SECOND EDITION

THE AMERICAN PSYCHIATRIC PUBLISHING

TEXTBOOK OF FORENSIC PSYCHIATRY

Edited by

Robert I. Simon, M.D.
Liza H. Gold, M.D.

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American Psychiatric Publishing, Inc.

Washington, DC
London, England

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Manufactured in the United States of America on acid-free paper
14 13 12 11 10 5 4 3 2 1
First Edition

Typeset in Adobe's Berkeley and Kabel

American Psychiatric Publishing, Inc.
1000 Wilson Boulevard
Arlington, VA 22209-3901
www.appi.org

SUSTAINABLE FORESTRY INITIATIVE
Certified Fiber Sourcing
www.sfiprogram.org

Library of Congress Cataloging-in-Publication Data
The American Psychiatric Publishing textbook of forensic psychiatry / edited by Robert I. Simon, Liza H. Gold. — 2nd ed.
p. ; cm.
Other title: Textbook of forensic psychiatry
Includes bibliographical references and index.
ISBN 978-1-58562-378-5 (hardcover : alk. paper)
1. Forensic psychiatry. I. Simon, Robert I. II. Gold, Liza H., 1958–
III. Title: Textbook of forensic psychiatry.
[DNLM: 1. Forensic Psychiatry. W 740 A5127 2010]
RA1151.A47 2010
614′.15—dc22

2010004299

British Library Cataloguing in Publication Data
A CIP record is available from the British Library.

Our knowledge is the amassed thought and experience of innumerable minds.

Ralph Waldo Emerson (1803–1882)

This text is dedicated to our professional colleagues, whose commitment to ethical practice and excellence continues to advance the field of forensic psychiatry.

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Contributors

Alan A. Abrams, M.D., J.D.
Professor of Clinical Psychiatry, Georgetown University Hospital, Washington, D.C.

Paul S. Appelbaum, M.D.
Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law; Director, Division of Law, Ethics and Psychiatry, Department of Psychiatry, Columbia University/ New York State Psychiatric Institute, New York, New York

Peter Ash, M.D.
Director, Psychiatry and Law Service; Chief, Child and Adolescent Psychiatry; and Associate Professor, Department of Psychiatry and Behavioral Sciences, Emory University, Atlanta, Georgia

Madelon V. Baranoski, Ph.D.
Associate Professor, Law and Psychiatry, Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut

Steven H. Berger, M.D.
Volunteer Clinical Assistant Professor of Psychiatry, Indiana University School of Medicine, Lafayette, Indianapolis, Indiana

F. William Black, Ph.D.
Emeritus Professor of Psychiatry and Neurology, Department of Psychiatry and Neurology, Tulane University School of Medicine, New Orleans, Louisiana

Brad Booth, M.D., FRCPC
Forensic Psychiatrist, St. Lawrence Valley Correctional & Treatment Centre—Secure Treatment Unit, Royal Ottawa Mental Health Centre; Assistant Professor, Department of Psychiatry, Division of Forensic Psychiatry, University of Ottawa; Education Director, Integrated Forensic Program, Ottawa, Ontario, Canada

John Bradford, M.D., FRCPC
Professor and Head, Division of Forensic Psychiatry, University of Ottawa; Professor of Psychiatry, Queen's University; Professor, School of Criminology, University of Ottawa; Associate Chief (Forensic), Royal Ottawa Healthcare Group, Brockville Mental Health Centre, Brockville, Ontario, Canada

J. Richard Ciccone, M.D.
Professor of Psychiatry and Director, Psychiatry and Law Program, University of Rochester Medical Center, Rochester, New York

Albert M. Drukteinis, M.D., J.D.
Adjunct Associate Professor of Psychiatry, Dartmouth Medical School; Director, New England Psychodiagnostics, Manchester, New Hampshire

Joel A. Dvoskin, Ph.D., ABPP
Clinical Assistant Professor, Department of Psychiatry, University of Arizona College of Medicine, Tucson, Arizona

Alan R. Felthous, M.D.
Professor and Director, Forensic Psychiatry Division, Department of Neurology and Psychiatry, Saint Louis University School of Medicine, St. Louis, Missouri

Liza H. Gold, M.D.
Clinical Professor of Psychiatry and Associate Director, Program in Psychiatry and Law, Department of Psychiatry, Georgetown University School of Medicine, Washington, D.C.

Thomas G. Gutheil, M.D.
Professor of Psychiatry, Department of Psychiatry, Beth Israel-Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts

Joshua C. W. Jones, M.D.
Clinical Assistant Professor of Psychiatry and Director of Education, Psychiatry and Law Program, University of Rochester Medical Center, Rochester, New York

James L. Knoll IV, M.D.
Associate Professor of Psychiatry and Director of Forensic Psychiatry, SUNY Upstate Medical University, Syracuse, New York; Director, Forensic Psychiatry Fellowship, Central New York Psychiatric Center, Marcy, New York

H. W. LeBourgeois III, M.D.
Assistant Professor of Psychiatry; Director, Forensic Psychiatry Fellowship, Department of Psychiatry and Neurology, Tulane University School of Medicine, New Orleans, Louisiana

Jeffrey L. Metzner, M.D.
Clinical Professor of Psychiatry, University of Colorado School of Medicine, Denver, Colorado

Donald J. Meyer, M.D.
Associate Director of Forensic Psychiatry, Beth Israel Deaconess Medical Center; Assistant Clinical Professor of Psychiatry, Harvard Medical School, Boston, Massachusetts

Douglas Mossman, M.D.
Director, Glenn M. Weaver Institute of Law and Psychiatry, University of Cincinnati College of Law; Adjunct Professor of Clinical Psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio

Debra A. Pinals, M.D.
Director, Forensic Education and Associate Professor of Psychiatry, Law and Psychiatry Program, Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts

Marilyn Price, M.D.
Clinical Instructor in Psychiatry, Harvard Medical School; Law and Psychiatry Service, Massachusetts General Hospital, Boston, Massachusetts

Stephen L. Read, M.D.
Clinical Professor Psychiatry, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, University of California, Los Angeles; and Psychiatrist, Greater Los Angeles Veterans Affairs Health Care System, Los Angeles, California

Patricia R. Recupero, J.D., M.D.
Clinical Professor of Psychiatry, Warren Alpert Medical School of Brown University; President and CEO, Butler Hospital, Providence, Rhode Island

Charles L. Scott, M.D.
Chief, Division of Psychiatry and the Law; Clinical Professor of Psychiatry; and Director, Forensic Psychiatry Fellowship, University of California Davis Medical Center, Sacramento, California

Michael C. Seto, Ph.D.
Consultant, Royal Ottawa Health Care Group, Brockville Mental Health Centre, Brockville, Ontario, Canada

Daniel W. Shuman, J.D.
M.D. Anderson Foundation Endowed Professor of Health Law, Dedman School of Law, Southern Methodist University, Dallas, Texas

Robert I. Simon, M.D.
Clinical Professor of Psychiatry and Director, Program in Psychiatry and Law, Department of Psychiatry, Georgetown University School of Medicine, Washington, D.C; Chairman, Department of Psychiatry, Suburban Hospital, Johns Hopkins Medicine, Bethesda, Maryland

John W. Thompson Jr., M.D.
Professor of Psychiatry; Vice Chairman and Chief, Adult Psychiatry; Director, Division of Forensic Neuropsychiatry, Department of Psychiatry and Neurology, Tulane University School of Medicine, New Orleans, Louisiana

Robert Weinstock, M.D.
Clinical Professor Psychiatry, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, University of California, Los Angeles; and Psychiatrist, Greater Los Angeles Veterans Affairs Health Care System, Los Angeles, California

Robert M. Wettstein, M.D.
Clinical Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

The following contributor to this book has indicated a financial interest in or other affiliation with a commercial supporter, a manufacturer of a commercial product, a provider of a commercial service, a nongovernmental organization, and/or a government agency, as listed below:

Brad Booth, M.D., FRCPC—*Consultant and speaker and recipient of unrestricted educational grants:* AstraZeneca, Eli Lilly, Janssen-Ortho.

The following contributors have no conflicting interests to report:

Peter Ash, M.D.
Madelon V. Baranoski, Ph.D.
Steven H. Berger, M.D.
F. William Black, Ph.D.
John Bradford, M.D., FRCPC
J. Richard Ciccone, M.D.
Albert M. Drukteinis, M.D., J.D.
Joel A. Dvoskin, Ph.D., ABPP
Alan R. Felthous, M.D.
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Charles L. Scott, M.D.
Michael C. Seto, Ph.D.
Daniel W. Shuman, J.D.
Robert I. Simon, M.D.
Robert M. Wettstein, M.D.

Foreword

Not long ago, a casual acquaintance who knows that I am a forensic psychiatrist asked me with a tone of puzzlement, "How much interaction is there between psychiatry and the law anyway?" Rarely do I get the opportunity to talk about my field in social settings, so—perhaps imprudently— I seized the moment.

"To start with," I said, "there are the ways in which the criminal justice system relies on psychiatric input, including assessments of defendants' competence to stand trial, criminal responsibility, and competence to waive their rights—along with presentence evaluations, and the less common assessments such as determination of prisoner's competence to be executed. Moreover, psychiatric testimony plays a critical role in the civil justice system as well, ranging from evaluations of plaintiff's emotional harms to assessments of decisional and performative competences, and including evaluations of disability, harassment claims, and malpractice issues. Forensic psychiatrists play an increasing role in correctional facilities, providing evaluations and treatment, and in hospitals settings, where they perform assessments of violence risk and committability, and consult on legal issues in psychiatric and general medical care."

At this point, before I could launch into a description of the more esoteric forensic roles that over the years I had been called on to fulfill, my interlocutor took advantage of a pause for breath to throw up his hands and say, "OK, I get it. I never knew there was that much to forensic psychiatry."

I suspect that he is not alone. Even other psychiatrists often are unaware of how rich and varied the world of contemporary forensic psychiatry really is. Indeed, the field has seen continued evolution and impressive expansion in recent years. For example, with greater societal concern about sex offenders has come the development of a nascent subspecialty in their evaluation and treatment. Greater receptivity on the part of the courts to claims of emotional harm has multiplied opportunities for injured parties to recover for the injuries they may have suffered, and offers an expanded focus of endeavor to forensic experts. What was once a specialty limited (at least in the United States)

almost entirely to evaluative functions has embraced the role of providing treatment in jails and prisons, spurred by the continued growth in the numbers of persons with mental illnesses behind bars.

At the same time, forensic psychiatry has seen a dramatic expansion in its empirical base. Opinions that were once grounded solely in personal—and too often idiosyncratic—impressions now can draw on previously unavailable sources of data. Judgments about the likelihood that a person is competent to make a decision about treatment or the probability that a defendant will commit a violent act can be informed by studies applying new structured approaches to these assessments, using rigorous methods. The same is true for evaluations of various forms of disability, psychiatric symptoms consequent to tortious acts, malingering, paraphilias such as sexual attraction to children, and even parenting capacity. Although the courts have sometimes been wary about accepting these innovative approaches—a caution clearly warranted when misguided expert witnesses attempt to posit scientific answers to moral questions—there seems no doubt that forensic psychiatry is moving steadily toward becoming an evidence-based specialty.

That trend may well be accelerated by the ongoing advances in our understanding of the brain, its functioning, and its pathologies. In recent years, we have begun to see the introduction into evidence of results from functional magnetic resonance imaging (fMRI), positron emission tomography (PET), and other techniques for visualizing brain function. These techniques have been employed in efforts to negate criminal responsibility, to demonstrate the presence of pain, and to determine whether consciousness is present in patients with profound neurologic impairments—but their ultimate value and appropriate uses still remain to be determined. Neuroscience-based lie detection technologies have been proposed and are being tested, and behavioral genetics has made its appearance on the witness stand as well. Not only will the forensic psychiatrist of the future need to develop excellent clinical skills, broad familiarity with legal principles, and knowledge of forensic assessment techniques, but he or she will also need to keep up with the latest advances in neuroscience and their utility in the courtroom.

Beyond advances in assessment techniques and the introduction of cutting-edge science, another energizing force in the field has been the growth and maturation of fellowship programs in forensic psychiatry. Whereas forensic practitioners once taught themselves how to perform evaluations and learned about relevant legal rules through hard and sometimes painful experience, a newer generation of psychiatrists is being trained in accredited subspecialty fellowships, often of excellent quality. The leaders of the field in coming years will have legal, clinical, and empirical backgrounds of unprecedented scope. Special training programs targeting the unique and underserved area of child and adolescent forensic psychiatry have been developed,

and the first research fellowships have begun to appear in the field as well. The advent of board certification and periodic recertification in forensic psychiatry should help practitioners to maintain their skills and knowledge base at a high level.

Thus, the time is propitious for the appearance of this second edition of *The American Psychiatric Publishing Textbook of Forensic Psychiatry.* The editors, Drs. Robert I. Simon and Liza H. Gold, themselves experienced and respected forensic psychiatrists, have recruited many of the leaders of our field—a substantial number newly added to this edition—to produce a wide-ranging and comprehensive overview of forensic psychiatry. With a decidedly practical emphasis, the contributors help forensic psychiatrists establish their practices, perform state-of-the-art evaluations, and use the latest assessment tools. Coverage includes rapidly developing subareas of the field, including child and geriatric forensic psychiatry, consultation to law enforcement, and use of the Internet. At the same time, the editors have not neglected the basics of our forensic work: conducting evaluations, writing reports, testifying, and practicing within accepted ethical norms.

This is an exciting time to pursue a career in forensic psychiatry, and this volume is a splendid accompaniment on that journey.

Paul S. Appelbaum, M.D.
Elizabeth K. Dollard Professor of Psychiatry, Medicine and Law
Director, Division of Law, Ethics and Psychiatry, Department of Psychiatry,
Columbia University/ New York State Psychiatric Institute
New York, New York

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Preface

We are pleased to present the second edition of *The American Psychiatric Publishing Textbook of Forensic Psychiatry.* As we noted in the preface to the first edition, the preacher in Ecclesiastes said, "of making books there is no end." This is no less true today than it was 5 years (or 2000 years) ago. Why then publish a second edition of this text just 5 years after the first?

Despite forensic psychiatry's status as an acknowledged subspecialty, general clinicians still perform the bulk of forensic assessment. When we published the first edition, no textbook of forensic psychiatry had been written for general clinicians. In organizing the first edition of this textbook for a general clinical audience, we returned full circle to the early years of the medical subspecialty of psychiatry, when forensic practice and general clinical practice were not differentiated. Isaac Ray, the first "forensic psychiatrist," in his 1838 landmark book *A Treatise on the Medical Jurisprudence of Insanity,* drew no distinction between the general psychiatrist and the forensic psychiatrist.

However, forensic psychiatry is still an evolving subspecialty. The past 5 years have seen changes and developments in the law and in forensic practice. General clinicians, as well as those who identify themselves primarily as forensic specialists, should be aware of these developments. Forensic experts who contributed chapters to the first edition have reviewed and incorporated these changes and discuss their practical implications in this second edition. New authors have contributed chapters on some essential forensic subjects covered in the first edition, providing new perspectives that also incorporate recent developments in the field.

The first edition also provided the opportunity to identify gaps in knowledge, both in subjects covered and in subjects omitted. Much to our delight, the enthusiastic reaction to our first edition included suggestions regarding subjects that deserved discussion in a general textbook of forensic psychiatry. We believe we have taken advantage of this opportunity in the second edition. Thus, in addition to updating the subjects covered in the first edition, the second edition has been expanded to include chapters, as suggested by our audience, on the subjects of forensic geriatric psychiatry and forensic psychi-

atry and the Internet. These chapters provide invaluable guidance in these cutting-edge areas of forensic practice.

Many areas of psychiatry require specialized knowledge. Clinicians receive training in subspecialty areas such as child and adolescent psychiatry, addiction psychiatry, and geriatric psychiatry through required and elective courses and clinical rotations in the course of their residency training. In contrast, exposure to formal didactic training in forensic psychiatry is still limited, and formal clinical training almost nonexistent, unless young psychiatrists pursue fellowships. Clinicians, unfamiliar with basic forensic practice, often fear to become involved in forensic cases and avoid forensic practice entirely. Alternatively, when their participation in forensic matters becomes unavoidable, they suffer undue anxiety and often recognize too late that they do not have the skills needed to provide competent services.

This book is not intended to turn the general clinician into a forensic specialist. As in any other subspecialty of medicine or psychiatry, general practitioners are encouraged to have some training and knowledge in the subspecialty and to practice within their expertise. They are also encouraged to recognize the limits of their expertise and to refer complicated cases to specialists. We hope to provide the basic information that general clinicians need to discharge forensic obligations, whether required or voluntarily, in a competent manner. We hope, too, to help them recognize the areas of practice that require advanced forensic skills and training, and encourage them to refer these cases to forensic subspecialists or obtain consultation. We also hope this volume contains much of interest to forensic specialists, who can always learn from the knowledge and experience of their colleagues. These chapters provide general clinicians and forensic specialists alike with concise reviews and accepted practices that will expand their level of expertise in this exciting and challenging subspecialty.

We take great pride in presenting this second edition of a collection of contributions from outstanding authorities in forensic psychiatry. As has often been observed, the intersection of the fields of psychiatry and the law creates a complicated and foreign terrain. Understanding the lay of this land is essential in order to negotiate it effectively. Although Isaac Ray did not differentiate between the general clinician and forensic specialist, Ray recognized that clinicians who entered the legal arena needed specialized skills to acquit themselves competently and urged his colleagues to acquire them. As Ray wrote in 1851:

> It cannot be too strongly impressed upon our minds that the duty of an expert is very different from those which ordinarily occupy our attention, and requires a kind of knowledge, and a style of reflection, not indispensable to their tolerably creditable performance. [Clinical and diagnostic skills] will

> render [the clinician] but indifferent service on the witness stand. There, he will feel the need of other resources than these, and fortunate will he be, if he do not learn his deficiency before he has exposed it. (Ray I: "Hints to the Medical Witness in Questions of Insanity." *American Journal of Insanity* 1851, Vol. 8, p. 55)

We hope that the combined knowledge and experience regarding forensic assessments and practice presented in this book will help guide both general clinicians and forensic specialists to a positive, rewarding experience in the field of forensic practice.

Robert I. Simon, M.D.
Liza H. Gold, M.D.

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Acknowledgments

Our thanks to American Psychiatric Publishing, Inc., for the opportunity to present this expanded second edition. Many thanks also to Ms. Tina Coltri-Marshall for her invaluable assistance in the day-to-day production of this book. We express our special appreciation to Patricia A. Simon and Ian J. Nyden, Ph.D., for their love and consistent encouragement. Finally, we gratefully acknowledge our chapter authors for their outstanding contributions. It has been gratifying to collaborate again with those who have updated their original contributions and with those who have contributed new chapters.

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PART I

Introduction to Forensic Psychiatry

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Chapter 1

Rediscovering Forensic Psychiatry

Liza H. Gold, M.D.

Plus ça change, plus c'est la meme chose.
[The more things change, the more they remain the same.]

Alphonse Karr (1849)

Forensic psychiatry has become an acknowledged and respected psychiatric subspecialty in recent decades. Psychiatrists have become increasingly aware of the need for expertise in legal aspects of psychiatric practice and in satisfying the legal system's need for psychiatric participation in adjudicating matters involving mental health. Training in forensic psychiatry is a core competency in psychiatric residencies. Social forces, including the influence of managed care on the practice of psychiatry, have played a role in stimulating interest in this subspecialty practice (Binder 2002; Rappeport 1999). Nevertheless, the intellectual challenges inherent in working at the interface of psychiatry and the law have drawn some of the most capable psychiatric practitioners to apply their skills in legal arenas.

Organizational and professional developments have reflected increasing interest in the practice of forensic psychiatry. The American Board of Forensic Psychiatry (ABFN), now disbanded, began certifying the accreditation of forensically trained psychiatrists in 1979. The American Board of Medical Specialties and the American Psychiatric Association officially recognized forensic psychiatry as a subspecialty in 1992 (Prentice 1995; Rappeport 1999). The American Board of Psychiatry and Neurology formally recognized forensic psychiatry as a subspecialty and took over the ABFN's certification process, issuing its first certification for Added Qualifications in Forensic Psychiatry in 1994.

The number of practitioners who identify themselves as forensic psychiatrists mirrors these institutional developments. The American Academy of Psychiatry and the Law (www.aapl.org), the professional organization of forensic psychiatrists, was founded in 1969 with only 10 members. In 2008, the American Academy of Psychiatry and the Law claimed almost 2,000 members. In the 1960s and 1970s, a limited number of fellowship programs were available, but interest in such training was almost nonexistent (Rappeport 1999). Currently, 50 forensic fellowships offer specialized training in the United States and Canada, and most of these programs are filled.

Nevertheless, despite appearing to be a new subspecialty, forensic psychiatry has been practiced for years, and psychiatrists establishing forensic practices are in fact only rediscovering their professional roots. Forensic and clinical psychiatry developed in tandem, and both were considered integral facets of the new profession. The field of psychiatry, arguably the first subspecialty of medicine[1] (Grob 1994), developed in the first decades of the nineteenth century. Forensic psychiatric practice played an important but underrecognized role in the development of psychiatry by connecting this new specialty with the field of medical jurisprudence. In doing so, forensic psychiatry helped the field of clinical psychiatry establish its professional identity.

