustainability. Accordingly, the committee should identify performance measures based on program goals; these measures should consider quantitative data on key aspects of program operation, as well as qualitative data on officers' and community members' perceptions of the program. It may be helpful to aggregate baseline data before program implementation for later comparisons with new program information. To the extent possible, existing law enforcement and mental health agency data collection mechanisms should be adapted to accommodate the program's specific needs; planners may consider engaging a university partner to guide these data collection efforts. The planning committee should work with law enforcement and mental health agencies to ensure that the data are collected accurately and appropriately.

The data law enforcement personnel collect should focus on questions most critical to the program's success in achieving its goals, including the number of injuries and deaths to officers and civilians; officer response times; the number of incidents to which specially trained officers responded; the number of repeat calls for service; officers' disposition decisions, such as linking a person with services; and time required and method used for custodial transfer. Data should be used to refine program operations as needed, as well as review individual case outcomes and determine if follow-up by a mental health professional is warranted.

Program leaders should gauge the attitudes of community leaders, the media, key public officials, and other policymakers toward the program. It may be helpful to engage elected officials early in the process and keep them involved—from the initial kickoff through refunding and long-term implementation—to promote sustainability and desired legislation. The committee also should survey officers—both specialized responders and others—so that law enforcement leaders can better assess the program's usefulness to the entire department and address any concerns. Based on this information, the planning committee should determine the most effective way to promote the program's positive impact on the community, individuals, and agencies and respond to program shortcomings or high-profile tragic events.

While in-kind contributions from partners can go a long way toward offsetting certain program costs, planners should identify and cultivate long-term funding sources to cover costs that would otherwise fall to the law enforcement agency to absorb. Requests for funding should be based on clearly articulated program goals and, to the extent possible, should incorporate data demonstrating program outcomes.

Departments also should focus on sustaining internal support for the program, such as offering refresher training to help officers refine their skills and expand their knowledge base. To promote longer-term commitments from specialized officers, departments also should provide incentives and other organizational support for serving in the program.

Conclusion

Many law enforcement agencies around the nation struggle to respond effectively to people with mental illnesses. Officers encounter these individuals when citizens call them to “do something” about the man exhibiting unusual behavior in front of their business, the woman sleeping on a park bench, or someone who is clearly in need of mental health services—whether or not a crime has been committed. Law enforcement professionals in many jurisdictions have lacked community-based support, guidance, and a clear framework for crafting a program to improve their response to people with mental illnesses.

But innovative solutions are at hand. Increasingly, law enforcement agencies of all sizes are implementing creative approaches despite scarce resources. The range of approaches in communities across the country reflects the realization that strategies must be tailored to each jurisdiction’s unique needs. These agencies are engaged in problem solving with a range of partners from diverse disciplines

and have access to a growing pool of programs and knowledge about promising practices. This publication outlines the essential elements of successful specialized law enforcement–based efforts that reflect this expanded knowledge base and experience to better guide practitioners initiating or enhancing their own programs.

The tone of the elements may suggest that these changes are easy to make. They are not. There are many challenges to these efforts, including politics, turf battles, competition for limited funding, lack of legal foundations for officers’ actions, and scarce law enforcement and community mental health resources. Leaders in jurisdictions that have implemented a specialized response acknowledge that it takes commitment to overcome these obstacles, but agree that the costs—in dollars and human lives—are too high to sanction continuing with only more traditional law enforcement responses to people with mental illnesses. Their efforts have resulted in increased public safety and improved public health.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The CSG Justice Center also coordinates the Criminal Justice/Mental Health Consensus Project. This project is an unprecedented national effort to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

The Police Executive Research Forum (PERF) is a national membership organization of progressive police executives from the largest city, county, and state law enforcement agencies. PERF is dedicated to improving policing and advancing professionalism through research and involvement in public policy debate. Read more at www.policeforum.org.