Although it has all but disappeared in the twenty-first century, the field of medical jurisprudence, the practice of medicine in relation to the law, has a long historical tradition and was a recognized branch of medicine in the nineteenth century. The relationships of insanity and the law constituted an acknowledged branch of this academic and practical field, long before clinical psychiatry evolved. The first "mad-doctors," or psychiatrists,[2] asylum doctors combined their interest and experience in mental disorders with the traditions of medical jurisprudence. They considered forensic practice an integral part of their professional role. As such, forensic psychiatry quickly became an influential component of American medicolegal practice (Mohr 1997).

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[1]The well-established practice of surgery evolved from a different historical tradition and not as a subspecialty of medicine.

The Making of History

The process by which medicine came to dominate discourse concerning mental illness has engendered debate and controversy among historians and sociologists of science and medicine (Scull 1981a). The controversies revolve around the validity of different perspectives of historiography. Internal (or Whiggish) histories of medicines, often written by medical practitioners, tend to portray medical history as the progressive advancement of objective knowledge and humanitarian benefits, generally without reference to external social forces (Smith 1981). Critics of this approach point out that conceptualizations of diseases and treatments unquestionably demonstrate the imprint of social and cultural forces, and failure to consider these forces results in an incomplete and biased perception of historical events (Starr 1982).

In contrast, some historians have focused their interpretations of history on the external forces that drove professionalization. Indeed, sociologists use the example of the medical profession to illustrate the developing prominence and hegemony of the middle class. These interpretations are weakened by their indifference to the content of medical knowledge and to the undeniable benefits that modernization has brought to medical treatment (Eigen 1991).

In this discussion, I will not attempt to resolve the historical and sociological debates that have characterized the history of psychiatry. As some historians have acknowledged, the once-fashionable distinction between the external and internal histories of medicine and science is not productive (Scull et al. 1996). The development of psychiatry cannot be understood entirely as an internal process related to scientific advancement. It also cannot be fully understood by interpretations that evaluate only external social forces such as the desire for professional aggrandizement or, more recently, the impact of managed health care on medical practice.

Multiple factors contributed to the emergence of psychiatry as a professional activity (Mohr 1997; Starr 1982). The rise of experts in madness and

---

[2]The term *mad-doctor* was once the standard English expression for medical men who sought to make a living from the treatment of the mentally disordered. The term most commonly used in the nineteenth century was *alienist*. The modern term *psychiatrist* originated in Germany and did not come into widespread use until the last third of the nineteenth century; the term was not generally preferred by the profession itself until the twentieth century (Scull et al. 1996).

the development of a separate field of medicine devoted to the evaluation and treatment of the insane was a complex phenomenon related to the needs of an increasingly sophisticated, industrialized society (Eigen and Andoll 1986; Grob 1994). In this chapter, I review the intimate association between the early development of organized psychiatry and forensic practice,[3] forensic psychiatry's role in the professional identity of early specialists in mental disorders, and the implications of this association for modern clinical and forensic practice.

Development of Forensic Psychiatry

Historical Vignette

In 1840, Edward Oxford was tried for firing a pistol at Queen Victoria. He pled not guilty by reason of insanity. At the beginning of the trial, the chief justice was adamant that no witnesses, including medical witnesses, could give an opinion on whether Oxford was insane, because this was the ultimate issue before the court. By the end of the trial, the medical witnesses were giving such opinions without objection by the prosecution or the judges (Freemon 2001). During the trial, the court questioned one medical witness, Dr. Hodgkin, about the basis of his opinion regarding Oxford's insanity:

> *Question by the court:* Do you conceive that this is really a *medical* question at all, which has been put to you?
> *Answer:* I do. I think medical men have more means of forming an opinion on that subject than other persons.
> *Question by the court:* Why could not *any* person form an opinion, from the circumstances which have been referred to, whether a person was sane or insane?

[3]This discussion will begin with developments in both England and the United States and then focus on the professional organization of psychiatry in the United States alone. Through the nineteenth century, English and American lawyers and asylum physicians closely followed cases on both sides of the Atlantic. Key English legal decisions were sometimes cited in the United States. United States civil and criminal legal practice was essentially derived from English common law until the mid-nineteenth century, when the legal cultures of the two countries began to diverge (Smith 1981).

Answer: Because it seems to require a careful comparison of particular cases, more likely to be looked to by medical men, who are especially experienced in cases of unsoundness of mind.
Question by the court: What is the limit of responsibility [for criminal behavior] a medical man would draw?
Answer: That is a very difficult point. It is scarcely a medical question.
(Review of the trials of Oxford and M'Naghten, with an account of their present condition, Vol. VII, 1851, cited in Freemon 2001, p. 369)

The Arrival of the Expert Psychiatric Witness

The testimony in the *Oxford* case demonstrates the existence by 1840 of a professional identity based on expertise in the evaluation of insanity. This development was new to the nineteenth century.[4] Before that time, the legal profession had seen little need for advice on legal issues pertaining to insanity (Eigen 1991, 1995, 2004; Eigen and Andoll 1986; Maeder 1985; Mohr 1993, 1997; Robinson 1996).[5] Beliefs about mental disturbance were deeply rooted in common culture. The defining of insanity, in the mid-eighteenth century, as total and complete want of reason and self-control set the bar for determining insanity so high that medical witnesses were rarely needed to identify its presence (Eigen 2004).

Cases that might involve psychiatric testimony, such as invalidating a will or a contract because of "lunacy"[6] or negating criminal responsibility, were considered social, not medical, issues. The prevailing definitions and criteria for cases were operationally related to the matter in question: whether the supposed lunatic appreciated his true relationship to the legatees, whether he un-

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[4]One prominent historian, however, argues that specialists in insanity, whose expertise derived from owning a mad-house, "came of age" on December 5, 1788, when King George III's physicians acknowledged their failure to manage the king's delirium and summoned the specialist mad-doctor Francis Willis to treat the king.

[5]Information regarding the role of expert psychiatric witnesses is based on historical records involving cases in which the insanity defense was invoked or in which testamentary capacity was challenged. Of these types of cases, the best studied are those involving the insanity defense (Eigen 1995; Mohr 1993).

[6]In the eighteenth and nineteenth centuries, terms such as *lunacy, lunatic, the deranged, madmen,* and *the insane* were used interchangeably to refer to individuals with mental disorders and were not considered pejorative. The use of these terms in this discussion reflects a historical tradition and is not meant to convey any negative meaning or implication.

derstood the terms of a contract and appeared able to exercise due care in transactions, and whether or not he knew his act was right or wrong (Mohr 1997).

The insanity defense did not arouse much medical attention before about 1800 (Porter 1987; Smith 1981). In fact, before the early nineteenth century, medical testimony was a rarity even at trials in which the issue of insanity was raised. In establishing insanity, the testimony of friends, neighbors, and relatives counted most (Porter 1987). For example, in 1724, Edward Arnold was tried for the attempted murder of Lord Onslow. Arnold's attorney attempted to prove that Arnold was insane, but no physician was called to testify. The first trial to include the testimony of a mad-doctor was that of Earl Ferrers. Dr. John Monro, physician to Bethlem Hospital,[7] provided testimony regarding Ferrers' uncle, who had been Monro's patient, and to the symptoms of insanity in general, but never actually examined Ferrers[8] (Eigen 1995; Freemon 2001; Maeder 1985). Only a few other cases contained recorded testimony of medical witnesses.

Most defendants were unlikely to be able to afford the services of a physician and therefore would be unlikely in the event of a trial to be able to produce as a medical witness a physician who had provided treatment prior to the offense. Only relatively affluent individuals, such as Lord Ferrers, or individuals who belonged to a community that looked after its own could produce physician testimony. An example of the latter category is provided by the Society for Visiting the Sick and Charitable Deeds, an organization established by the London Sephardic Jewish community. This group employed a doctor who appeared two or three times at the Old Bailey, London's central criminal court, on behalf of Jews accused of shoplifting (Walker 1968).

By the mid-1800s, however, medical witnesses had become a regular fixture at insanity prosecutions, indicating that the courts had come to acknowledge a professional with specialized expertise. In the latter half of the eighteenth century, the relative frequency with which lunatics appeared in the dock at the Old Bailey increased (Walker 1968), as did participation of medical witnesses in their trials. In 1760, mad-doctors appeared in only 1 in 10 insanity

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[7]This Dr. Monro was the second in a family dynasty of Monros who served as superintendents of Bethlem Hospital. The first of the dynasty, James Monro, was medical director from 1728 to 1752. A member of the Monro family occupied this position until 1833.

[8]Ferrers was arraigned before the House of Lords for having murdered his steward, pleaded madness, and found himself in the awkward position of having to conduct his own defense to prove he was insane. He was found guilty and hanged (Porter 1987).

trials. Beginning in 1760 with the Ferrers case, and ending with the trial of Daniel M'Naghten[9] in 1843, 43% of the cases that came before the Old Bailey offered evidence regarding the prisoner's mental state. By 1840, specialists in insanity testified in almost half of all insanity cases concerned with a property offense and almost 90% of trials involving personal assault (Eigen 1991, 1995; Eigen and Andoll 1986; Freemon 2001; Robinson 1996).

This dramatic increase in the presence of medical testimony was due in part to the liberal use of capital punishment. In the 1700s, England applied the death penalty to a wide range of personal and property offenses under what was referred to as the "Bloody Code."[10] The English legal system developed a series of escapes from execution, one of which was a plea of insanity (Eigen 1995; Walker 1968). Many of the defense medical witnesses in these trials were well known for their opposition to the death penalty. One of the witnesses in the Oxford trial frankly admitted that his opposition to capital punishment biased his opinion concerning the presence or absence of insanity (Freemon 2001). Nevertheless, as described by J.P. Eigen, the dramatic increase in the legal participation of experts in insanity "suggests that by the time of the M'Naghten trial, the specialist in forensic psychiatry had arrived" (Eigen 1991, p. 452).

Basis of Forensic Expertise: The Development of Clinical Psychiatry

The increased role of physicians in the courts coincided with the development of clinical psychiatry, as demonstrated by the shift in the content of physicians' testimony in the early decades of the 1800s. Before 1825, almost half of the medical witnesses in insanity trials testified about friends or former patients. Physicians' courtroom testimony was a consequence of a social or professional encounter that predated the crime. Thus, their testimony did little more than validate lay testimony.

In contrast, by the late 1820s, the medical witness was likely to be an asy-

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[9]The spelling of the name "M'Naghten" has at least 16 variants (see Maeder 1985). In this discussion, I have arbitrarily chosen to utilize the spelling that follows the convention adopted by the *American Journal of Psychiatry.*

[10]Under the code, for example, any theft valued at 30 shillings or more was a hanging offense (Eigen 2004). In the spirit of reform typical of the Age of Enlightenment, sentencing policy in the 1830s changed significantly. The "Bloody Code" was repealed, most property offenses were no longer deemed capital crimes, and capital punishment for most felonies was restricted.

lum physician or jail surgeon who, similar to the practice of modern experts, provided a formal diagnosis in the course of a post-crime "investigation" of the accused's sanity. These medical witnesses claimed that their sustained familiarity with the mentally ill provided them with a level of professional insight into insanity not shared by the casual or lay observer, or even by the general medical practitioner (Eigen 1991; Eigen and Andoll 1986). Over half of all known post-1825 relationships between medical witnesses and defendants began after the crime, either while the defendant was in detention awaiting trial or while he or she was confined in a mad-house. This expert testified on the basis of "specialized knowledge" and not personal familiarity with the defendant.

The Asylum Movement and Moral Treatment

The medical expert's specialized knowledge was a direct result of the development of the asylum in the early nineteenth century. The physicians associated with these institutions claimed that their study and treatment of large numbers of patients provided them with special expertise in matters pertaining to insanity. General physicians who offered testimony in the eighteenth century might see one or two cases of mental derangement a year. In contrast, asylum physicians could cite a wealth of experiences in treatment and case management. The more experience in treatment, the more credible the opinion. Even general practitioners began to defer in court to specialists with greater numbers of patients (Eigen 1991, 1995; Eigen and Andoll 1986; Freemon 2001).

References to "mad-houses" in England can be traced back to the seventeenth century, and some existed even before then. Most, like Bethlem Hospital in London,[11] had their origin as religious or municipal charities (Scull et al. 1996). Institutionalization of the insane in the American colonies first appeared in the eighteenth century.[12] Until the close of the eighteenth century, however, mad-houses were not primarily medical institutions; their goals

[11]Bethlem, originally Bethlehem Hospital, was established in 1247 by the order of St. Mary of Bethlehem and began admitting lunatics in 1377. In 1547, King Henry VIII took Bethlem away from the religious orders, made it into a hospital for indigent lunatics, and granted its charter to the City of London (Porter 1987).

[12]The Public Hospital for the Insane, opened in 1773 in Williamsburg, Virginia, was the first hospital devoted exclusively to the care of the mentally ill in colonial America.

were custodial rather than remedial (Walker 1968). In England and the United States, families or local communities were responsible for providing care for the insane (Grob 1994; Walker 1968). Only the most dangerous or violent individuals were institutionalized, generally in jails. Common medical treatments of insanity, when provided, were based on traditional theories of humoral imbalances, the mainstay of medical theory and treatment for centuries, and standard interventions of bloodletting, blistering, and purging were used to restore humoral balances (Grob 1994).

The asylums of the nineteenth century were a new phenomenon. Their origins lay in the rationalism and optimism associated with the Age of Enlightenment. This eighteenth-century philosophy posited that although man was corrupt and imperfect, this was not his natural state. The belief that men could better themselves, and that society was responsible for assisting its more imperfect members to better themselves, led to humanistic and progressive social movements. Naturalistic and secular explanations of human behavior replaced mystical or divine explanations. The successes of science in astronomy and physics, the rapid strides made in technology, and the struggles for political democracy in the United States, France, and England were practical proofs of the validity of the belief that man could control his environment and improve his life on earth (Barton 1987; Dain 1964; Grob 1994).

Explanations of insanity, which had previously been considered a demonstration of divine intervention or punishment, also began to reflect a rational, humanistic perspective. By the mid-eighteenth century, madness came to be considered a pathological condition that could be cured (Grob 1994; McGovern 1985; Mohr 1997). In 1758, Dr. William Battie wrote the first book dedicated entirely to mental illness, *Treatise on Madness,* in which he declared that insanity was as manageable and curable as other disorders.[13] By the latter part of the eighteenth century, medical interest in insanity was on the upswing (Scull 1981b). Lunatics were increasingly seen as a group who could be treated—and who deserved to be treated (Porter 1987).

Phrenology, considered the first science of the brain, was a central theoretical underpinning of this increased professional interest and provided a

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[13]Battie was the first English physician of status to make treatment of the mad his primary concern, the first to give clinical instruction on insanity, and the first to deliver lectures on mental diseases. He was one of the very few psychiatrists to become president of the Royal College of Physicians. Along with John Monro, the second of the Monro dynasty at Bethlem Hospital, Battie became the leading "mad-doctor" of his time (Hunter and MacAlpine 1982; Scull 1981b; Walker 1968).

physical basis for the development of medical theories of insanity and the specialty of psychiatry during the first four decades of the nineteenth century (Coliazzi 1989; Cooter 1981; Dain 1964; Scull 1981b). This new "science" provided a clear physiological explanation of the brain's operations. Phrenology proposed that the brain was composed of discrete anatomical organs, each of which was associated with certain functions, emotions, or behavioral traits. Taken together, these explained mental organization and could account for both normal and abnormal mental function. Doctors developed medical models of madness that connected the brain and other organs to mental disturbances.

Physicians and laypeople alike began to call for more humane and humanistic treatment of the insane. If insanity could be cured, something more than standard medical treatments of blistering and purging was needed. At the end of the eighteenth and the start of the nineteenth century, a method of treatment was developed that promised new hope in ameliorating the seemingly incurable affliction of madness.

In 1801, Philippe Pinel, in his *Traité medico-philosophique sur l'aliénation mentale,* described his success at curing the insane through a program he called "traitement moral."[14] Pinel concluded that a carefully constructed social environment could help bring the emotions under control better than medical treatment or mechanical restraints. He amassed empirical evidence demonstrating his effective moral treatment of the insane and promoted a reformed asylum milieu using innovative management techniques emphasizing social and psychological interventions (Porter 1997). Pinel's ideas on the treatment of insanity were translated into multiple languages and spread quickly. An English translation, *A Treatise on Insanity,* was published in 1806 and was widely known in the United States.

William Tuke in England came independently to conclusions similar to those of Pinel. Tuke put his theories in practice by founding the York Retreat in 1792, where he emphasized kindness and compassion in the care of the insane. The goal of Tuke's moral treatment was to provide humane care and to demonstrate that the mad could learn to control themselves and their behaviors. Tuke implemented his philosophy of treatment by creating attractive surroundings in which patients were treated like family or guests. Mechanical

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[14]The adjective *moral,* as in moral treatment or moral insanity, began with the French. Its original usage was not to distinguish "moral" from "immoral" but rather to distinguish between the patient's mind as opposed to somatic pathology (Mohr 1997; Porter 1987). However, the English use of the terms *moral treatment* and *moral insanity* came to refer to both affective forms of insanity and insanity thought to be caused by or related to immoral behaviors.

restraints, intimidation, and bloodletting were not permitted. In contrast to the York Retreat, "Bethlem Hospital…appeared as a kind of medieval hell" (Porter 1997, p. 497). William Tuke's theories and practices were widely disseminated by Samuel Tuke's publication of *Description of the Retreat* in 1813, which spread news of William Tuke's work to both sides of the Atlantic (McGovern 1985; Porter 1997). Vincenzio Chiarugi in Italy and Benjamin Rush in the United States also played roles in developing theory and practice associated with the new moral treatment of the insane (Barton 1987; Dain 1964; Weiner 2008).

Moral treatment lent itself well to newly developing theories regarding the etiology of madness. In addition to somatic etiologies, physicians came to believe that the majority of cases of mental disease resulted from degenerate behaviors or the pressures of an increasingly industrialized society. Degenerate behavior was typically defined as any behavior that departed from normative Victorian, Protestant, and bourgeois standards held both in England and in the United States (Smith 1981). Behavior or social problems that could result in mental imbalance included intemperance, masturbation, overwork, domestic difficulties, excessive ambition, faulty education (or, in women, too much education), personal disappointments, marital problems, excessive religious enthusiasm, jealousy, and pride (Grob 1994).

Moral therapy assumed that confinement in a well-ordered institution was an indispensable part of the treatment of insanity. The work of Pinel, Tuke, and others led to the conclusion that recovery from mental derangement, particularly disorders with "moral" (i.e., immoral) causes, was not only possible but also probable. A judicious mix of medical and moral treatment could correct the effects of improper behavioral patterns or a deficient social environment. Once the individual was in a regulated environment, natural restorative elements could act upon the deranged mind, leading to a reversal of mental disturbances. In addition, an authoritarian regimen could be employed in ways that persuaded patients to internalize the behavior and values of normal society and thus promote recovery (Grob 1994).

At the time these theories of treatment were being developed in the late eighteenth century, numerous social factors had made the traditional and informal methods of caring for the mentally ill less effective.[15] The Enlightenment's faith that long-standing problems could be solved by purposeful human intervention based on a combination of intellectual and scientific ap-

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[15]These social factors included significant growth of the population and a proportionate increase in the numbers of mentally ill people, as well as urbanization, industrialization, and the decentralization of families (Grob 1994).

proaches resulted in the concept of using institutions to help solve social problems (Grob 1994). The humanitarian spirit of reform combined with medical theory resulted in the founding of insane asylums in the United States and England. For most of the nineteenth century, doctors believed that the majority of cases of insanity were curable, but only if patients were treated in specially designed buildings (Yanni 2007).

After 1800, systematic provision began to be made for segregating the insane into specialized institutions (Scull et al. 1996). Mental asylums were among the greatest public works of the nineteenth century, consuming huge amounts of public money from the 1820s through the end of the century (Dain 1964; Grob 1994; Mohr 1997). These new asylums, built on grand scales, were promoted as progressive and were considered the only effective and humane sites for the treatment of insanity (Porter 1997). Asylums were centers of cultural and practical activity: they featured lecture series, literary journals by and for patients, and dramatic groups. Patients also learned and worked at useful and marketable skills such as farming and manufacturing activities (Reiss 2008).

The earliest American asylums for the treatment of the insane, often founded through citizen philanthropy, opened in the first two decades of the nineteenth century and were modeled on the work of Pinel and Tuke (McGovern 1985). Between 1825 and 1850, responsibility for the care and treatment of the insane slowly fell under the jurisdiction of asylums established and administered by the states.[16] From 1825 to 1865, the number of asylums in the United States grew from 9 to 62. Most of these were state-supported (McGovern 1985).

Around 1800, no more than a few thousand lunatics were confined in a variety of institutions in England, including mad-houses and jails. In 1808, Parliament passed an act empowering the establishment of public lunatic asylums. By 1900, the number had increased exponentially to about 100,000 (Porter 1987).

Most nineteenth-century physicians accepted the precepts of moral treatment, which did not involve somatic theory. Nevertheless, they maintained that insanity was ultimately rooted in the biological organism, particularly the brain. Moral therapy therefore needed to be incorporated within a medical model and prescribed in conjunction with conventional medical

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[16]In the United States, Dorothea Dix, one of the great social reformers in American history, was a driving force in the development of institutions for the mentally ill. Her social and political activism is credited with the building of 32 mental hospitals and the development of the policy of state responsibility for the care of the mentally ill (Barton 1987; Grob 1994).

therapeutics (Porter 1997). Physicians who espoused moral treatment were generally unwilling to apply it without the use of common remedies such as bloodletting, purging, and blistering, and drugs such as opium and morphine, tonics, and cathartics (Grob 1994). The ability of physicians to apply both moral and medical theory to the treatment of the insane led in large part to their ascendancy to positions of authority within the asylum system.

Worcester State Hospital in Massachusetts, opened in 1833, typified the institutions of this period. The hospital was structured to maximize contemporary moral and medical treatment. Unlike existing asylums, Worcester State admitted relatively large numbers of patients. Under the administration of the physician Samuel B. Woodward, its first superintendent, it quickly acquired a national reputation. Between 1833 and 1845, Woodward reported that the recovery rate of individuals insane for a year or less averaged between 82% and 91%. These statistics seemed to prove that insanity could be cured with prompt medical and moral treatment. Woodward himself soon became widely regarded as the most established authority in the treatment of mental disorders in the United States (Barton 1987; Grob 1994; Scull 1981b).

The catalyst for the new field of psychiatry proved to be the associated emergence of the bricks-and-mortar institutions for lunatics. The presence for the first time of large numbers of patients in one place encouraged scientific observation and new paradigms of mind and body (Porter 1987). The medical profession and informed physicians increasingly acknowledged asylum physicians as experts in matters pertaining to insanity. They demonstrated their faith in the skills and opinions of these specialists by sending patients to the asylums, adopting their views when testifying in court cases, and reading their articles published in medical journals. The popular press also gradually accepted the special role of asylum doctors. Newspapers and popular journals published excerpts from their annual reports, described activities at the hospitals, and urged the building of more asylums (Dain 1964; McGovern 1985).

Partial Insanity

The confinement of the mentally ill created opportunities for the accumulation of observations of patient behavior and symptoms. These observations led to new descriptions and classifications of mental illness. Before the eighteenth century, deranged reason was considered the sine qua non of all cases of insanity, regardless of what other manifestations were present. Once large numbers of patients were admitted to asylums, the early psychiatrists began developing theories that introduced gradations and variations of in-

sanity.[17] These began to replace older, sharper distinctions between persons who were clearly deranged and those who were merely troubled.

Toward the end of the eighteenth century, physicians specializing in mental illness accepted the concept that people could be "partially" insane—that is, not totally irrational. The theories of the French clinicians Pinel and Jean Etienne Esquirol (in his *Des Maladies Mentales,* published in 1838) were highly influential in the development of theories of partial insanity, an insanity that could affect the emotions without necessarily affecting reason. James Cowles Prichard, in his book *A Treatise on Insanity and Other Disorders Affecting the Mind* (1835), was the first to use the term *moral insanity* to describe this type of insanity. Prichard defined moral insanity as a type of mental disorder "consisting in a morbid perversion of feelings, affections and active powers, without an illusion or erroneous conviction impressed upon the understanding: it sometimes coexists with an apparently unimpaired state of the intellectual faculties" (p. 20). He argued that although the disorder was difficult to diagnose with certainty, observation, as well as the authority of Pinel and Esquirol, proved that this illness did exist (Coliazzi 1989; Dain 1964; Dain and Carlson 1962; Eigen 1991; Maeder 1985; Mohr 1997; Porter 1997; Smith 1981).

Physicians postulated that moral insanity resulted from a localized physical change in the brain just as did other traditionally recognized forms of insanity. Physicians and medical authors in the early nineteenth century, including Prichard, frequently used the word *lesion* in discussing mental illness. This word evoked the spirit of the new empirically based clinical medicine institutionalized in France. In using this term in connection with partial insanity, physicians such as Prichard explicitly invoked an organic etiology for this newly defined form of insanity. For example, in his testimony in the Oxford trial, Dr. Hodgkin called Oxford's form of insanity "a lesion of the will" (Freemon 2001).

Phrenological theories were easily invoked to support the concepts both that an individual's moral (or emotional) faculties might be deranged while those of reason remained intact and that such derangement resulted from a

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[17]Through such observations, general paresis, epilepsy, and "idiotism" were recognized as distinct disorders. Emil Kraepelin's classification of psychiatric disorders, the *Lehrbuch der psychaitrie,* originally published as a brief compendium in 1883, grew through its nine editions into an encyclopedia of nineteenth-century psychiatry (Gach 2008) and was the culmination of a century of descriptive clinical psychiatry accumulated through asylum admissions. Kraepelin's nosological classifications provided the framework for modern psychiatric nosology, reflected in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1980).

specific lesion in the brain (Dain and Carlson 1962). These references to lesions generally lacked empirical support, except in a few cases in which autopsies revealed the presence of a brain tumor or other gross abnormality. The acceptance of their presence rested on faith rather than observation. Nevertheless, this optimism, derived from the development of clinical medicine based on pathology in the early nineteenth century, gave rise to a new confidence that empirical methods would soon systematically uncover the physical causes of mental illness (Grob 1994; Smith 1981).

Before the 1830s, the concept of partial or moral insanity encountered relatively little opposition in the United States. In the decade following the appearance of Prichard's work, moral insanity became an important and controversial issue in American psychiatry. Moral insanity served as a catchall term for many forms of mental illness in which intellectual powers seemed to remain partially or completely intact. The concept of such a disorder was not unanimously accepted, and debate regarding its existence continued throughout the century. Nevertheless, by the 1840s, most physicians prominent in the treatment of the mentally ill had accepted, at least to some extent, the existence of moral or partial insanity (Rosenberg 1968).

Diagnoses of partial insanity, such as delusions, monomania, and moral insanity, cast doubt on the layman's or even the general physician's ability to discern sanity from purposeful and seemingly rational behavior (Eigen 1991; Eigen 2004; Robinson 1996). As J.P. Eigen points out, "Where the 18th-century courtroom was only prepared to accept global delirium as the criterion that could preclude the defendant's inability to know 'what he was about' and therefore render him a person incapable of choosing to do wrong, nineteenth-century juries were presented with a *partial* insanity, but one that was argued to be sufficiently debilitating to carry exculpatory significance" (Eigen 2004, p. 401). The fact that a defendant actively constructed the elements of the crime—that is, demonstrated rational planning to execute the crime—did not necessarily demonstrate that he or she was aware of the nature or consequences of the act. In fact, according to these new theories, what might appear to the untrained observer to be reasoning and planning might, to the psychiatric expert, indicate the workings or force of a delusion (Eigen 2004).

The concept of partial insanity opened the door to a forensic role for psychiatrists. The second quarter of the nineteenth century witnessed a sixfold increase in medical participation in insanity trials at the Old Bailey. Half of all medical witnesses who appeared in these trials employed a form of partial insanity to support their diagnosis of insanity (Eigen 1991).

The *Hadfield* case was the first to introduce into the courts both the theoretical shift and its implications for expert witness testimony. James Hadfield was indicted for high treason for attempting to kill King George III in 1800. In this case, Hadfield's partial insanity was said to involve mental derangement

limited to the formation of delusions (Freemon 2001). Hadfield's counsel, the well-known jurist Thomas Erskine, argued that Hadfield's delusional thinking affected only part of his mind and was able to demonstrate that Hadfield's delusions developed after he had sustained head injuries during the course of military service. Erskine obtained the testimony of Dr. Alexander Crichton, an eminent author in the field of insanity (Weiner 2008),[18] who stated that Hadfield's head wound could result in a form of insanity that might spare the rational powers and be evident only in particular subjects (Freemon 2001; Robinson 1996). After a trial lasting only one day, Hadfield was found not guilty and sent to Bethlem Hospital.[19]

Successful defenses of insanity had been a regular feature of Old Bailey trials for at least 60 years (Walker 1968). The *Hadfield* case, however, made clear that the ordinary perceptions of the courts or of laymen could not provide conclusive evidence of a defendant's sanity. A form of partial insanity that could not be appreciated by ordinary people required the introduction of witnesses with special expertise in the recognition of this hidden condition (Freemon 2001). Such professional insight could be derived only from close inspection, repeated observations, and comparison of large numbers of the deranged, which were only available in asylums and prisons (Eigen 1991). Thus, asylum doctors were well positioned to step into a forensic role. That they were able to do so with relative ease was the result of their association with the historical traditions of medical jurisprudence.

Medical Jurisprudence

Doctors had, of course, provided courtroom testimony prior to the development of clinical psychiatry and the asylum system. The field of *medical juris-*

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[18]Dr. Crichton, author of *An Inquiry into the Nature and Origins of Mental Derangement,* published in 1798, 2 years prior to the Hadfield trial, examined Hadfield the night before the trial. Dr. Crichton later became physician to Tsar Alexander I of Russia.

[19]Until the *Hadfield* case, acquitted lunatics were either sent to jail or released to the custody of their family, depending on what seemed appropriate to the court. Hadfield's case prompted passage of the Act for the Safe Keeping of Insane Persons Charged With Offences (also known as the Criminal Lunatics Act) of 1800, which created a new class of detainees, "Criminal Lunatics." The act created an automatic process whereby the court could order an individual acquitted on the grounds of insanity "to be kept in strict custody, in such place and in such manner as to the court shall seem fit, until His Majesty's pleasure be known" (Walker 1968, p. 78; see also Porter 1987). Despite one escape attempt, Hadfield died in Bethlem in 1841 after 40 years of confinement, at the age of 69 (Maeder 1985; Walker 1968).

prudence, defined as the interaction between those who possessed medical knowledge and those who exercised legal authority, encompassed issues relating to criminal justice, public health, and the functions of public medical examiners and coroners. Physicians had provided testimony for centuries regarding cause of death, wounds, poisoning, and other matters (including signs of witchcraft). Furthermore, from at least the sixteenth century, they occasionally offered testimony on matters relating to madness and insanity in European courts.

The fact that the new specialists in madness were medically qualified enabled them to fit into the expert witness role established by the traditions of medical jurisprudence occupied by physicians and draw on the respect accorded to its practitioners (Eigen 1991). Historically, the mad-doctor in court had never been very far from challenges to claims of expert knowledge. The medical qualifications of the asylum doctors allowed them to draw on centuries of tradition, conferring a certain status to their participation in legal proceedings. At the same time, providing courtroom testimony was a public means for the new asylum physicians to reinforce their claims to specialized expertise in the diagnosis and treatment of the insane, especially in regard to partial or moral insanity.

During the first half of the nineteenth century, medical schools endorsed the concept that medical jurisprudence was an essential aspect of professional training for future physicians. The first formal chair in medical jurisprudence was created in Edinburgh in 1807; in the United States, the first chair was created at Columbia University in New York in 1813 (Mohr 1993). Most American medical schools had faculty chairs in medical jurisprudence by 1840. Nearly every lecturer in every course on medical jurisprudence addressed the subject of insanity. Medical literature related to jurisprudential issues, including mental disorders, multiplied dramatically between 1820 and 1850. Almost all comprehensive publications dealing with the subject included a detailed discussion of legal issues relating to insanity.

Of this literature, the most influential was the work of T.R. Beck, a professor of medical jurisprudence at Western Medical College in Albany, New York. Beck wrote the first American text on the subject, *Elements of Medical Jurisprudence,* published in 1823. The two-volume text was an attempt to summarize the issues that had concerned medicolegalists since the Middle Ages. It was reprinted in 12 editions through 1860 and became the most frequently cited medicolegal text in American court cases (Mohr 1993).

Beck emphasized the importance of the role of the medical expert in legal cases: "It need hardly be suggested that in many instances, a legal decision depends on the testimony of medical witnesses" (Beck 1823, Vol. 1, p. vii). Beck also emphasized the importance of the adjudication of insanity as a major aspect of medical jurisprudence. In 1841, Beck wrote, "The nature of insanity as

excusing from the responsibility of criminal acts was one of the two primary subjects in legal medicine" (Mohr 1993, p. 122). Although Beck was not a psychiatrist, his interest and work in the role of insanity in the field of medical jurisprudence led him to become president of the Board of the Utica State Asylum of New York, further demonstrating the close connection between the field of medical jurisprudence and the newly developing field of psychiatry.

The first volume of Beck's *Elements* contained a chapter, entitled "Mental Alienation," that specifically covered aspects of the subject relevant to civil and criminal cases. These included the symptoms that constitute a state of insanity; the problems of sanity in court proceedings; the various types of mental impairment short of insanity; monomania and partial insanity; and the state of mind necessary to make a valid will (Mohr 1993). This chapter defined the next two centuries of the history of forensic psychiatry in the United States.

Psychiatrists, Moral Insanity, and Medical Jurisprudence

The spirit of Enlightenment reform included a commitment on the part of physicians to help improve society. The medical community regarded itself as an integral part of the program of human and social improvement. Many physicians believed that training in medical jurisprudence would enhance the public contribution of physicians toward the betterment of society by helping them achieve a working relationship with lawyers, judges, and legislators. Most medical jurisprudents believed they could help society deal with the troubling and difficult problems posed by mental illness, and many felt it was their social duty to do so (Mohr 1993; Robinson 1996).

The new specialists in mental disorders took the same position. The increasing numbers of texts on the causes and treatments of moral insanity were accompanied by increasing numbers of texts devoted to the medical jurisprudence of insanity. Both typically urged the medical community to recognize the existence of moral and partial insanity and to provide medical testimony regarding this and other mental illnesses as their social duty.

Benjamin Rush provides the earliest example of the psychiatric specialist who believed a physician's social duty demanded legal involvement and whose theories included a belief in partial insanity. Rush was a major influence in the development of the field of psychiatry. He advocated more humane treatment of the insane despite his use of most of the common eighteenth-century rem-

edies, such as bloodletting, restraint, and stimulation of terror as shock therapy (Dain 1964). Rush also believed that certain insane persons suffered primarily from affective or volitional impairment and, although mentally disordered, demonstrated no impairment in their ability to reason (Dain 1964; Porter 1997). He called this disorder "moral derangement," which he defined as "that state of mind in which the passions act involuntarily through the instrumentality of the will, without any disease in the understanding" (Rush 1811/1977, p. 380).

Rush encouraged all physicians to develop stronger medicolegal skills as part of their obligations to society:

> They entertain very limited views of medicine who suppose its objects and duties are confined exclusively to the knowledge and cure of diseases. Our science was intended to render other services to society. It was designed to extend its benefits to the protection of property and life, and to detect fraud and guilt in many of their forms. This honour has been conferred upon it by the bench and the bar, in all civilized countries both in ancient and modern times. That part of our science, which qualifies us to discharge these important civil duties, has been called medical jurisprudence. (Rush 1811/1977, p. 363)

Rush urged his medical students to obtain a strong grounding in the medical jurisprudence on insanity. He explicitly connected the concept of moral insanity to medical jurisprudence and discussed in detail "those states of the mind which should incapacitate a man to dispose of his property, to bear witness in a court of justice, and exempt him from punishment for the commission of what are called crimes by the laws of our country" (Rush 1811/1977, pp. 365–366).[20]

John Haslam's *Medical Jurisprudence as It Relates to Insanity* (1817) was the first major work specifically calling for the use of medical experts in diagnosing and treating the insane on the basis of their expertise in cases involving insanity. Haslam occupied a position at the forefront of the mad-doctoring trade as the resident apothecary of Bethlem[21] (Scull et al. 1996). His book was reprinted in the first major compilation on medical jurispru-

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[20]Rush (1811/1977) concluded this first documented lecture on the medical jurisprudence of insanity by stating that the only objection to the use of medical knowledge for legal reasons might be that such testimony could result in the "more certain and general" conviction for offenses punishable by death. The solution to this problem, Rush stated, was "sure and infallible": the abolition of death as a punishment in all cases including murder (p. 393).

[21]Haslam was dismissed from his position in 1816 as a result of a Parliamentary investigation into conditions at Bethlem (Scull et al. 1996).

dence to appear under an American imprint, *Tracts on Medical Jurisprudence* by Thomas Cooper, published in Philadelphia in 1819.

In some instances, Haslam stated, an individual's insanity is evident and demonstrable without the need of a medical practitioner's testimony. Nevertheless, he argued, many insane people can conduct themselves with propriety and appear perfectly reasonable, and "ordinary persons have been much deceived" by such appearances:

> Is the person accused, of insane mind? ... In those cases where the prisoner is so bereft of his reason, that any twelve men would not entertain a different opinion, where numerous evidences appear to testify to repeated acts of insanity, which are so manifest that they cannot be otherwise interpreted; and where he has been confined and treated for this malady, the physician will have an easy duty to perform: but it is in cases which appear to be involved in difficulty, where the disorder, although existing and directing the actions, is not so ostensibly developed that the medical evidence becomes important, and capable by sagacity, experience and truth, of explaining and characterizing the state of the person's intellect. (Haslam 1817, pp. 2–3)

Cases of partial insanity, Haslam observed, involved considerable doubt about the person's state of mind. He insisted that medical specialists were uniquely qualified to detect such forms of madness and were certainly more skilled in their diagnosis than the general populace because of their asylum experience (Eigen and Andoll 1986). He noted, "Patient enquiry, daily communication with deranged persons and attentive observation of their habits, confer the means of judging on medical practitioners, and more especially on those, who have for a series of years, solely confined their practice to this department of the profession" (Haslam 1817, pp. 7–8). Haslam also indicated that, unlike the lay observer, the trained observer could identify those attempting to escape responsibility by feigning madness (Eigen 1991).

Isaac Ray and the Consolidation of Medical Jurisprudence and Clinical Psychiatry

Isaac Ray is associated with the development of forensic psychiatry more than any other nineteenth-century physician. Ray's *A Treatise on the Medical Jurisprudence of Insanity,* published in 1838, became the standard text on the subject throughout the nineteenth century. The first edition of Ray's book was followed a year later by two reprintings, one in London and the other in Edinburgh. The second edition appeared in 1844, and three more revised editions followed in 1853, 1860, and 1871.

Ray's *Treatise* was the most comprehensive and systematic English presentation of the medical understanding of insanity in the context of litigation (Mohr 1997). Ray drew on the work of authors such as Haslam, Pinel, and Prichard. He laid out various types of mental disorders as understood by these experts and described the ways in which enlightened courts should deal with each type.

The *Treatise* established Ray as a leading authority in the jurisprudence of insanity and earned him an international reputation. The influence of Ray's work spanned the Atlantic and the twentieth century. Ray's *Treatise* was quoted extensively by the defense in the M'Naghten trial in 1843, and it was cited again more than a century later by Judge David Bazelon in his decision in *Durham v. United States* (1954; Robinson 1996). More than any other nineteenth century psychiatrist, Isaac Ray has had the greatest impact on current scholarship in legal and forensic psychiatry (Dietz 1978).

Ray epitomized the type of physician attracted to medical jurisprudence during the first half of the nineteenth century. He was strongly influenced by French medicine, committed to the scientific method, and optimistic about the treatment of insanity and the future role of medical experts in court proceedings. Notably, Ray came to forensic psychiatry through medical jurisprudence rather than vice versa. At the time he wrote the *Treatise,* Ray was 31 years old and a general practitioner in Maine, with no particular expertise in treating the insane. After publication of the *Treatise,* Ray became the administrator of the Maine Insane Asylum in Augusta from 1841 to 1845, and then administrator of Butler Hospital for the Insane in Providence, Rhode Island from 1845 to 1866 (Hughes 1982; McGovern 1985).

Like Rush and other adherents of medical jurisprudence, Ray believed that medical practitioners were obligated to address the legal status of the insane and to educate the courts and the public. He believed that the public had a claim on such services from physicians, especially those who occupied official positions:

> The frequency with which questions of insanity are now raised in courts of justice, has rendered it a very common duty for those who are engaged in our department of the healing art, to give their testimony in the capacity of experts…I see no reason why [this duty] should be evaded, upon any other ground, than interference with other engagements, but many reasons why it should be cheerfully and intelligently performed. (Ray 1851, pp. 53–54)

Isaac Ray also held that insanity was a physical disease (Cooter 1981; Dain 1964; Hughes 1982; Scull 1981b). He believed that the clinical features of insanity were the result of pathological changes in the brain. As a vocal advocate of phrenology, he accepted the existence of subtle and varying grades

of insanity based on the existence and disturbances of discrete faculties and propensities in cerebral tissue. He became the foremost American proponent of the concept that impairment of the will or the emotions could occur in the absence of impaired cognition or rationality. He noted that "the insane mind is not entirely deprived of this power of moral discernment, but on many subjects is perfectly rational, and displays the exercise of a sound and well balanced mind, is one of those facts now so well established, that to question it would only betray the height of ignorance and presumption" (Ray 1838/1989, p. 32).

Ray criticized American courts for retaining concepts of insanity based solely on derangement of reason, concepts that he considered narrow and outdated (Mohr 1997). He observed, "Few, probably, whose attention has not been particularly directed to the subject, are aware how far the condition of the law relative to insanity is behind the present state of our knowledge concerning that disease" (Ray 1838/1989, p. vii). Ray believed that if the courts and the public could be educated up to the levels of understanding attained by experts in mental illness, fewer citizens would have to suffer punishments for actions they could not willfully control or reasonably understand.

Ray also became an ardent and capable defender of the special standing of experienced clinicians, particularly asylum physicians, in adjudicative settings in which questions of mental health were at issue. Most "experts," he observed, were simply general practitioners who rarely saw insane patients and were unfamiliar with the current literature. Determinations regarding insanity, particularly moral insanity, required familiarity with the more subtle manifestations of insanity that could only derive from expertise gained from observing and treating large numbers of such patients. Ray wrote: "Cases of doubtful mental condition are not those whose true character can be discerned at a glance. The delicate shades of disorder can only be recognized by one who has closely studied the operations of the healthy mind, and is familiar with that broad, debatable ground that lies between unquestionable sanity, and unquestionable insanity" (Ray 1851, p. 55).

Ray considered the physicians who manage "lunatic asylums and retreats for the insane" (Ray 1838/1989) uniquely qualified to provide such testimony: "An enlightened and conscientious jury…will be satisfied with nothing less than the opinions of those, who have possessed unusual opportunities for studying the character and conduct of the insane, and have the qualities of mind necessary to enable them to profit by their observations" (pp. 58–59). Fortunately, Ray noted, such a group of physicians was available.

The Asylum Physicians: Psychiatry's First Expert Witnesses

The physicians serving in mental hospitals as superintendents, assistant superintendents, and visiting physicians exercised a virtual monopoly over the care of the insane by the mid-nineteenth century (Dain 1964). By the 1840s, the branch of medicine concerned with mental illness had developed into a recognized specialty associated with asylums. The number of asylum superintendents and physicians probably never exceeded 200, and for much of the time before 1865, there were fewer than 100. Nevertheless, by mid-century, the expertise of these new specialists in the diagnosis and treatment of insanity, although not universally accepted, was widely acknowledged.

The increasing use of psychiatric witnesses seems to have been more court-inspired than professionally generated (Eigen 1991). Scientific advances, social and political reforms, and the Enlightenment's optimism regarding the social reform resulted in the increased reliance of courts and legislatures on medical witnesses and scientific authorities (Robinson 1996). Problems seldom arose in cases where defendants were obviously irrational, demented, or hallucinatory. In contrast, courts found highly problematic those cases where defendants claimed moral or partial insanity. The identification of these forms of insanity and their implications for legal responsibility required the testimony of physicians with specialized knowledge. More and more, especially in high-profile trials, asylum superintendents, authors, and lecturers in insanity acted as expert medical witnesses (Eigen 1991).

As noted, Ray is the nineteenth-century psychiatrist most closely associated with forensic practice. However, many of the era's preeminent asylum physicians regularly provided expert witness services to the courts. These physicians took for granted that providing expert testimony was part of the new specialized practice of psychiatry. The most difficult cases were often referred to established experts for evaluation and testimony. The asylum physicians' sustained professional association and clinical experience with the insane spoke directly to the common law requirement that an expert opinion be based on specialized knowledge beyond that available to the layperson (Eigen 1991). The two roles of clinical physician and expert witness were widely considered compatible and congruent, and physicians were encouraged to provide both types of services.

As a result, then as now, certain mad-doctors became celebrated for their courtroom testimony, their treatises on forensic psychiatry (Porter 1997), and their theories regarding insanity, as demonstrated by the careers of the

leaders in this new field. In 1844, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), the first medical specialty organization in the United States,[22] was founded by 13 of these specialists (Barton 1987; Grob 1994).[23] At its first meeting, all the members of the group agreed that the jurisprudence of insanity was one of five primary subjects that needed to be addressed by the organization (Medical Association 1845).

Isaac Ray was one of the founding members of AMSAII. He served as vice president from 1851 to 1855, and as the organization's president from 1855 to 1859. Ray's forensic orientation and influence on the newly developing profession are self-evident. However, the professional identity of other founding members also included the practice of medical jurisprudence in relation to insanity (Dain 1964; McGovern 1985). These other early specialists in mental disorders included Samuel Woodward, the first president of the organization and the superintendent of Worcester State Asylum in Massachusetts; Luther V. Bell, the superintendent of McLean Asylum, also in Massachusetts; Pliny Earle, superintendent of the Bloomingdale Asylum in New York; and Amariah Brigham of the Hartford Retreat and, later, the Utica State Asylum in New York (Barton 1987). All played key roles in the shaping the character of early American psychiatry.

The founding members of AMSAII were all widely known physicians who had much in common: they were asylum superintendents, they endorsed the concept of partial or moral insanity (Dain and Carlson 1962), and many were strongly influenced by phrenology and its somatic implications (Cooter 1981; Dain 1964; Hughes 1982; Scull 1981b). The asylum psychiatrists did not differentiate between the roles of clinician and expert witness. Providing expert testimony based on their specialized expertise was an unquestioned part of this new specialty practice.

Members of the AMSAII testified regularly in the courts. For example, in 1846, Dr. Amariah Brigham served as the prime witness and personal consultant for former New York State governor William H. Seward in Seward's use of the insanity plea in the defense of two murderers, Wyatt and Freeman (Spiegel and Spiegel 1998). Brigham helped Seward prepare his defense by

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[22]In 1841, the Association of Medical Officers of Asylums and Hospitals for the Insane was founded in England. This professional organization ultimately became the Royal Medico-Psychological Association and, later, the Royal College of Psychiatrists.

[23]In 1892, the organization changed its name to the American Medico-Psychological Association, which, in 1922, became the American Psychiatric Association.

sending him several books to read, including Prichard's *A Treatise on Insanity and Other Disorders Affecting the Mind;* Esquirol's *Mental Maladies, A Treatise on Insanity;* Samuel Tuke's *Description of the Retreat;* and Isaac Ray's *A Treatise on the Medical Jurisprudence of Insanity*.[24] Brigham also provided dramatic courtroom testimony in the case.[25]

Luther V. Bell also regularly provided forensic testimony. In 1843, he testified for the defense in the widely known case of Abner Rogers. Rogers was tried for murdering the warden of the prison in which he was already incarcerated and pled insanity (Ray 1873). Bell was also consulted in 1857 by the defense in a case before the Eighth Circuit Court in Illinois. The defendant, accused of murder, claimed that an overdose of chloroform during a surgical procedure had resulted in damage to his brain and caused insanity. He was acquitted on the grounds of insanity and sent to the Illinois State Asylum. The prosecutor in this case was Abraham Lincoln (Spiegel and Suskind 1997).

Other superintendents and asylum physicians also provided statements and testimony to the courts. In 1845, a Dr. Allan, described by Isaac Ray as "the worthy superintendent of the Kentucky Lunatic Asylum" (Ray 1873/1973, p. 237), provided testimony in an attempt to prevent the execution of a convicted murdered who had unsuccessfully pled insanity. J.H. Worthington, superintendent of Friends' Asylum for the Insane in Philadelphia, and S. Preston Jones, Assistant Physician of the Pennsylvania Hospital for the Insane, addressed the court to the same end in the case of a convicted murderer who pleaded insanity on the basis of a history of epilepsy (Ray 1873/1973). In 1866, Dr. Charles Nichols, Superintendent of the Government Hospital for the Insane, now known as St. Elizabeths Hospital, provided testimony in the successful defense of a woman, Mary Harris, who was acquitted on the basis of insanity of the murder of her former lover. Dr. Lee, assistant physician at the Worcester State Hospital, provided testimony in 1848 regarding issues of insanity in a case involving a contested contract (Ray 1848).

These specialists also testified in testamentary cases. In the highly publicized Parish will case of 1856, Amariah Brigham testified that the late tes-

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[24]Although Seward lost both of these highly publicized cases, they helped establish his fame as a jury lawyer and a legal expert on the jurisprudence of insanity. Seward eventually served as a New York State senator, the governor of New York, and a U.S. senator. In 1860, after losing the nomination for president to Abraham Lincoln, Seward was appointed secretary of state by Lincoln (Spiegel and Spiegel 1998).

[25]During his testimony, Brigham pointed at a man sitting in court and was proven correct when he declared that he, Brigham, recognized the man to be deranged and insane simply from his looks. In a letter to his wife, Seward said that "Brigham was wonderful" on the witness stand (Spiegel and Spiegel 1998, p. 240).

tator was sane. In an early "battle of the experts," Samuel Woodward, Isaac Ray, and Luther Bell had provided opinions that the testator was insane (Dain 1964; Mohr 1993; Zilboorg 1944). Lesser-known asylum physicians also provided testimony in cases involving contested wills. In the Angell will case, a Dr. Tyler, associated with McLean Asylum, provided an opinion concurring with Dr. Isaac Ray that the testatrix was insane when she wrote her will and codicils (Ray 1873/1973). In 1847, Drs. Woodward, Brigham, and Bell, as well as Isaac Ray, testified in the Oliver Smith will case (Ray 1848).

The interest in and importance of forensic practice in early clinical psychiatry were reflected in the content of the *American Journal of Insanity*, AMSAII's official publication. Amariah Brigham founded and published the journal in 1844, some months before the founding of AMSAII, but it immediately became the representative journal of the association. The journal was the first periodical in the English language devoted exclusively to issues regarding "psychological medicine" (Bunker 1944, p. 196). It quickly acquired a broad audience in both the United States and Britain and gained a reputation as the most authoritative American periodical dealing with insanity (Dain 1964; Grob 1994).

The early years of the *American Journal of Insanity* demonstrate that a forensic identity was an integral aspect of the developing specialty of psychiatry. The medicolegal orientation of the editors is unmistakable. Some of the forensic activities of the journal's first editor, Amariah Brigham, have already been reviewed. Even more notably, upon Brigham's death in 1849, T.R. Beck became the journal's second editor and served in that capacity from 1850 to 1854. Although he was not a psychiatric specialist, Beck was an expert in medical jurisprudence and, as discussed previously, the author of the widely known *Elements of Medical Jurisprudence* (1823).

From its inception, the *American Journal of Insanity* frequently published papers on the relationship between psychiatry and the law. In the first 10 years of publication (1844–1854), authors and editors publicized, reviewed, and commented on significant trials. Authors often expressed indignation that nonspecialists served so frequently as expert witnesses on mental illness (Stokes 1855).

The very first volume (1844–1845) contained an article entitled "Medical Jurisprudence of Insanity" by C.B. Coventry (1845), professor of medical jurisprudence at Geneva College and a member of the Board of Managers of Utica State Asylum.[26] Coventry discussed the M'Naghten rules, formulated the previous year, and stated regretfully that the 15 English jurists who devised the M'Naghten rules failed to take the existence of moral insanity into consid-

[26]Coventry, along with Amariah Brigham, also provided testimony in Seward's unsuccessful defense in the Wyatt and Freemon trials.

eration. Coventry's article strongly implied that the M'Naghten rules failed to consider the fundamental principles of clinical psychiatry. In addition to this article, the first volume included case histories involving the medical jurisprudence of insanity (pp. 75–77); an article by Samuel Woodward (1845) entitled "Homicidal Impulse"; book reviews of two new texts on the subject of the medical jurisprudence of insanity (pp. 281–283, 370–372); and a detailed review of the trial of Abner Rogers, which extensively quoted the testimony of Drs. Bell, Woodward, and Ray (Coventry 1845, pp. 258–274).

Highly publicized or significant trials were regularly reviewed and discussed. T.R. Beck, for example, provided comments on the case of Lord Earl Ferrers (Case of Lord Ferrers 1845). Many issues included reviews of books and journals on medical jurisprudence and forensic medicine. The cases of *Oxford* and *M'Naghten* were reviewed in detail (Review of the Trials of Oxford and M'cNaughten 1851). Cases of contested wills and the capacity to enter a contract were also discussed. In a seminal 1851 article entitled "Hints to the Medical Witness in Questions of Insanity," Ray gave practical advice to psychiatrists serving as experts. Although it is more than 160 years old, this article discusses many of the problems that modern expert witnesses still encounter, including the influence of adversarial bias, the unscientific nature of cross-examination, surprisingly familiar trick questions, and the need to maintain composure on the witness stand.

Indeed, during the first three or four decades of its publication, almost every issue of the *American Journal of Insanity* contained a discussion of medicolegal principles or an account of court proceedings in a criminal case in which a plea of insanity had been entered or in which AMSAII's members had testified (Bunker 1944). Many of these were discussed in detail. The percentage of forensic articles published in these years was significantly higher than that represented by forensic articles in the modern *American Journal of Psychiatry*.

The 1840 trial of Edward Oxford in England marked the high point in the arrival of expert psychiatric witnesses (Freemon 2001). Edward Oxford, age 18 years, was charged with high treason for shooting at Queen Victoria and Prince Albert while they rode in their carriage. His trial reflected the influence of the new experts in madness and their theories regarding partial insanity. Five physicians testified at Oxford's trial. All five testified that Oxford was insane. Two had treated members of Oxford's family, but three were of the new class of expert.[27] These three specialists had interviewed Oxford the night before the trial. They invoked their clinical credentials in treating

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[27]One expert, John Conolly, the author of *An Inquiry Concerning the Indications of Insanity* (1830) and the physician in charge of Hanwell Lunatic Asylum in Middlesex, testified in many insanity trials and was one of the first to develop a reputation as a "hired gun" who would testify that a person who suffered virtually any form of mental dysfunction, no matter how slight, was insane (Freemon 2001).

large numbers of patients to support their opinions (Freemon 2001; Moran 1986). Two testified that Oxford's form of insanity was labeled "a lesion of the will" and made reference to French authors such as Esquirol on the subject (Eigen 1991; Freemon 2001). Oxford was found not guilty on the grounds of insanity.[28]

The Backlash Against Forensic Psychiatry

The next highly publicized trial involving the testimony of experts in an insanity defense, the M'Naghten trial, resulted in a backlash against psychiatric testimony. In 1843, Daniel M'Naghten was tried for murdering Edward Drummond, Sir Robert Peel's private secretary. M'Naghten's trial involved nine medical witnesses.[29] All concurred that M'Naghten's acts were the result of delusion. The principal medical expert was Edward Thomas Monro, the fourth generation of Bethlem's Monro family. The majority of witnesses gave their opinions after having seen M'Naghten for only a few minutes. Two of these witnesses had not interviewed M'Naghten at all (Maeder 1985; Walker 1968). Isaac Ray was the expert in absentia: his *Treatise* was quoted extensively by defense counsel (Quen 1974; Robinson 1996). The prosecution offered no medical evidence at all. The chief justice stopped the trial after hearing the testimony of the experts, and the jury found M'Naghten not guilty on the grounds of insanity. M'Naghten was sent to Bethlem Hospital (Maeder 1985; Walker 1968).[30]

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[28]Oxford was committed to Bethlem Hospital and spent the next 27 years in confinement. Most people who interviewed him thought he was sane. Oxford was among the first patients transferred to the new Broadmoor Criminal Lunatic Asylum when it opened in 1864. In 1867, a discharge warrant was issued on the condition that he leave the country and never return. Then 45 years old, Oxford boarded a ship for Melbourne, Australia, and nothing more is known about him (Freemon 2001; Maeder 1985).

[29]Two witnesses were physicians to the Royal Lunatic Asylum in Glasgow. Two other witnesses had written books on madness (Freemon 2001).

[30]M'Naghten was one of the first male patients transferred to the Broadmoor Criminal Lunatic Asylum when it opened in 1864. He died there of tuberculosis in 1865 at age 52.

The verdict resulted in an outpouring of resentment.[31] The success of M'Naghten's defense, the judges' direction that the jury find M'Naghten not guilty by reason of insanity, the role that medical texts and witnesses played, and fears that insanity and a lack of responsibility would become confused all contributed to the indignation and outrage the trial provoked. In response to the public outcry, the House of Lords posed five questions to the 15 judges of the Queen's Bench intended to clarify points of law raised by the trial, including the appropriate role of expert testimony. The answers to these questions, which became known as the M'Naghten rules (1844), addressed the increasingly controversial role of medical experts and the legal definition of insanity.

The M'Naghten rules defined the legal standard of insanity as the inability to distinguish right from wrong. This formula scotched the psychiatric claim for the recognition of disorders of partial insanity without disorder of cognition (Porter 1997). All the new specialists in insanity agreed that limiting diagnosis to disorders in knowledge or reasoning was to deny current understanding of mental disorders. Nevertheless, the M'Naghten rules took an opposite stance that carried an authoritative weight and guided the Anglo-American law of insanity for the next century.[32] By 1900, they had been adopted as law in England, throughout the British Empire, and in almost every American state (Freemon 2001; Maeder 1985; Smith 1981).

In the United States, the murder trial of Abner Rogers in 1845 in Massachusetts aroused similar public prejudice against the plea of insanity. The defense attorneys claimed that Rogers was insane and had committed the act as a result of his disease. The prosecution explicitly relied on the M'Naghten rules and insisted that even if Rogers was insane, which they doubted, he was still responsible. The prison physician testified that Rogers was feigning insanity. The judge was sympathetic to a defense of insanity as testified to by three experts: Bell, Woodward, and Ray. The judge stated, "The opinions of professional men on a question of this description are competent evidence, and in many cases are entitled to great consideration and respect" (Coventry

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[31]Between 1840 and 1882, Queen Victoria was shot at five times, threatened with shooting once, and struck with a brass cane once (James et al. 2008). She was indignant at M'Naghten's acquittal. She reportedly commented that she did not believe that anyone who wanted to murder a conservative prime minister could be insane (Maeder 1985).

[32]Not surprisingly, Ray and other leading psychiatrists criticized the M'Naghten rules as psychologically unsound. Ray stated that the mental impairment of the insane is indicated by their feelings of freedom from the obligation of the law, not by their failure to recognize the illegality of the act. Ray felt it was absurd to expect the insane to act "reasonably" while delusional (Payne and Luther 1980).

1845, p. 270). Rogers was found not guilty on the grounds of insanity and sent to Worcester State Asylum, where he came under Woodward's care.[33]

Another similar backlash in public feeling occurred in response to the increasing role of psychiatric experts in cases involving wills. Ultimately, the public's concern regarding the power of these specialists to overturn wills through retroactive rulings of testamentary incompetence resulted in litigation in some states curtailing such testimony (Mohr 1993, 1997). The popular feeling against such medical testimony was expressed by one judge in an 1857 trial of a man accused of poisoning his wife. The defense argued that the defendant suffered from "homicidal mania." The prosecution described him as merely depraved. After hearing testimony regarding the insanity of the defendant, the judge sided with the prosecution. He said to the jury, "Experts in madness! Mad doctors! Gentlemen, I will read you the evidence of these medical witnesses—these 'experts in madness'—and if you can make sane evidence out of what they say, do so; but I confess it's more than I can do" (quoted in Smith 1981, p. 136).

Clinical and Forensic Psychiatry Part Ways

During the middle to latter half of the nineteenth century, the insanity plea and the public role of psychiatry became a matter of dispute (Porter 1997) and increasing criticism. The psychiatric experts acknowledged that judges, jurors, and the public had developed a growing distrust of the value and honesty of expert testimony (Mohr 1993). In 1845, AMSAII's president, Samuel Woodward, observed: "It cannot be denied that there is a suspicion abroad in the community, that these new views of medical jurisprudence tend to prostrate the ends of justice, by disturbing the settled principles of criminal law" (Woodward 1845, pp. 323–324). By mid-century, the medical jurisprudence of insanity had resulted in the development of serious credibility problems for those who claimed expertise in the subject of insanity.

From 1850 to 1900, the forensic practice of psychiatry became less popular among asylum doctors. Practicing physicians were increasingly battered by medicolegal interactions. The pressures discouraging the practice of forensic psychiatry included the effects of courtroom testimony on clinical reputations; internal dissension regarding the concepts of partial and moral insanity; criticism of asylums and asylum medicine; accusations that asylum

[33]"After some months of confinement, while at chapel, he [Rogers] begged to leave the room as it was 'full of dead bodies.' His request not being heeded, he bolted head first through the window, fell fourteen feet, and died the next day" (Ray 1873, p. 220).

psychiatrists were primarily administrative and custodial rather than clinical specialists; and challenges from the new field of neurology[34] (Grob 1994; McGovern 1985; Mohr 1993; Smith 1981).

The sociopolitical backlash against the new theories of insanity and the physicians who propounded them in their courtroom testimonies was reflected in a steady stream of articles, essays, and lectures. These reminded both professionals and lay citizens that the issue of insanity had become a nightmare in the courts that reflected poorly on medical experts involved in such cases. As described by James Mohr, "Insanity had shifted from an area in which physicians were humane heroes to one in which they were unjustly imprisoning the innocent in asylums and making excuses for guilty criminals" (1993, p. 248). The first generation of psychiatrists, the founders and early members of AMSAII (and especially Isaac Ray), continued to promote a forensic role for psychiatrists. By mid-century, however, evidence mounted that physicians were consciously avoiding involvements with legal situations (Mohr 1993).

As behaviorism and psychoanalysis became the dominant schools of psychological thought in the twentieth century, the legal concept of insanity became increasingly separated from the basic and clinical medical sciences. Freud believed that psychoanalytic principles should be applied very cautiously, if at all, in legal proceedings (Goldstein 1983). Nineteenth-century psychiatry and the law alike had been comfortable sharing the term *insanity.* By the early twentieth century, psychiatrists stopped using the word *insanity,* ceding the term and whatever definitions it might encompass to the legal profession (Tighe 2005). In 1922, when the American Medico-Psychological Association changed its name to the American Psychiatric Association, it simultaneously changed the name of its journal from *American Journal of Insanity* to *American Journal of Psychiatry*. In 1923, William Alanson White, the superintendent of St. Elizabeths Hospital in Washington, D.C., the foremost forensic psychiatrist in the country, contended that *insanity* was a legal term with no medical meaning (Quen 1983). The integral role of the medical jurisprudence of insanity to the practice of clinical psychiatry was lost.

M'Naghten Revisited: The Hinckley Trial

In the past 100 years, the role of the expert psychiatric witness has continued to raise debate. The arguments and skepticism raised by claims of non-

[34]The trial of Charles Guiteau for the assassination of President James Garfield, the most celebrated American insanity trial of the nineteenth century, established the expertise of neurologists in matters pertaining to mental disorders (Rosenberg 1968).

responsibility associated with mental illness in the nineteenth century have not lessened or been resolved. More than a century after *M'Naghten,* the controversies regarding the appropriate role of expert psychiatric witnesses again rose to the forefront of public consciousness in the wake of the John Hinckley trial. And as in the *M'Naghten* case, public outrage over the verdict in the Hinckley trial led to another reexamination and redefinition of the laws governing criminal responsibility and the insanity defense.

In 1982, John Hinckley was found not guilty by reason of insanity of all charges stemming from an attempted assassination of President Ronald Reagan. As in the *M'Naghten* case, the public interpreted the verdict to mean that Hinckley had gotten away with his crimes. This interpretation was based, in part, on the fact that although committed to a psychiatric hospital, Hinckley theoretically could have been declared well and released the next day, and thus might have served no time.[35] The ensuing debates, which included calls for the abolition of the insanity plea, ultimately resulted in the Insanity Defense Reform Act of 1984 (Maeder 1985), just as the *M'Naghten* case resulted in a redefinition of the laws of insanity in the nineteenth century.

The medical profession, including the specialty of psychiatry, took a hard look at its role in legal proceedings in the wake of the Hinckley trial. Alan Stone, a past president of the American Psychiatric Association (1979 to 1980), noted the increased interest in forensic practice. Stone questioned the scientific and ethical basis of psychiatrists' participation in legal proceedings (Stone 1984), raising a firestorm of debate that was recently revisited but remains unresolved.[36] The American Medical Association (1984) took an even more extreme position. Its Committee on Medicolegal Problems drafted a special report on the subject, declaring bluntly, "the special defense of insanity should be abolished." Despite pleas for moderation from the presidents of the American Bar Association and the American Psychiatric Association, the American Medical Association's House of Delegates voted in 1983 to accept its committee's report (Mohr 1993).

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[35]John Hinckley remains confined at St. Elizabeths Hospital in Washington, D.C., where he was committed after the verdict. Unlike time-limited prison sentences, commitment to a psychiatric hospital has an indefinite time limit. Release is based on meeting certain defined criteria, and commitment can continue until the individual meets criteria for release. Although it is possible that individuals could be immediately released after being found not guilty by reason of insanity for serious crimes, individuals often spend a longer time confined in psychiatric hospitals than they would have spent in prison had they pled guilty, been convicted, and been given a determinate sentence.

[36]See the *Journal of the American Academy of Psychiatry and the Law*, Volume 36, No. 2, 2008.

Conclusion

To the extent that a whole specialty, like an individual, may enact repetitive themes and patterns, a heightened awareness of these patterns and their contexts may lead to more self-conscious shaping of professional organizational and individual development (Wallace 2008). An understanding of the origins of forensic psychiatry and its close relationship with clinical practice facilitates understanding of the role of the expert witness, and its challenges and rewards. As in the past, all parties in the legal system at various times actively seek out psychiatric participation in litigation. Understanding how expert psychiatric testimony can assist the court in coming to a variety of legal determinations is facilitated by an understanding of the origins of the expert psychiatric witness and the integral nature of such functions to the profession of psychiatry.

The relationship between the law and psychiatry is dynamic—the involvement of psychiatrists in the legal system affects the practices of both psychiatry, clinical and forensic, and the law. The response of the psychiatric and medical community to the public outrage over the Hinckley verdict demonstrated that the practice of forensic psychiatry still raises the same issues and challenges as it did 150 years ago. Claims of expertise in the identification and treatment of mental illness continue to provoke skepticism among laymen and among some litigators and courts. The problems faced by Isaac Ray and his colleagues in the mid-nineteenth century, and faced by forensic psychiatrists today, continue to revolve around the fact that "insanity" is a legal concept, which "the law hopelessly confuses with disease" (Tighe 2005, p. 255).

Some of the difficulties involved in providing expert services to the courts have also remained the same over the past century and a half. Isaac Ray (1851) warned that an expert "must make up his mind to have his sentiments travestied and sneered at, his motives impugned, and pit-falls dug in his path" (pp. 66–67). In 1994, Phillip Resnick, a prominent forensic psychiatrist, observed that "[n]o professional undergoes more intense scrutiny than the psychiatrist who testifies in court." He warned that it takes courage to undergo what amounts to a "crucifixion by criticism" (Resnick 1994, p. 39). Nevertheless, Resnick draws the same conclusions as did Benjamin Rush, Isaac Ray, and other psychiatrists for whom the practice of forensic psychiatry was a social and professional obligation: "A life spent serving justice is a life well spent" (Resnick 1994, p. 39).

Despite these problems, psychiatrists are rediscovering that the forensic practice of psychiatry can be professionally rewarding. Nevertheless, psychi-

atrists interested in engaging in forensic practice should heed the words of Isaac Ray. As noted in the preface to this volume, Ray warned that "it cannot be too strongly impressed upon our minds that the duty of an expert is very different from those which ordinarily occupy our attention, and requires a kind of knowledge, and a style of reflection, not indispensable to their tolerably creditable performance" (Ray 1851, p. 55). Ray advised clinicians to acquire skills beyond those of clinical practice before entering the courtroom.

This suggestion is as insightful and practical today as it was when first made more than 150 years ago. The most effective forensic psychiatrists are those who are "bilingual" and speak the language of both psychiatry and the law. As Tighe (2005, p. 257) has observed, "Not one shared language, but fluency in two disparate ones, is the mark of mastery in this field." The subsequent chapters in this book will enable clinicians to explore and develop the skills necessary in the practice of forensic psychiatry.

Key Points

- The practice of forensic psychiatry developed in conjunction with the development of the specialty of clinical psychiatry.
- The ability to provide expert opinions and testimony, since the development of the specialty of clinical psychiatry, has been based on special knowledge and expertise that arise from clinical practice.
- The legal system has historically requested that psychiatrists provide forensic services to educate the court in matters that are beyond the knowledge of the layperson.
- Although forensic psychiatry developed simultaneously with and as an important adjunct to the practice of clinical psychiatry, the practice of forensic psychiatry requires skills that differ from those associated with clinical practice.

Practice Guidelines

1. Be aware of the significant differences between the practices of clinical and forensic psychiatry.
2. Obtain appropriate forensic training in order to provide the courts with quality expert services.

3. Make certain that your clinical skills provide a basis for your claims of expertise.
4. Be prepared for challenges to your professional reputation and opinions, no matter how extensive your clinical experience or your forensic skills. The legal system is adversarial.
5. Remember that the courts ultimately settle the matter in dispute. The expert's testimony is but one part of a legal case, seen in its entirety only by the court.

References

American Medical Association: Insanity defense in criminal trials and limitation of psychiatric testimony. Report of the Board of Trustees. JAMA 251:2967–2981, 1984

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

Barton WE: The History and Influence of the American Psychiatric Association. Washington, DC, American Psychiatric Press, 1987

Beck TR: Elements of Medical Jurisprudence. Albany, NY, Webster's and Skinner's, 1823

Binder R: Liability for the psychiatrist expert witness. Am J Psychiatry 159:1819–1825, 2002

Bunker HA: Psychiatric literature, in One Hundred Years of American Psychiatry. Edited by Hall JK, Zilboorg G, Bunker HA. New York, Columbia University Press, 1944, pp 195–271

Case of Lord Ferrers. American Journal of Insanity 2:188–189, 1845

Coliazzi J: Homicidal Insanity, 1800–1985. Tuscaloosa, University of Alabama Press, 1989

Conolly J: An Inquiry Concerning the Indications of Insanity. London, John Taylor, 1830

Cooper T: Tracts on Medical Jurisprudence. Philadelphia, PA, John Webster, 1819

Cooter R: Phrenology and British alienists, ca 1825–1845, in Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era. Edited by Scull A. Philadelphia, University of Pennsylvania Press, 1981, pp 58–104

Coventry CB: Medical jurisprudence of insanity. American Journal of Insanity 1:258–274, 1845

Dain N: Concepts of Insanity in the United States, 1789–1865. New Brunswick, NJ, Rutgers University Press, 1964

Dain N, Carlson ET: Moral insanity in the United States, 1835–1866. Am J Psychiatry 118:795–801, 1962

Dietz PE: Medical criminology notes No. 4: Measuring the impact of Isaac Ray: a citation analysis. Bull Am Acad Psychiatry Law 6:249–255, 1978

Durham v United States, 214 F.2d 862 (1954)

Eigen JP: Delusion's odyssey: Charting the course of Victorian forensic psychiatry. Int J Law Psychiatry 27:395–412, 2004

Eigen JP: Mad-doctors in the dock: Forensic psychiatry's early claims to expert knowledge. Transactions and Studies of the College of Physicians of Philadelphia 13:445–462, 1991

Eigen JP: Witnessing Insanity: Madness and Mad-Doctors in the English Court. New Haven, CT, Yale University Press, 1995

Eigen JP, Andoll G: From mad-doctor to forensic witness: the evolution of early English court psychiatry. Int J Law Psychiatry 9:159–169, 1986

Freemon FR: The origin of the medical expert witness: the insanity of Edward Oxford. J Leg Med 22:349–373, 2001

Gach J: Biological psychiatry in the nineteenth and twentieth centuries, in History of Psychiatry and Medical Psychology. Edited by Wallace ER, Gach J. New York, Springer, 2008, pp 381–418

Goldstein RL: Sigmund Freud: Forensic psychiatrist. Bull Am Acad Psychiatry Law 11:273–277, 1983

Grob GN: The Mad Among Us: A History of the Care of America's Mentally Ill. New York, Free Press, 1994

Haslam J: Medical Jurisprudence as It Relates to Insanity According to the Law of England. London, C Hunter, 1817

Hughes JS: In the Law's Darkness: Insanity and the Medical-Legal Career of Isaac Ray, 1807–1881. Ann Arbor, MI, University Microfilms International, 1982

Hunter R, MacAlpine I: Three Hundred Years of Psychiatry, 1535–1860. Hartsdale, NY, Carlisle Publishing, 1982

James DV, Mullen PE, Pathé MT, et al: Attacks on the British Royal Family: The Role of Psychotic Illness. J Am Acad Psychiatry Law 36:59–67, 2008

Maeder T: Crime and Madness: The Origins and Evolution of the Insanity Defense. New York, Harper & Row, 1985

McGovern C: Masters of Madness: Social Origins of the American Psychiatric Profession. Hanover, NH, University Press of New England, 1985

Medical Association: Meeting of the Association of the Medical Superintendents of American Institutions for the Insane. American Journal of Insanity 1:253–258, 1845

Mohr JC: Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America. Baltimore, MD, Johns Hopkins University Press, 1993

Mohr JC: The origins of forensic psychiatry in the United States and the great nineteenth century crisis over the adjudication of wills. J Am Acad Psychiatry Law 25:273–284, 1997

Moran R: The punitive uses of the insanity defense: the trial for treason of Edward Oxford (1840). Int J Law Psychiatry 9:171–190, 1986

Payne H, Luther R: Isaac Ray and forensic psychiatry in the United States. Forensic Sci Int 15:115–127, 1980

Porter R: Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency. London, Athone Press, 1987

Porter R: The Greatest Benefit to Mankind: A Medical History of Humanity. New York, WW Norton, 1997

Prentice SE: A history of subspecialization in forensic psychiatry. Bull Am Acad Psychiatry Law 23:195–203, 1995

Prichard JC: A Treatise on Insanity and Other Disorders Affecting the Mind (1835). New York, Arno Press, 1973

Quen JM: Anglo-American criminal insanity: an historical perspective. Bull Am Acad Psychiatry Law 2:115–123, 1974

Quen JM: Isaac Ray and the development of American psychiatry and the law. Psychiatric Clin North Am 6:527–537, 1983

Rappeport JR: Thirty years and still growing. J Am Acad Psychiatry Law 27:273–277, 1999

Ray I: A Treatise on the Medical Jurisprudence of Insanity (1838). Birmingham, AL, Gryphon Press, 1989

Ray I: A contract sought to be avoided on the ground of insanity. American Journal of Insanity 5:79–94, 1848

Ray I: Hints to the medical witness in questions of insanity. American Journal of Insanity 8:53–67, 1851

Ray I: Contributions to Mental Pathology (1873). Delmar, NY, Scholars' Facsimiles and Reprints, 1973

Reiss B: Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture. Chicago, IL, University of Chicago Press, 2008

Resnick PJ: Guidelines for courtroom testimony, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. New York, Chapman and Hall, 1994, pp 34–40

Review of the Trials of Oxford and M'cNaughten, with an account of their present condition. American Journal of Insanity 7:317–358, 1851

Robinson DN: Wild Beasts and Idle Humours: The Insanity Defense From Antiquity to the Present. Cambridge, MA, Harvard University Press, 1996

Rosenberg CE: The Trial of the Assassin Guiteau: Psychiatry and Law in the Gilded Age. Chicago, IL, University of Chicago Press, 1968

Rush B: On the study of medical jurisprudence, in Sixteen Introductory Lectures by Rush B (1811). Oceanside, NY, Dabor Science Publications, 1977, pp 363–395

Scull A: Introduction, in Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era. Edited by Scull A. Philadelphia, University of Pennsylvania Press, 1981a, pp 1–3

Scull A: The social history of psychiatry in the Victorian era, in Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era. Edited by Scull A. Philadelphia, University of Pennsylvania Press, 1981b, pp 5–32

Scull A, MacKenzie C, Hervey N: Masters of Bedlam: The Transformation of the Mad-Doctoring Trade. Princeton, NJ, Princeton University Press, 1996

Smith R: Trial by Medicine: Insanity and Responsibility in Victorian Trials. Edinburgh, Edinburgh University Press, 1981

Spiegel AD, Spiegel MB: The insanity plea in early nineteenth century America. J Community Health 23:227–247, 1998

Spiegel AD, Suskind PB: Chloroform-induced insanity defense confounds lawyer Lincoln. History of Psychiatry 8:487–500, 1997

Starr P: The Social Transformation of American Medicine. New York, Basic Books, 1982

Stokes WH: On a court of medical experts in cases of insanity. American Journal of Insanity 10:112–122, 1855

Stone AA: The ethical boundaries of forensic psychiatry: a view from the ivory tower. Bull Am Acad Psychiatry Law 12:209–219, 1984

Tighe JA: "What's in a name?": a brief foray into the history of insanity in England and the United States. J Am Acad Psychiatry Law 33:252–258, 2005

Walker N: Crime and Insanity in England, Vol 1. Edinburgh, Edinburgh University Press, 1968

Wallace ER: Historiography, in History of Psychiatry and Medical Psychology. Edited by Wallace ER, Gach J. New York, Springer, 2008, pp 3–115

Weiner DB: The Madman in the Light of Reason: Enlightenment Psychiatry, in History of Psychiatry and Medical Psychology. Edited by Wallace ER, Gach J. New York, Springer, 2008, pp 281–303

Woodward S: Homicidal impulse. American Journal of Insanity 1:323–326, 1845

Yanni C: The Architecture of Madness: Insane Asylums in the United States. Minneapolis, University of Minnesota Press, 2007

Zilboorg G: Legal aspects of psychiatry, in One Hundred Years of American Psychiatry. Edited by Hall JK, Zilboorg G, Bunker HA. New York, Columbia University Press, 1944, pp 507–588

Suggested Readings

Dain N: Concepts of Insanity in the United States, 1789–1865. New Brunswick, NJ, Rutgers University Press, 1964

Freemon FR: The origin of the medical expert witness: the insanity of Edward Oxford. J Leg Med 22:349–373, 2001

Grob GN: The Mad Among Us: A History of the Care of America's Mentally Ill. New York, Free Press, 1994

Maeder T: Crime and Madness: The Origins and Evolution of the Insanity Defense. New York, Harper & Row, 1985

Mohr JC: Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America. Baltimore, MD, Johns Hopkins University Press, 1993

Porter R: Mind-Forg'd Manacles: A History of Madness in England From the Restoration to the Regency. London, Athlone Press, 1987

Quen JM: Anglo-American criminal insanity: an historical perspective. Bull Am Acad Psychiatry Law 2:115–123, 1974

Ray I: A Treatise on the Medical Jurisprudence of Insanity (1838). Birmingham, AL, Gryphon Press, 1989

Ray I: Hints to the medical witness in questions of insanity. American Journal of Insanity 8:53–67, 1851

Robinson DN: Wild Beasts and Idle Humours: The Insanity Defense From Antiquity to the Present. Cambridge, MA, Harvard University Press, 1996

Rosenberg CE: The Trial of the Assassin Guiteau: Psychiatry and Law in the Gilded Age. Chicago, IL, University of Chicago Press, 1968

Scull A (ed): The Social History of Psychiatry in the Victorian Era. Philadelphia, University of Pennsylvania Press, 1981, pp 1–3

Smith R: Trial by Medicine: Insanity and Responsibility in Victorian Trials. Edinburgh, Edinburgh University Press, 1981

Tighe JA: "What's in a name?": a brief foray into the history of insanity in England and the United States. J Am Acad Psychiatry Law 33:252–258, 2005

Walker N: Crime and Insanity in England, Vol 1. Edinburgh, Edinburgh University Press, 1968

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Chapter 2

Introduction to the Legal System

Daniel W. Shuman, J.D.

The practice of good clinical psychiatry is the foundation of good forensic psychiatry. However, psychiatrists who bring only good clinical psychiatry to the courtroom are often frustrated by their forensic experiences. They are asked to play a very different role in the courtroom than in their professional world outside the courtroom, and the settings in which these roles are played out are shaped by different values. A core concern of a clinical psychiatrist treating a patient who reports being sexually assaulted is beneficence. A psychiatrist retained by the apartment building owner the claimant is suing for having inadequate security may not inflict trauma to convince the claimant to drop the case. But the psychiatrist's role is to learn about the cause and the magnitude of the injuries, which may well not be beneficent. Similarly, if the plaintiff's forensic psychiatrist thinks a trial might traumatize the claimant, it is not the task of the forensic psychiatrist to persuade the claimant or his or her attorneys to seriously consider an offer on the table in the same way that it might be appropriate to raise the issue in therapy. Moving between the clinical and forensic worlds successfully and effectively requires a mastery of the different rules that apply in each setting and an understanding of the different values that apply in each domain. For example, although confidentiality is the hallmark of effective clinical psychiatry, presentation to the court of the results of a forensic

examination is premised on the absence of confidentiality. Successful forensic psychiatrists understand these distinct rules and values, even if they do not always agree with them.

In this chapter, I examine some of the fundamental differences in clinical and forensic psychiatric practice and the implications of these differences. I then consider how the role of truth varies in these two realms. I begin with a discussion of the differences in the mechanics of consent and the related notion of autonomy in clinical and forensic psychiatry. I also explore the legal system's choice of the adversary system in the search for truth, as well as the implications of this process in the use of expert witnesses. Understanding these differences is necessary to appreciate how forensic practice and clinical practice differ, and what the legal system expects of forensic psychiatrists and why.

Consent and Autonomy in Clinical and Forensic Psychiatry

Forensic relationships rest on a fundamentally distinct foundation from private practice treatment relationships. One of the most profound differences in clinical and forensic psychiatric practice is the role of consent. *Consent* is a prerequisite to psychiatric treatment (at least in private practice settings), and private practice patients are free to leave treatment at any time for any reason without penalty. The adult sexual assault victim who seeks care may leave treatment prematurely, just as he or she was at liberty to enter treatment or not. Treatment rendered in the absence of effective consent is unlawful as well as unethical.

Although a forensic examination should not occur in the absence of consent, in the clinical setting consent operates in a different way. A criminal defendant who asserts an insanity defense must submit to an examination by the state's expert, without having input into the choice of that expert's selection or evaluation methods or without being precluded from presenting expert evidence in support of an insanity defense (*Henry v. State* 1991). If the sexual assault patient sues the owner of the building in which the assault occurred, claiming that the owner should have provided better security, she will not be permitted to refuse to be examined by the defendant's expert and still maintain that damage claim, again without input into the choice of that expert's selection or evaluation methods (*Newell v. Engel* 1994). Litigants who place their mental condition at issue may not withhold consent to a

psychiatric examination by an opponent's expert without penalty, nor do they have the option available to a private practice patient of refusing a particular diagnostic test or technique.

Consent is grounded in concerns about personal autonomy. Clinicians typically hold their patients' autonomy in high regard and seek to avoid exercising control over their patients' lives. One of the common goals of treatment is to assist patients in taking responsibility for their own decisions. However, in the litigation setting, psychiatric expert witnesses often unavoidably wield significant power over litigants. For example, litigants understand that a court-ordered examiner's report about the best interest of the child whose custody is at issue is likely to have a significant impact on the decision-maker (Champagne et al. 2001). Psychiatrists serving as expert witnesses exercise power over other people—power that psychiatrists treating private practice patients seek to avoid.

Clinical psychiatrists try to help their patients get better, provide them with evaluation and treatment, and avoid actions that are likely to harm them (American Psychiatric Association 2001). The goal of the forensic psychiatrist is not to provide beneficial treatment but to acquire and communicate information. Forensic psychiatrists are ethically obligated to avoid causing unnecessary harm, for example, by protecting the confidentiality of communications that are not relevant to the issue before the court (American Academy of Psychiatry and the Law 2005; Appelbaum 1990). However, it is the duty of the forensic psychiatrist to gather and communicate accurate, relevant information to the court, even if it will cause harm to a litigant (American Academy of Psychiatry and the Law 2005).

Consider the case of a forensic psychiatrist retained by the liability insurer for the building owner being sued by the sexual assault patient. The psychiatrist concludes that the plaintiff indeed suffered severe mental distress but that it was not caused by the defendant's wrongdoing and instead resulted from a prior injury. The psychiatrist knows that the impoverished plaintiff has no health insurance. The obligation of the forensic psychiatrist is to provide an accurate assessment of the cause of the current emotional distress, without regard to its impact on the plaintiff's ability to obtain mental health care. It is not the forensic psychiatrist's duty to find a solution that will enable the plaintiff to obtain mental health care or other necessary support. Similarly, a psychiatrist who undertakes an examination of a prisoner's competence to be executed is obligated to provide accurate information to the court about whether the prisoner's "mental illness prevents him from comprehending the reasons for the penalty or its implications" (*Ford v. Wainwright* 1986, p. 399). The psychiatrist must proceed without regard to the fact that a finding of competence to be executed will cause the prisoner's death (see also American Psychiatric Association 2008).

The role of truth in clinical versus forensic psychiatry is another important distinction that helps to explain what the courts expect of psychiatric expert witnesses. Although ascertaining historical truth may not be the goal of clinical psychiatry, the efficacy of some psychiatric treatments turns on truth, for example, in determining the efficacy of sertraline in treating posttraumatic stress disorder (Davidson et al. 2001). Although truth may matter for treatment, clinical psychiatrists rarely have the resources or the time for these sorts of inquiries. The goal of the psychiatrist treating the patient who claims to have been sexually assaulted is not to determine whether the sexual assault occurred. Treating psychiatrists do not have investigators or subpoena power, nor do insurance companies reimburse for these activities.

In contrast, the legal system has the time and the resources to engage in these inquiries, although it is inherently limited in its ability to validate truth in individual cases. For example, it is simply not possible to be certain whether the person, who authored a will some years ago and is now deceased, had "sufficient mental capacity to know the nature and extent of his property and the natural objects of his bounty and to formulate a rational scheme of distribution" (*In re Estate of Herbert* 1996). Everything that takes place in life is not recorded on videotape, and the ability to reconstruct legally relevant past events with a high degree of confidence will be determined to a large extent by happenstance (Simon and Shuman 2002).The serendipitous presence of a witness may account for the legal system's ability to determine whether a patient was assaulted by her date, as she claims, or consented, as he claims.

This does not imply that accuracy is unimportant to the law, only that its subject matter imposes inherent limits on the nature of the inquiry. Common sense tells us that accuracy and truth matter to the law. Convicting the wrong person does not make society safer and risks undermining society's confidence in the criminal law, in addition to the horror inherent in the reality of imprisoning an innocent person. Wrongly finding a psychiatrist liable for malpractice confuses everyone in the profession about how they are expected to behave, imposes unnecessary costs on psychiatrists and their patients, and erroneously maligns a professional's reputation.

But as commonsensical as truth may seem as a goal of the legal system, careful consideration reveals that truth is not its only goal. Rule 102 of the Federal Rules of Evidence, which articulates the goals of the rules of evidence that govern admissibility at trial, illustrates some of the other goals:

> These rules shall be construed to secure fairness in administration, elimination of unjustifiable expense and delay, and promotion of growth and development of the law of evidence to the end that the truth may be ascertained and proceedings justly determined.

The rule articulates the goal of ascertaining truth as well as eliminating "unjustifiable expense and delay" and acknowledges that "proceedings [be] justly determined." Closer analysis reveals how these goals may compete in individual cases.

The adage "justice delayed is justice denied" reflects an understanding that justice is tied to the passage of time. "Memories fade and witnesses die," both of which interfere with the ability to achieve accuracy in the face of significant delays. Criminal defendants must be convicted or released, deserving civil plaintiffs compensated, and unjustly accused civil defendants exonerated—all in a timely manner, if justice is to be done (Shuman 2000). Yet we also know that careful investigation takes time, and in some instances the passage of substantial time may bring about the discovery of new evidence or investigational techniques (such as the DNA techniques now resulting in the exculpation of some convicted rapists) (Shuman and McCall Smith 2000). Thus, the avoidance of unnecessary delay and the search for truth may exert conflicting legal demands.

The rules of evidence also recognize that courts must balance expense and the discovery of truth. Courts are public entities beholden to legislative bodies that fund them, and they themselves face competing fiscal demands. A court's time must be managed with an awareness of these demands. Accordingly, the pursuit of truth must be tempered by fiscal responsibility. Litigants are also faced with fiscal limitations on expenditures. In a legal dispute over a $50,000 claim, it is not economical for a party to spend more than that amount to prevail. It may not be reasonable for a party to pay an expert to do everything that could be done to reach an accurate result. Thus, containing expense and attaining truth may exert conflicting demands.

Truth and justice, goals of the rules of evidence that are commonly regarded as synchronous, may also conflict. A civilized society regards the use of evidence obtained through torture as unjust, even if such methods produced a truthful result. Similarly, discovering inculpatory information from a criminal defendant by leading him or her to believe that the forensic psychiatric examination was for the purpose of treatment would be regarded as unjust. For this reason, psychiatrists are obligated to clarify with the litigants the purpose of the examination and to provide the names of the persons to whom the findings will be disclosed (Shuman 1993).

Apart from the ways in which justice, delay, and expense may conflict with obtaining truth in litigation, there are other competing demands on the legal system's search for truth. The attempt to foster certain therapeutic relationships (physician-, psychologist-, and psychotherapist-patient) with a relational privilege limits the ability of courts to compel disclosure of confidential communications cloaked by those privileges. Thus, relational privileges may also limit the discovery of truth in litigation (Shuman and Weiner

1987). Peer review privileges that encourage health care facilities to learn from errors in order to reduce morbidity and mortality may also limit litigants' access to relevant evidence (Tex. Occ. Code § 160.007, 2002). In addition, rape shield laws that seek to protect victims of sexual assault by placing their prior sexual history off limits may limit access to relevant evidence (Fed. R. Evid. 412; see Gold 2004).

Within this pragmatic framework of competing demands, the adversarial model seeks to achieve truth by placing the responsibility for its discovery in the hands of those who have the greatest interest in the outcome: the parties. That approach to the discovery of truth contrasts starkly with the methods of science and accounts for much frustration on the part of experts schooled in the methods of scientific investigation. As I have noted elsewhere, "The adversarial model assumes we are more likely to uncover the truth about a contested event as the result of the efforts of the parties who have a self-interest in the discovery of proof and exposing the frailties of an opponent's proof than from the efforts of a judge charged only with an official duty to investigate the case" (Shuman 2001, p. 269). This model also embodies constitutional norms ensuring that litigants have the opportunity to tell their story and confront their opponents. Proponents of the adversarial model understand the use of the word *adversary* in this context to have a positive meaning, and successful forensic psychiatrists learn not to take personally the demands of a zealous advocate.

The decision to use an adversarial model that relies heavily on amateur lay decision-makers (i.e., jurors) has profound implications for the use of experts. Expert witnesses are permitted to offer opinion testimony on issues that a fact-finder would otherwise lack the capacity to assess competently. Moreover, experts are neither independent agents nor directors of the adversary system. The parties employ their own experts in our legal system. This use of partisan experts whose believability is judged by laypersons has created a schism within the legal system about how to scrutinize the admissibility of experts, as I have described in the past:

> To understand how the law addresses claims of expertise requires an understanding of two very different ideals about trials which vie for dominance in the U.S. judicial system. These two ideals, represented by the traditional adversarial approach and the gatekeeper approach, reflect two different ways of accommodating the tension among core values at stake in the dispute resolution process—accuracy, fairness, efficiency, consistency, and accessibility. (Shuman 2001, p. 268)

The search for truth takes place in the larger context of a democratic society in which tensions between demands for scientific accuracy and popular decision-making color the use of experts. Raising the threshold for the

admissibility of experts limits democratic decision-making, whereas lowering the threshold limits the ability to protect jurors from unreliable claims of expertise. In *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), the U.S. Supreme Court wrestled with these tensions in its articulation of the standard for the admissibility of scientific evidence under the Federal Rules of Evidence. Addressing these tensions, the Court discussed the differences in the pursuit of truth in the courtroom and the laboratory:

> Petitioners…suggest that recognition of a screening role for the judge that allows for the exclusion of "invalid" evidence will sanction a stifling and repressive scientific orthodoxy and will be inimical to the search for truth….It is true that open debate is an essential part of both legal and scientific analyses. Yet there are important differences between the quest for truth in the courtroom and the quest for truth in the laboratory. Scientific conclusions are subject to perpetual revision. Law, on the other hand, must resolve disputes finally and quickly. The scientific project is advanced by broad and wide-ranging consideration of a multitude of hypotheses, for those that are incorrect will eventually be shown to be so, and that in itself is an advance. Conjectures that are probably wrong are of little use, however, in the project of reaching a quick, final, and binding legal judgment—often of great consequence—about a particular set of events in the past. We recognize that, in practice, a gatekeeping role for the judge, no matter how flexible, inevitably on occasion will prevent the jury from learning of authentic insights and innovations. That, nevertheless, is the balance that is struck by Rules of Evidence designed not for the exhaustive search for cosmic understanding but for the particularized resolution of legal disputes. (*Daubert v. Merrell Dow Pharmaceuticals, Inc.* 1993, pp. 596–597)

Recognizing that the adversarial model is "designed not for the exhaustive search for cosmic understanding but for the particularized resolution of legal disputes" highlights the tension between truth and considerations of fairness and justice.

Considerations of fairness and justice also speak strongly to the issue of process. Process concerns are addressed in the due process clause contained in the Fifth Amendment (applicable to federal governmental action) and the Fourteenth Amendment (applicable to state governmental action) to the Constitution. Due process has two important but different constitutional meanings—substantive due process and procedural due process. *Substantive due process* refers to the power of the courts to declare legislation unconstitutional because it does not reasonably advance a legitimate governmental goal. For example, in *Kansas v. Hendricks* (1997, p. 352), the U.S. Supreme Court heard and rejected a substantive due process challenge to Kansas's statutory scheme for civil commitment of a dangerous sex offender who had a mental abnormality. The act defined mental abnormality as a "congenital or acquired condition affecting the emotional or volitional capacity which

predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others." The Court responded with the following statement:

> Kansas argues that the act's definition of "mental abnormality" satisfies "substantive" due process requirements. We agree. Although freedom from physical restraint "has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action,…that liberty interest is not absolute. The Court has recognized that an individual's constitutionally protected interest in avoiding physical restraint may be overridden even in the civil context." (*Kansas v. Hendricks* 1997, p. 356)

Forensic psychiatrists can provide assistance in efforts to understand the impact of legislation on behavior in assessments of substantive due process claims.

Procedural due process refers to limitations on the process used by the government to deprive a citizen of life, liberty, or property. The hallmark of procedural due process is a meaningful opportunity to be heard. Thus, for example, the U.S. Supreme Court's decision in *Ake v. Oklahoma* (1985), recognizing an indigent defendant's right to expert assistance in presenting an insanity defense, was grounded in procedural due process:

> This Court has long recognized that when a State brings its judicial power to bear on an indigent defendant in a criminal proceeding, it must take steps to assure that the defendant has a fair opportunity to present his defense. This elementary principle, grounded in significant part on the Fourteenth Amendment's due process guarantee of fundamental fairness, derives from the belief that justice cannot be equal where, simply as a result of his poverty, a defendant is denied the opportunity to participate meaningfully in a judicial proceeding in which his liberty is at stake…without the assistance of a psychiatrist to conduct a professional examination on issues relevant to the defense, to help determine whether the insanity defense is viable, to present testimony, and to assist in preparing the cross-examination of a State's psychiatric witnesses, the risk of an inaccurate resolution of sanity issues is extremely high. With such assistance, the defendant is fairly able to present at least enough information to the jury, in a meaningful manner, as to permit it to make a sensible determination….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. (*Ake v. Oklahoma* 1985, p. 83)

In the civil context, procedural due process has frequently been addressed to notice and a timely opportunity to be heard (*Goldberg v. Kelly 1970*). If the sexual assault patient had been receiving Social Security Disability benefits, those benefits could not be properly suspended without timely notice

and an opportunity to be heard. Forensic psychiatrists may assist in implementing this right of procedural due process or assessing the impact of its denial.

Process considerations also serve other purposes beyond a fair opportunity to present a claim or defense. Because there are not enough law enforcement personnel to force the law on the citizenry, voluntary compliance with the law is at the heart of a successful democratic system of government. Process considerations are thought to play an important role in the public's confidence in and compliance with the rule of law: "The adversarial model also assumes that the parties' participation in the investigation and telling of their story, and the use of a decision maker who is independent of the investigation of the case, will enhance support of the judicial system and confidence in its decisions" (Shuman 2001, p. 269).

These demands on the legal system have important implications for the role of the actors in the adversarial model. Most psychiatrists who testify as experts do so as retained experts at the behest of one of the parties to litigation (Cecil and Willgang 1992). Although courts have the power to appoint experts to serve the court in a neutral role, that power is exercised only in selected categories of cases such as child custody determinations (Champagne et al. 2001) and competency to stand trial.

To encourage the public to come forward and give evidence, all witnesses are immune from defamation claims based on their testimony. Serving as a forensic expert, however, provides no halo of relief from a professional malpractice claim (*Bruce v. Byrne-Stevens* 1989). A psychiatrist who agrees to serve as an expert for a party on an issue in which he or she is not yet an expert, foolishly hoping to learn on the job and causing a meritorious claim to be dismissed, is fair game for a malpractice claim. However, many jurisdictions provide immunity for court-appointed experts.

The role of retained expert also has important implications for the rules that govern psychiatrists' conduct. Unlike the treating psychiatrist's communications with a patient, which are governed by the psychiatrist-patient privilege (or its equivalent), a forensic psychiatrist's communications with a litigant, whose attorney retained him or her, are governed by the attorney-client privilege. Communications between a litigant and a psychiatrist functioning in a forensic role are privileged only to the extent that they assist in the fulfillment of the attorney's role. Thus, a forensic relationship initiated by the litigant, rather than the litigant's attorney, will not be cloaked by either the attorney-client privilege or the psychotherapist-patient privilege. The forensic psychiatrist's duty of confidentiality (e.g., the duty to maintain confidences and the competing duty to warn third persons or report child abuse) is also modified by the forensic role, although there is little statutory or case law that clarifies the full scope of these differences.

The Health Insurance Portability and Accountability Act (HIPAA) also has a role. The limits on judicial discovery of protected health information are neither absent nor absolute in the forensic context. Protected health information may be disclosed with written patient consent; a court order that limits disclosure to this case and requires return or destruction of the protected health information; or a response to formal discovery that is accompanied by an assurance that the patient has been informed and been given opportunity to object (45 CFR 164.500 et seq.). HIPAA preempts conflicting state law (*Holman v. Rasak* 2008) except when the state protections are more stringent (*Smith v. American Home Products Corp. Wyeth-Ayerst Pharmaceutical* 2003).

Although the psychiatrist's employment in a litigation context is determined by an advocate, the forensic psychiatrist is ethically obligated to exercise independent judgment (American Academy of Psychiatry and the Law 2005). Thus, successful forensic psychiatric practice demands a precarious balance between advocacy and objectivity (Shuman and Greenberg 2003). Moreover, unlike lay witnesses, whose existence and numbers are typically fixed at the time of the incident at issue (e.g., the eyewitnesses to a collision), potential expert witnesses typically constitute a much larger pool, and this results in pressure to conform to the advocate's demands. As an illustration, in 2009 there were 1,693 psychiatrists certified in the subspecialty of forensic psychiatry by the American Board of Psychiatry and Neurology, from among whom attorneys might choose a board-certified forensic psychiatrist. The number of practicing forensic psychiatrists who are not board certified further expands the pool of potential experts. Attorneys may therefore "audition" a large group of experts and employ only the expert who is most supportive of their case.

Striking a balance between objectivity and advocacy is made all the more difficult by the manner in which experts contribute to the trial process. Although the psychiatrist expert may contribute to the advocate's decision about the issues that will be relevant in the case (e.g., by reporting that an insanity defense cannot be supported but suggesting psychiatric grounds for mitigation of capital punishment), neither the issue before the court nor the questions asked of the expert are decided by the expert. Experts are not asked on the stand if there is anything else they would like to say. Their input at trial is ultimately in the form of a question-and-answer colloquy in which the attorney asks the questions, the expert gives the answers, and nonresponsive answers may be stricken from the record with an accompanying judicial scolding.

The practice of good forensic psychiatry is much more than the practice of good clinical psychiatry in the courtroom. It requires the psychiatrist to succeed in an environment with rules and values that are often at odds with

those that dominate the psychiatrist's clinical domain. Yet it also demands that the psychiatrist not abandon professional judgment. It is no small feat to balance these demands.

Irreconcilable Differences Between Therapeutic and Forensic Practice

Therapeutic practice and forensic practice are distinct; however, a psychiatrist may be asked to perform both functions on behalf of a patient-litigant. For example, the psychiatrist who has treated the sexual assault patient may be asked by the patient's attorney to testify as a treating expert about the patient's treatment and prognosis, which presents no inherent conflict. Then, without any discussion, the plaintiff's lawyer asks the psychiatrist about the proximate cause of the emotional problems from which the plaintiff claims to suffer. Questions of competence and causation that require the application of a legal standard to contested facts are within the realm of a forensic expert, not a treating expert. These therapeutic and forensic functions are inconsistent and should not be simultaneously performed on behalf of a patient-litigant (Greenberg and Shuman 1997; Strasburger et al. 1997). Failure to maintain these role boundaries threatens the efficacy of therapy and the accuracy of the judicial process.

Psychiatrists may appropriately testify as treating experts (subject to privilege, confidentiality, and qualifications) without risk of conflict on matters of

- Reported history, as provided by the patient
- Mental status
- Clinical diagnosis
- Care provided to the patient and the patient's response to it
- Patient's prognosis
- Mood, cognitions, or behavior of the patient
- Other relevant statements that the patient made in treatment

These matters, presented in the manner of descriptive "occurrences" and not psycholegal opinions, do not raise issues of judgment, foundation, or historical truth. Therapists do not ordinarily have the requisite database to testify appropriately about psycholegal issues of causation (i.e., the relationship of a specific act to claimant's current condition) or capacity (i.e., the relationship of diagnosis or mental status to legally defined standards of functional

capacity). These matters raise problems of judgment, foundation, and historical truth that are problematic for treating experts (Greenberg and Shuman 1997, p. 56).

The potential harm of the therapeutic-forensic role conflict cannot be obviated by the patient-litigant's consent, because the consequences of such a conflict not only involve the particular patient-litigant but also affect the interests of the judicial system in the discovery of truth. These irreconcilable conflicts and the harm they portend are explained by examining four fundamental differences in the therapeutic and forensic roles.

The first fundamental difference is that the goals of the therapeutic and forensic relationship fundamentally and irreconcilably differ. Whereas the goal of the therapeutic relationship is to help the patient, the goal of the forensic relationship is to provide information to the legal system. A treating psychiatrist who seeks to serve the informational demands of the legal system as a forensic expert compromises treatment, and a treating psychiatrist testifying as a forensic expert who seeks to serve the therapeutic interests of the patient compromises the informational demands of the legal system.

The second fundamental difference in the therapeutic and forensic roles, as previously discussed, is that the role of truth differs fundamentally and irreconcilably in the forensic versus the therapeutic relationship. Courts seek to realize truth, albeit pragmatically. Thus, forensic psychiatrists are expected to use multiple independent sources of information to validate a litigant's claims and the information provided in support of them. In therapy, narrative truth matters more than historical truth. As observed by the American Psychological Association, "[T]he goal of therapy is not archeology" (1998, p. 936). The use of multiple independent sources of information to validate a patient's claims in therapy is uncommon and presents a threat to confidentiality. Treating psychiatrists do not and cannot expect to acquire information about the truth of information asserted by their patients to the level of confidence that the legal system expects of forensic psychiatrists. Treating psychiatrists who cross these boundaries by testifying as forensic experts who assume that they have discovered historical truths about their patients are often incredulous when cross-examined with persuasive evidence to the contrary that was not available to them as therapists.

The third fundamental difference in the therapeutic and forensic roles is judgment. An important characteristic of a good treating psychiatrist is to be nonjudgmental, to assist in developing a positive, trusting therapist-patient alliance. In contrast, an effective forensic psychiatrist, operating in an environment fraught with incentives for secondary gain, is judgmental and skeptical about the claims of the person being evaluated. If the psychiatrist has not occupied a position of trust, acting judgmentally toward the patient-litigant may cause legal harm but not emotional harm. However, if the psy-

chiatrist has developed a trusting therapist-patient alliance, a judgmental forensic assessment risks serious emotional harm to the patient, whereas a nonjudgmental forensic assessment risks harm to the legal process.

The fourth fundamental difference in the therapeutic versus the forensic role is how society addresses the reliability of the psychiatrist's methods and procedures. Society takes a laissez-faire attitude toward psychotherapeutic techniques. Licensed mental health professionals are permitted to offer, and competent adult patients are permitted to consent to, the use of a particular talk therapy without scientific proof of its efficacy. For example, analysts are not required to present rigorous scientific proof to the government or their patients that psychoanalysis is an effective form of treatment as a condition of its use. The judicial system is not so trusting. Legal rules governing the admissibility of experts' testimony permit the legal system to demand proof of the reliability of the procedures employed by psychiatrists who are providing expert testimony that is not demanded of treating psychiatrists.

It is appropriate for forensic psychiatrists to treat patients who are not their forensic clients and to serve as forensic experts in cases that do not involve their patients. However, it is typically not appropriate for a psychiatrist to occupy both roles on behalf of a particular patient-litigant. Mixing these roles portends negative outcomes in both domains. Learning to resist this temptation is an important lesson for psychiatrists who hope to provide both clinical and forensic services.

What the Law Demands of the Forensic Psychiatrist

The law's approach to the admissibility of expert testimony is characterized by a preference for lay testimony. Particularly in jury trials, the law expects the parties to present the testimony of lay witnesses to describe their first-hand sensory impressions of relevant events to the jurors; it expects jurors to draw inferences from the data or reach opinions based on the data to apply to the ultimate issue(s) in the case. However, the law recognizes that lay witnesses and lay jurors lack the capacity to understand and apply specialized knowledge. The law has therefore acknowledged a specific role for expert witnesses in the litigation process, to fill the gaps in understanding that would result if only lay testimony were provided.

Courts protective of juries once demanded that juries had to be incapable of resolving an issue without expert assistance before considering the ad-

mission of an expert's testimony on that issue. That standard has been liberalized in most jurisdictions to admit expert testimony that would be helpful to jurors even if they could conceivably resolve the issue without expert testimony. The liberalized standard of helpfulness is, however, still demanding. Consider a criminal prosecution of the person charged with the sexual assault of the patient he has been treating. In his defense, the defendant claims that the complainant consented to sexual relations. A psychiatrist's testimony that the complainant is being truthful when she says she was sexually assaulted would be rejected as intruding on the jury's province without providing useful assistance to the jury (*State v. Bressman* 1984). Conversely, expert psychiatric testimony describing and applying scientific research about common characteristics of victims of sexual assault is more likely to be regarded as meeting the helpfulness requirement (*State v. Allewalt* 1986).

The law subjects all testimony—lay and expert—to two levels of scrutiny; however, this scrutiny is more explicit in the case of expert witnesses. First, the judge must determine that the witness is legally competent to testify. Second, the fact-finder (the jury, if the case is being tried in the presence of a jury; otherwise, the judge) must determine the weight to assign the witnesses' testimony in its deliberations. All witnesses are subject to the legal competence requirement. Thus, for example, if a witness (lay or expert) refuses to take an oath or affirmation "calculated to awaken the witness' conscience and impress the witness' mind with the duty to [testify truthfully]" (Fed. R. Evid. 603), the witness would not be legally competent to testify.

There are two additional legal competence requirements for expert witnesses. First, because experts such as psychiatrists rest their claims of expertise, in whole or in part, on the collective research and experience of their profession, they must prove that they have the appropriate qualifications to claim membership in the relevant branch of that profession. In a psychiatric malpractice case alleging inappropriate drug prescriptions leading to a fatal drug overdose, legal competence would demand not only proof of general psychiatric education and training but also specialized training and experience in psychopharmacology.

Second, because experts such as psychiatrists rest their claims of expertise, in whole or in part, on the accuracy of the methods and procedures they use, they must prove that solid grounds exist to support the reliability of these methods and procedures. Competing legal tests emphasize general professional acceptance of the techniques versus independent scientific testing demonstrating the reliability of the technique (Shuman 2005). The older test, which arose in a federal court of appeals decision in *Frye v. United States* (1923), turned to the scientific community from which a new scientific method emerged to ask about its general acceptance. Although *Frye* has been

replaced in the federal courts and many state courts, it still remains the relevant test for the admissibility of new scientific evidence in many states.

In 1993, the U.S. Supreme Court concluded that in federal court *Frye* did not survive the promulgation of the Federal Rules of Evidence in 1974. The Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993) substituted a pragmatic test grounded in Karl Popper's conceptualization of falsifiability as the hallmark of the scientific enterprise. That test asks the trial judge to consider, among other factors, whether the technique or theory had been or could be tested, whether it was subjected to professional scrutiny through peer review and publication, whether it yielded an acceptable rate of error, and whether it had been accepted in the relevant scientific community. Ultimately, the rigor applied to the admissibility determination may turn on who is scrutinizing the proffered testimony as much as the standard that is applied. To satisfy the most demanding threshold standard of scrutiny, to prepare for rigorous cross-examination, and to satisfy professional ethical requirements, forensic psychiatrists should assume that the most demanding scientific standards that their professional colleagues use will apply. Hence, they should only present information derived from demonstrably reliable methods and procedures (Shuman and Sales 2001).

Psychiatrists who act as expert witnesses bring expertise acquired outside of the legal controversy to information generated within the legal controversy. Another set of legal rules (Fed. R. Evid. 702 and 703) addresses the information (basis) to which the forensic psychiatrist's expert knowledge is applied. Courts must determine whether the opinion is based on information that is sufficiently reliable. The courts' concern with the reliability of the information on which the expert relies for the factual basis of an opinion is illustrated by the following judicial observation:

> As late as 1980, Texas law disallowed admission of expert opinions based solely on hearsay evidence, mainly because this basis for the expert's testimony was not considered sufficiently trustworthy.…The Court's adoption of the Rules, however…allowed an expert to base opinion testimony entirely on inadmissible evidence, but the concern for the trustworthiness of the underlying basis for the expert's opinion did not evaporate. Instead, Rule 703 requires that if an expert intends to base an opinion solely on hearsay evidence that it must be of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject. (*E.I. du Pont de Nemours and Co. v. Robinson* 1995, p. 463)

Once the psychiatric expert witness has formulated an opinion, the next legal threshold is the form in which that opinion may be expressed. The issue here that has been a source of controversy is the *ultimate opinion rule* (or "ultimate issue rule"). With their preference for lay jury decision making, common-law courts once assiduously excluded any expert testimony that touched on

the ultimate legal issue the jury was being asked to address as an intrusion on the province of the jury. When the Federal Rules of Evidence were adopted in 1974, their drafters rejected the "ultimate issue rule" as a legal artifact that no longer served a useful purpose. Not only were there innumerable appeals attempting to sort out what the ultimate legal issues were in a particular case, but the ultimate issue rule assumed that jurors lacked the capacity to distinguish the expert's reasoning and conclusions. In addition, the drafters of the federal rules noted that other rules permitted the court to exclude confusing or unhelpful expert testimony (Fed. R. Evid. 403; Fed. R. Evid. 702). The states that adopted a version of the Federal Rules of Evidence followed suit and jettisoned rules that excluded expert testimony merely because it embraced an ultimate issue in the case. A decade later, however, the reaction to the John Hinckley not guilty by reason of insanity verdict led to a partial reintroduction of the ultimate issue rule in federal criminal trials:

> No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto. Such ultimate issues are matters for the trier of fact alone. (Fed. R. Evid. 704[b])

Thus, experts testifying to the defendant's mental state in an insanity defense in federal court are now restricted from testimony "that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts" [18 U.S.C.S. § 17 (2002)].

This limitation on ultimate issue testimony by experts does not apply in federal civil cases or the vast majority of state courts that have not adopted this provision. In those instances not covered by Federal Rule of Evidence 704(b) or a state law equivalent, some advocate that forensic psychiatrists should not address the ultimate issue as a matter of ethics, because such matters involve legal or moral issues on which they have no claim of expertise (Goldstein 1989). Although this is an admirable goal, the approach asks nonlawyers to take on a legal determination that the courts abandoned as impracticable. Moreover, the ethical response to ultimate-issue testimony is frustrating for judges and lawyers, and it is an inadequate justification for a psychiatric expert witness to refuse a court order to answer a question.

A preferable approach is for psychiatrists "to testify or not testify about ultimate issues, based on their data rather than arbitrary rules" (Rogers and Shuman 2000, p. 48). In this approach, the expert is asked to ascertain whether there are solid grounds based on the use of reliable methods and procedures to answer the question, without regard to whether it is an ultimate issue. Indeed, this approach is the test that psychiatrists providing ex-

pert opinions should apply to all issues they are asked to address. A decision as to whether the data provide a reliable basis for a response should guide psychiatrists' responses to all questions. For example, if a psychiatrist is asked in a sexual assault prosecution whether the complainant's post-event behavior suggests that she consented to sexual relations with the defendant, the response ought not to turn on whether this is an ultimate issue in the case. Rather, it should turn on whether there are any validated procedures that permit a psychiatrist to make this postdiction with a high degree of reliability (Simon and Shuman 2002).

The legal and ethical rules that govern the behavior of psychiatrists functioning as expert witnesses are neither intuitive nor flexible. They impose a set of restrictions on the conduct of psychiatrists that attorneys use for the benefit of their clients and to the detriment of those who stand in the way of achieving their clients' goals. Psychiatrists who choose to enter this forensic realm must, at their peril, master these unique legal rules.

Conclusion

In the not-so-distant past, most psychiatrists, along with other physicians, diligently sought to avoid testifying in legal proceedings. That situation has changed for numerous reasons, including decreased reimbursement to physicians for patient care (as a result of managed care) and increased lucrative opportunities for forensic experts. Forensic psychiatry is a growth industry. Yet the forensic world is not to be entered into casually. It is a subspecialty with a culture and a language foreign to most psychiatrists, which is best learned through specialized education and training.

Key Points

- Fundamental differences exist in the goals of clinical psychiatry (beneficence) and forensic psychiatry (truth, fairness).
- Fundamental differences exist in the duty of confidentiality in clinical psychiatry and forensic psychiatry.
- The form and function of judicial gatekeeping standards (i.e., *Frye v. United States* [1923], *Daubert v. Merrell Dow Pharmaceuticals, Inc.* [1993]) are an outgrowth of the right to trial by jury.

Practice Guidelines

1. Obtain comprehensive education and training addressing the ethical guidelines and legal rules that govern the practice of forensic psychiatry before providing expert witness services or consultations.
2. Avoid mixing therapeutic and forensic roles.
3. Provide expert testimony only on questions for which your education, training, and experience provide specialized expertise.
4. Use methods and procedures whose reliability has been tested and proven according to the most demanding standards of the profession.
5. Offer opinions that are based on sufficient reliable information.
6. Present your findings in a manner that permits the fact-finder to follow your analysis.

References

Ake v Oklahoma, 470 U.S. 68 (1985)

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry, Adopted May 2005. Available at: http://www.aapl.org/pdf/ethicsgdlns.pdf . Accessed July 30, 2009.

American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 2001 Edition. Washington, DC, American Psychiatric Association, 2001

American Psychiatric Association: Capital Punishment Position Paper 2008. Available at: http://psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/200801.aspx. Accessed July 30, 2009.

American Psychological Association: Working Group on Investigation of Memories of Childhood Abuse: Final Conclusions of the American Psychological Association. Psychology, Public Policy, and Law 4:933–939, 1998

Appelbaum PS: The parable of the forensic psychiatrist: ethics and the problem of doing harm. Int J Law Psychiatry 13:249–259, 1990

Bruce v Byrne-Stevens, 776 P.2d 666 (Wash. 1989)

Cecil JS, Willgang TE: Defining a role for court-appointed experts. FJC Directions 4:6–17, 1992

Champagne A, Easterling D, Shuman DW, et al: Are court-appointed experts the solution to the problem of expert testimony? Judicature 84:178–183, 2001

Daubert v Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993)
Davidson J, Pearlstein T, Londborg P, et al: Efficacy of sertraline in preventing relapse of posttraumatic stress disorder: results of a 28-week double-blind, placebo-controlled study. Am J Psychiatry 158:1974–1981, 2001
E.I. du Pont de Nemours and Co v Robinson, 923 S.W.2d 549 (Tex. 1995)
Ford v Wainwright, 477 U.S. 399 (1986)
Frye v United States, 293 F. 1013 (D.C. Cir. 1923)
Gold LH: Sexual Harassment: Psychiatric Assessment in Employment Litigation. Washington, DC, American Psychiatric Publishing, 2004
Goldberg v Kelly, 397 U.S. 394 (1970)
Goldstein RL: The psychiatrist's guide to right and wrong: part II: a systematic analysis of exculpatory delusions. Bull Am Acad Psychiatry Law 17:61–67, 1989
Greenberg SA, Shuman DW: Irreconcilable conflict between therapeutic and forensic roles. Prof Psychol Res Pr 28:50–57, 1997
Henry v State, 574 So.2s 66 (Fla. 1991)
Holman v Rasak, Mich. App. 761 N.W.2d 391 (2008)
In re Estate of Herbert, 1996 Haw. App. LEXIS 162
Kansas v Hendricks, 521 U.S. 346 (1997)
Newell v Engel, 899 P.2d 273 (Colo. App. 1994)
Rogers R, Shuman DW: Conducting Insanity Defense Evaluations, 2nd Edition. New York, Guilford, 2000
Shuman DW: The use of empathy in forensic examinations. Ethics Behavior 3:289–302, 1993
Shuman DW: When time does not heal: understanding the importance of avoiding unnecessary delay in the resolution of tort cases. Psychol Public Policy Law 6:880–897, 2000
Shuman DW: Expertise in law, medicine, and health care. J Health Polit Policy Law 26:267–290, 2001
Shuman DW: Psychiatric and Psychological Evidence, 3rd Edition. Deerfield, IL, Clark Boardman Callaghan, 2005
Shuman DW, Greenberg SA: The expert witness, the adversary system, and the voice of reason: reconciling impartiality and advocacy. Prof Psychol Res Pr 34:219–224, 2003
Shuman DW, McCall Smith A: Justice and the Prosecution of Old Crimes: Balancing Legal, Psychological and Moral Considerations. Washington, DC, American Psychological Association, 2000
Shuman DW, Sales BD: Daubert's wager. Journal of Forensic Psychology Practice 1:69–77, 2001
Shuman DW, Weiner MF: The Psychotherapist-Patient Privilege: A Critical Examination. Springfield, IL, Charles C Thomas, 1987
Simon RI, Shuman DW: Retrospective Assessment of Mental States in Litigation: Predicting the Past. Washington, DC, American Psychiatric Publishing, 2002
Smith v American Home Products Corp. Wyeth-Ayerst Pharmaceutical, 855 A.2d 608 N.J. Super. (2003)
State v Allewalt, 517 A.2d 741 (Md. 1986)

State v Bressman, 689 P.2d 901 (Kan. 1984)
Strasburger LH, Guthiel TH, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–456, 1997
Tex. Occ. Code § 160.007 (2002)

Suggested Readings

Gold LH, Shuman DW: Evaluating Mental Health Disability in the Workplace. New York, Springer, 2009
Greenberg SA, Shuman DW: Irreconcilable conflict between therapeutic and forensic roles. Prof Psychol Res Pr 28:50–57, 1997
Shuman DW: The use of empathy in forensic examinations. Ethics Behavior 3:289–302, 1993
Shuman DW: Psychiatric and Psychological Evidence. Deerfield, IL, Clark Boardman Callaghan, 2005
Shuman DW, Greenberg SA: The expert witness, the adversary system, and the voice of reason: reconciling impartiality and advocacy. Prof Psychol Res Pr 34:219–224, 2003
Simon RI, Shuman DW: Retrospective Assessment of Mental States in Litigation: Predicting the Past. Washington, DC, American Psychiatric Publishing, 2002

Chapter 3

Starting a Forensic Practice

Liza H. Gold, M.D.

Steven H. Berger, M.D.

In this chapter, we provide general suggestions for starting a private practice in forensic psychiatry, and include discussion of some of the common pitfalls clinicians may find along the way. By *forensic psychiatric practice,* we mean providing evaluations of individuals not already in treatment with the evaluating clinician for use in legal or administrative purposes. Regardless of whether psychiatrists are following a primarily private clinical practice business model or are salaried clinical or administrative employees, a private practice in forensic psychiatry can be a challenging but rewarding addition to a psychiatrist's professional life. We then offer suggestions for creating an infrastructure to develop a private practice in forensic psychiatry, which can be added to either a private clinical practice or a salaried clinical position.

Developing Forensic Skills

The skills involved in a clinical evaluation for forensic purposes differ from those involved in clinical evaluations for treatment. General clinicians evolve into forensic practitioners by learning these skills. The skill set that serves the clinician well in treatment settings will not suffice in forensic settings, and forensic skill sets are not generally obtained in the course of most psy-

chiatric residencies. The most direct method of developing forensic expertise involves obtaining training in a forensic psychiatry fellowship. Alternatively, psychiatrists become familiar with forensic skills by obtaining employment that includes forensic work. Finally, some psychiatrists add forensic work to a clinical practice and obtain additional formal or informal forensic training.

A forensic psychiatry fellowship is a fifth postgraduate training-year program, completed after 3 years of a general psychiatric residency. Of course, a general psychiatrist can do the work of any subspecialty, even without subspecialty training or board certification. However, some of the steps involved in starting a forensic practice will occur automatically with fellowship training. For example, until 1999, psychiatrists who had not completed a forensic fellowship could sit for the subspecialty Forensic Psychiatry board certification. Since 1999, the American Board of Psychiatry and Neurology has allowed only those who have completed an accredited forensic fellowship to sit for the examination and become board certified (American Board of Psychiatry and Neurology, Inc. 2009). A list of accredited forensic fellowship programs in the United States and Canada can be found on the American Academy of Psychiatry and the Law (AAPL) Web site (www.aapl.org).

Alternatively, a psychiatrist may obtain employment that includes forensic psychiatry work. With or without forensic fellowship training, the position a psychiatrist selects upon completion of general psychiatric residency training determines how much forensic psychiatry work he or she will have at the start of a career. For example, a job with a forensic service such as a court clinic will expose the clinician to a significant amount of forensic work and help him or her develop forensic skills. A state hospital or community mental health center employee is likely to have to provide evaluations and testimony when needed, particularly for civil commitment. Often, individuals who have taken salaried positions that include forensic work become interested enough to pursue specialty training and board certification, with the hope of creating either a primary or adjunctive private forensic practice.

The last method of obtaining forensic skills involves psychiatrists working judiciously on private forensic cases in addition to a clinical practice. If they have not completed a forensic fellowship, these psychiatrists often obtain additional formal or informal training, through mentorship, peer supervision, and continuing medical education in forensic psychiatry offered through professional organizations such as AAPL. The following vignette describes a psychiatrist taking this route into forensic practice.

Case Vignette

Dr. M is a private-practice child and adolescent psychiatrist. He spends about half his time seeing inpatients on a private-practice basis at a local hospital

and the other half seeing outpatients in his private office. One day, Dr. M receives a call from an attorney seeking an expert to evaluate and testify in a child custody case. Dr. M typically tries to avoid having to testify in court, even for his private-practice patients. He advises the attorney that he has never provided such an evaluation or testimony outside his clinical practice. The attorney is not deterred, stating that he is seeking someone who has never testified as an expert before, because the attorney believes this will lend credibility to Dr. M's testimony.

After some consideration, Dr. M begins to see the attorney's request as an opportunity to develop a forensic practice in an area where he has years of expertise. Dr. M decides he is interested, but he has no idea how to go about adding a forensic practice to his clinical practice. Obviously, he can only be hired once on the basis of a qualification as a "neophyte" expert. Dr. M agrees to provide forensic services to the attorney in the hopes of learning what a private practice in forensic psychiatry might entail. Dr. M has a positive experience in the case and decides he would like to do more forensic work. How should Dr. M go about building a forensic practice?

How to Start a Forensic Psychiatric Private Practice

Clinical and Forensic Psychiatric Practice: Peaceful Coexistence

Before pursuing the addition of a forensic practice, psychiatrists should understand that although clinical and forensic practice may peacefully coexist in a psychiatrist's professional life, forensic work is distinct from clinical work. Keeping one's clinical cases and forensic cases free of overlap is highly recommended. Occupying the dual roles of the treating clinician and the independent psychiatric evaluator in the same case usually results in creating ethical conflicts (Greenberg and Shuman 1997; Strasburger et al. 1997; see also Chapter 5, "Ethics in Forensic Psychiatry," this volume).

Scheduling issues can make peaceful coexistence of forensic and clinical cases challenging (Gutheil 2009). Whereas psychiatrists have complete control over scheduling clinical patients, they have little control over a court's schedule or priorities. A case may be scheduled for trial months in advance but, at the last minute, may be postponed, delayed, or settled. Attorneys may need unanticipated last-minute testimony at a motion or hearing. Scheduled testimony may also be delayed because the case is taking longer to try than the attorney expected. For example, attorneys have no control over the length

of time opposing counsel spends in examination or cross-examination, over the number of motions presented, or of how long it may take a judge to rule on motions.

Nevertheless, balancing the unpredictable time requirements of forensic cases with a stable clinical practice is possible and essential. Psychiatrists should give some thought as to how to manage this balance as they begin to add forensic cases to a private practice or salaried job. Full-time private forensic psychiatric practices are rare. The basis for psychiatrists' expertise in providing opinions to the legal system is their clinical experience and training. A healthy clinical practice allows psychiatrists to keep their clinical skills sharp as well as allowing them to demonstrate that the basis of their expertise is grounded in their daily clinical practice.

In addition, having a salaried job or a private clinical practice provides a base of financial stability that enables forensic practitioners to turn down questionable cases or cases for which they do not have the appropriate expertise (Gutheil 2009). Typically, the further away psychiatrists move from clinical practice, the more vulnerable they are to temptations to cross ethical boundaries in pursuit of forensic cases. Even if they are able to insulate themselves from these temptations and maintain ethical integrity, lack of a clinical practice causes them to remain more vulnerable to attorneys' questions regarding their expertise and credibility. Finally, in some states, psychiatrists are required to spend a certain amount of time in clinical practice in order to qualify to provide expert testimony in that state (Federation of State Medical Boards 2009).

Find a Mentor

Regardless of the route used to develop forensic skills, finding a mentor early in a forensic career can be the most important step in developing a forensic practice. Successful professionals and business owners in every field of endeavor attest to the invaluable assistance they received from a mentor in starting their careers.

Forensic psychiatry is not typically a "team sport." Each forensic psychiatrist is theoretically or practically competing for the same market share of clients. More established forensic practitioners may look at new forensic psychiatrists as competition that threatens their income. Nevertheless, some are more than willing to share their experience and contacts.

Psychiatrists who undertake a forensic fellowship may find a mentor within or through their fellowship program. Psychiatrists adding a forensic practice later in their clinical careers may have to work a bit harder to find individuals who are willing to share the benefit of their experience. Mentors

may be local practitioners or established forensic psychiatrists practicing in other states. Attendance at regional or national meetings of forensic organizations, such as AAPL or similar organizations, is an excellent way of establishing contact with potential mentors.

Both those receiving mentorship and those providing it can benefit from these relationships. New forensic psychiatrists receive supervision from an experienced forensic psychiatrist, as well as formal and informal career advice, from how to market a forensic practice to how to collect money from recalcitrant clients. Mentors, who are typically well established in their forensic practices, often receive more referrals than they can manage in their own practice. In addition to the satisfaction many find from passing along the benefit of their experience, those who provide mentorship often appreciate having a reliable and competent clinician to whom they can refer potential clients.

Think About Image

Psychiatrists beginning a forensic practice should actively take into account how their business practices and tools affect their image and reputation. The professional image a psychiatrist wishes to convey is reflected in the psychiatrist's e-mail address, business card design, Web site design, printed letterhead, and stationery. For example, the more professional the design and paper used in a business card or stationery, the more professional the psychiatrist will appear to potential clients.

Similarly, a psychiatrist's e-mail address and practice name reflects the attitude with which he or she approaches psychiatry and forensic cases. E-mail addresses such as shockdoc@gmail.com or pinkshrink@aol.com might be considered clever but are unprofessional. Such "tags" convey the wrong message to an attorney seeking a psychiatric expert in legal matters that may involve life and death or large amounts of money. Addresses such as drmichaelsmith@bellsouth.net or jjonesmd@verizon.net portray a more professional image. Persons interested in adding a forensic practice to their clinical or administrative work should carefully consider the impression these business tools make on colleagues and potential clients as they consider how to establish themselves in their community as forensic psychiatrists.

Know Thy Clients

Psychiatrists beginning to undertake forensic work should understand who comprises their potential referral base. Most psychiatrists do not conceptu-

alize their work as "providing services to clients." In our clinical practices, we provide treatment to patients. Thinking of our work as providing services requires a paradigm shift, but one that is necessary to creating an adjunctive forensic private practice. The client or customer of the forensic psychiatrist is the party who retains the psychiatrist to work on the case. Although psychiatrists evaluate individuals, the individual evaluee is not the psychiatrist's client, even if the individual undergoing evaluation retains the party who then retains the psychiatrist.

Case Vignette *(continued)*

Dr. M has hung out his "forensic" shingle. Shortly thereafter, he receives a call from Mr. W, asking for an evaluation and written report. Mr. W says that he is experiencing severe anxiety, due to the pressure his supervisor puts on him at work. Mr. W explains that he is not seeking treatment but wants to Dr. M to evaluate him and write a report. Mr. W says he wants to use the report to convince his employer to pay him workers' compensation benefits for a one-month leave of absence and to obtain accommodations under the Americans with Disabilities Act, including a different supervisor. Mr. W says he will pay Dr. M his full fee once Mr. W has successfully achieved these goals.

This is one of Dr. M's first forensic calls. He is anxious to begin his forensic practice, but he is not sure whether Mr. W's goals are legally realistic, even if Mr. W does have an anxiety condition related to his employment. Should Dr. M agree to provide services and provide them according to Mr. W's conditions?

The forensic psychiatrist's potential *referral sources* typically include attorneys, courts, insurance companies, and large employers but usually do not directly include plaintiffs or defendants. Attorneys retain forensic psychiatrists for civil, criminal, and administrative cases that may involve psychiatric issues. Courts and judges retain forensic psychiatrists to evaluate and testify as court-appointed independent examiners. The most common criminal evaluations for which attorneys and courts retain forensic experts are questions of competency to stand trial and insanity.

Contracting with attorneys rather than contracting directly with evaluees is a generally recommended business practice. Making agreements with evaluees can create a multitude of ethical, legal, clinical, and business problems. Not the least of these is the business arrangement in which the psychiatrist works directly for the evaluee, who cannot help but apply pressure on the psychiatrist for a favorable opinion. Even if the forensic clinician resists this pressure and provides an objective opinion, the appearance of advocacy, appropriate for an attorney, is inappropriate for the forensic psychiatrist (American Academy of Psychiatry and the Law 2005; see also Chapter 5,

"Ethics in Forensic Psychiatry," this volume). In addition, regardless of the objectivity of Dr. M's evaluation, whether the evaluee achieves his or her goals is beyond the control of the psychiatrist. The employer's decisions should not play any role in whether Dr. M is paid for the time spent in providing evaluations and reports.

Despite his desire to begin a forensic practice as soon as possible, Dr. M should advise Mr. W to consult an attorney or, if Mr. W has already done so, to have the attorney contact Dr. M to discuss the case. The attorney can clarify whether Mr. W's goals pass the legal muster of the Workers' Compensation and Americans with Disabilities Act laws. If the attorney feels that psychiatric evaluation is appropriate or will be helpful to the client, and if Dr. M is interested in providing an evaluation in this case (and is qualified to do so), the attorney can contract directly with Dr. M to evaluate the case.

Employers also retain forensic psychiatrists as independent evaluators to clarify psychiatric questions involving employees. These referrals usually come through employers' human resources departments, in-house medical departments, or subcontractor medical benefits management companies. Examples of such cases include fitness for duty evaluations, risk assessment of dangerousness, reasonableness of a Family and Medical Leave Act application, and reasonable accommodation under the Americans with Disabilities Act (see Gold and Shuman 2009).

In addition, insurance companies retain forensic psychiatrists to clarify questions that may arise when individuals attempt to access benefits from their insurance policies (Gold and Shuman 2009). The psychiatric questions involved in insurance cases vary depending on the type of policy and the issues defined by that policy. For example, an insurer may refer a case for evaluation to determine whether a claimant fulfills the definition of disability in his disability insurance policy or if an individual's condition preexisted the event for which benefits are claimed.

Establishing a Reputation and Obtaining Referrals

Assuming Mr. W has an attorney, how would that attorney know who to call to obtain a forensic evaluation? A private-practice forensic psychiatrist commonly gets his or her first forensic case when a client approaches him or her to evaluate a case, as in the case vignette. Potential clients know of forensic psychiatrists from the psychiatrists' incidental involvement in their patients'

legal matters, or psychiatrists' clinical or academic activities. All these can help establish a reputation that will engender calls from attorneys and other potential clients. For example, incidental forensic reports and testimony provided by a treating psychiatrist may put the psychiatrist's work within view of attorneys and insurance companies. If the psychiatrist demonstrates good written and oral communication skills as well as clinical expertise, attorneys or insurance companies may call the psychiatrist to work on similar cases as a forensic expert.

However, psychiatrists who want to build a busy forensic practice should not just sit and wait for the phone to ring. Dr. M got lucky with his first case. To obtain another, Dr. M needs to be proactive, to make himself known to potential clients. A business model of simply waiting to be called is likely to be as successful as that of a tow truck service that waits to be called when a car breaks down. Sometimes a court or attorney will call a local psychiatrist listed in the phone book, looking for someone to evaluate a case, just as the tow truck company is likely to get some random calls for service. Nevertheless, Dr. M is not likely to acquire many cases with such a passive strategy.

Market Position

A physician setting up a clinical practice intentionally or unintentionally establishes a market position. For example, a psychiatrist may label himself or herself a general psychiatrist or a specialist. A specialist designates a practice parameter such as an age group, diagnostic group, treatment setting (such as inpatient or outpatient), or activity (such as administrative or research). The parameter limits can be firm, such as limiting a practice to inpatient services only, or flexible, such as a child psychiatrist who works primarily with children and adolescents but will also treat a certain number of adult patients.

Psychiatrists starting a forensic practice should make a conscious strategic decision regarding their market position goals. As in clinical psychiatry, forensic psychiatrists may initially accept cases from all categories for which they are qualified by training, education, or experience. On the other hand, they may start out by defining special interests, such as criminal, sex offense, or child custody cases, and accept only cases related to their special interests. If a clinician has a large number of forensic referrals from the outset, then accepting only cases in a forensic subspecialty may yield an adequate number of cases. However, beginning forensic psychiatrists who define a narrow area of interest may acquire cases in which a particular expertise is sought, but they are likelier to receive fewer calls. In contrast, the more types of cases they accept, the more likely they are to attract a larger number of potential clients. Although the temptation to specialize from the outset may be strong,

the novice forensic practitioner will do better by accepting a wide range of cases (Gutheil 2009).

Psychiatrists who choose to provide forensic services in a wide range of legal cases nevertheless should refuse cases outside their area of expertise (Gutheil 2009). Offering opinions that are beyond one's expertise is unethical (American Academy of Psychiatry and the Law 2005). In addition, psychiatrists who offer opinions outside their area of expertise are more likely to find themselves disqualified by the courts as experts (see Chapter 2, "Introduction to the Legal System," this volume). Legal disqualification becomes a matter of public record that can and will be used to cast doubt on the psychiatrist's qualifications, expertise, and testimony in future cases.

Moreover, from a business perspective, lack of expertise is likelier to result in a compromised work product. Providing less than adequate or incomplete reports, testimony, or other forensic service, whether because of a lack of expertise or some other problem, is worse for one's reputation (and future referrals) than refusing a case. If a forensic psychiatrist is unfamiliar with the diagnosis at the heart of a legal matter, is unable to remain objective because of the nature of the case, or is unable to do high-quality work on a case because he or she is pressed for time, a clinician should opt to refuse the case rather than run the risks associated with compromising his or her reputation. A clinician can still assist potential clients by providing referrals to forensic psychiatrists who do accept such cases or may have more time.

An attorney often does not choose a specialty area of practice. Rather, the specialty chooses an attorney. An attorney at the beginning of his or her career may be asked by a fire insurance company to defend a fire loss claim. After successfully resolving the litigation, the attorney may develop a reputation as being adept at handling this kind of case and thus receive more referrals for such cases, both from the original insurance company and from other insurance companies. The attorney may eventually have enough referrals to ultimately limit his or her practice to fire insurance defense cases.

The same process often occurs for the forensic psychiatrist. At first, the clinician may be offered a variety of cases. Eventually, the psychiatrist becomes recognized as having particular expertise or experience with certain types of cases: criminal, personal injury, employment, and the like. The clinician thus establishes a reputation in a psychiatric forensic subspecialty. Eventually, referrals for those types of cases may make up the majority of that forensic practice.

Subspecialty interests in a forensic practice should not, however, be related to any specific "side" of the legal system. A psychiatrist should try to avoid being pigeonholed as a "defense expert," a "prosecution expert," or a "plaintiff's expert." Although establishing this type of one-sided forensic practice can be a highly successful market position, it is generally associated

with a reputation as a "hired gun." This epithet is defined as an expert witness who sells testimony instead of time (Gutheil 2009). The psychiatrist who accepts cases only for prosecutors, plaintiffs, or defendants creates the appearance of being biased toward that side of the adversarial legal system and reduces the expert's credibility. The forensic psychiatrist should seek to balance his or her practice by providing services based on the relevancy of his or her expertise, not on which side of the legal system wants to utilize the psychiatrist's services.

Curriculum Vitae

The most effective curriculum vitae (CV) is one that is current, concise, well-organized, and targeted toward the desired client base. A CV is an essential business and marketing tool for establishing a forensic practice. The CV describes the forensic psychiatrist's unique expertise that makes him or her valuable to a potential client. It is commonly the first formal introduction of a psychiatrist's credentials and capabilities. For a forensic psychiatrist starting a practice, elements that may provide an edge over another psychiatrist's CV should be included.

The CV should list the usual credentials, such as education, licenses, hospital staff memberships, and published works. It should also list credentials or areas of expertise that may be of interest and value to clients—for example, working as a court clinic psychiatrist or having expertise in the diagnosis and treatment of sexual offenders. Other activities to consider include academic positions, membership in professional organizations and their committees, participation or offices in community or other volunteer organizations, and awards and other types of public recognition. Table 3–1 provides a list of suggested headings for a forensic psychiatrist's CV.

A psychiatrist, especially one who is interested in pursuing forensic work, should avoid the temptation to "pad" his or her CV. This can range from outright fabrication, such as listing degrees that have never been earned, to exaggerating one's job responsibilities, titles, or recognition in the community. Aside from the moral problems associated with lying about or exaggerating experience, an individual discovered to have falsified professional qualifications or experience loses all credibility, even in areas in which he or she has truthfully presented his or her accomplishments and expertise.

If a new forensic psychiatrist feels his or her CV appears too "thin," he or she should consider joining professional organizations and committees or state medical boards, writing for journals or lay publications, providing community education, or participating in any of the professional or community activities discussed below. Such steps are not intended simply to bulk-up a CV.

TABLE 3–1. The forensic curriculum vitae: suggested headings to organize and present information

1. Identifying data: name, contact information, including e-mail address and Web site
2. Board certification
3. Academic appointments
4. Areas of expertise (summarize as bulleted list; include languages spoken if fluent in languages other than English)
5. Education
6. Licensure
7. Awards
8. Job experience summary
9. Professional affiliations: organizations, committees, chairmanships
10. Public service activities
11. Journal affiliations: peer reviewer, editorial board
12. Publications
13. Presentations

Rather, these activities allow the new forensic psychiatrist to demonstrate his or her skills, commitment, and abilities, as well as broaden contacts and provide additional networking resources. Adding these qualifications to one's CV after doing professional, academic, research, or community work is a bonus for marketing but should not be the goal of the endeavor.

A psychiatrist should avoid listing personal information on his or her CV, such as a spouse's name, children's names, or home address. A CV represents a professional, not a personal, history, and such information is neither appropriate nor relevant in a professional context. Also, any document, including the expert's CV, may become part of the public record in court proceedings and may be widely disseminated on the Internet. For security and privacy reasons, the clinician should prioritize protecting his or her family from identification in court records and from potential exposure to intrusive reporters, adversarial evaluees, or even disgruntled patients who might find personal information through forensic activities.

Networking

Referral sources are more likely to contact people they know or have met than people whose names are simply listed in the phone book. *Networking,* or

using connections generated by an individual's professional or personal contacts, can also be used to generate referrals to one's private forensic practice. For example, a psychiatrist employed at a community mental health center may occasionally have patients who require civil commitment. The commitment hearing brings the psychiatrist into contact with at least two attorneys and a judge. If appropriate, the psychiatrist can mention to the attorneys and judge that he or she is available for other sorts of forensic psychiatry cases separate from his or her community mental health center employment. If it is inappropriate to mention availability at the time, the psychiatrist can call or write the attorneys and judge after the case is concluded. Other types of cases that would not conflict with one's community mental health center duties might include competence, insanity, or disability evaluations. The psychiatrist should be certain that state law or the terms of his or her employment do not prohibit taking such cases if he or she is employed in another capacity by the state.

Networking can also involve using connections in the medical community. Dr. M should make sure his psychiatric and psychological colleagues know of his interest in forensic psychiatry as he confers with them on other matters in the course of daily work. The more people who know of Dr. M's interest in forensic practice, the more likely Dr. M's name will come up in other people's conversations about forensic issues. Colleagues and potential referral sources can also be advised of Dr. M's forensic interests through his stationery or signature, which includes "_____ [first name], _____ [last name], M.D., General and Forensic Psychiatry."

Potential referral sources sometimes contact medical societies to find physicians interested in working on cases. The society refers the client to its members who are involved in the area of the client's interest. Dr. M should consider joining local and national medical societies and identify himself as someone who is available for forensic referrals. Joining a committee related to forensic issues, such as the ethics committee or the malpractice committee, will make a practitioner more visible and, therefore, more likely to get referrals through the society. The medical organizations that can potentially generate referrals are the state and local medical societies or the national, state, and local specialty societies.

A clinician's connections to people in the legal field can also be used to let others know of one's availability for forensic work. For example, if working with an attorney to settle one's parent's estate, the opportunity can be used to mention interest in forensic work. That attorney may then mention the psychiatrist's name when the topic comes up at informal occasions, such as lunch with other attorneys, or on formal occasions, such as when a legal colleague inquires about a referral to a forensic expert.

Professional, Community, and Volunteer Activities

Volunteering professional services or time is one way to begin or expand networking. It is also a way to advertise availability for forensic services and demonstrate the quality of those services, both of which increase visibility to potential clients. Table 3–2 summarizes the many avenues forensic psychiatrists may take to begin to establish a reputation and a referral base within their local and regional communities.

Volunteering in the community builds name recognition and reputation, even if not directly associated with professional referral sources. The more one's name is recognized, the more likely potential clients will think of that name when an expert is needed. Depending on the kind of work the psychiatrist wishes to do, the psychiatrist can call, write, or visit attorneys or legal agencies who provide pro bono (at no charge) services and offer to evaluate a case pro bono or at significantly reduced rates. Clients who may benefit from volunteer forensic psychiatric services exist at local, state, and national levels.

By volunteering to work on a case pro bono or for a token fee, psychiatrists show a willingness to contribute to the welfare of the community as well as to make potentially important referral contacts. A judge who needs an independent psychiatric evaluation in a case is more likely to call a psychiatrist who spoke at the Mental Health America support group that his niece attended than a psychiatrist listed in the phone book about whom he has never heard anything. Volunteering in professional groups also serves to put one's name and work in front of the people who hire expert witnesses.

Any positive involvement in the community will foster name recognition and enhance one's reputation in the eyes of clients. Dr. M, with his expertise in child and adolescent psychiatry, could volunteer, for example, to serve on civic committees or councils attempting to address issues of school violence. Community venues for which psychiatrists can volunteer are listed in Table 3–3.

Advertising and Registries

Traditional advertising presents a host of difficulties. A psychiatrist who advertises services as an expert witness could easily be interpreted as offering to sell opinions, again creating the impression of being a "hired gun" and associated problems with credibility on the witness stand. In addition to being potentially ethically compromising (or at least creating the appearance of less than pure ethical character), such practices are generally a waste of time

TABLE 3–2. Potential referral sources and methods for establishing a referral base

Volunteer	
Legal agencies	Court services: civil or criminal
	Judges and magistrates
	Attorneys: private, prosecutors, public defenders, legal aid
Contact	
Insurance companies	Disability evaluations
	Severity of psychiatric illness (health insurance)
Medical benefits management companies	Fitness for duty evaluations
	Family Medical Leave Act evaluations
	Disability (disability insurance claims)
	Americans with Disabilities Act evaluations
	Violence risk assessments
Malpractice insurance company claims department (and malpractice attorneys)	Evaluation of psychiatric malpractice claims
Register to provide evaluations for government agencies	
State disability determination service	New applicants for Social Security Disability Insurance benefits or continuation of coverage
County medical Medicaid office	Evaluations
Provide education via speaking, teaching, and writing	
Local bar associations	Speaker for events
	Teacher for continuing legal education events
Law schools	Lecturer
Writing	
Columns, articles, books	Legal publications
	Psychiatric publications
	Lay publications

TABLE 3–3. Volunteer or community service opportunities

Community organizations	Civic organizations, e.g., a committee to decrease school violence
	Churches, synagogues, or other religious institutions
	Public or private school, college boards, or committees
	Service organizations: Rotary, Knights of Columbus, etc.
	Advocacy organizations such as National Alliance on Mental Illness or Mental Health America.
Publications (on almost any topic in almost any venue)	Letters to the Editor
	Articles
	Periodic column
	Editor
Other media (radio, television)	Interviewee on psychiatric topics
	Media resource news stories of psychiatric interest
	Talk show guest/host
	Internet blog on psychiatric topics
	Web site (as volunteer effort for educating the community)

and money. The target audience of potential forensic psychiatric clients is very narrow. In general, it includes only attorneys, judges, large employers, and insurance companies. Of these, only a small number actually hire forensic psychiatrists. The audience for newspaper, radio, or other such media advertising is too broad to be effective.

Psychiatrists adding a forensic practice to a preexisting clinical practice or salaried position or who are moving to a new location can send announcements to potential clients. Announcements are a form of advertising, but also a way to keep people apprised of how to contact the psychiatrist. Psychiatrists who send announcements of changes in practice or location may not generate many cases, but they do notify clients about their presence in the community.

Psychiatrists interested in adding forensic cases to their practices should consider other methods of advertising their availability for forensic services. For example, every state has a Disability Determination Service that evaluates

applicants for Social Security Disability benefits. By joining such a panel, the psychiatrist is, in a way, advertising his or her availability for this type of evaluation. Similarly, some states have workers' compensation panels, malpractice claim evaluation panels, and other such services. The physicians listed on the panels are called, usually by an attorney on one side or the other, when a case requires evaluation. Forensic psychiatrists can have themselves added to the lists in the states where they are licensed.

Attorneys sometimes use registries or intermediary agencies to find expert witnesses. For example, when attorneys do not know any experts in a particular field, they can look up a general category of expert using national or local registries, or they can contact an agency that matches attorneys with experts. Experts must sign up with the registries or agencies to be listed. Signing up with such registries or agencies is typically free; the attorneys pay the fees to use the registry or agency. Nevertheless, registering with such agencies is problematic. Typically, they generate few, if any, referrals. In addition, when testifying, opposing attorneys often ask if the psychiatrist advertises his or her services. Again, an affirmative answer creates the impression that the psychiatrist is advertising to sell his or her testimony rather than time. As a general rule, such registries and agencies should be avoided.

Attorneys are likely to place the most reliance on their own experience in choosing an expert. If they do not know an appropriate expert, attorneys in need of a psychiatric expert most commonly obtain names of experts from other attorneys (Gutheil 2009). Therefore, "advertising," or promotional activities such as giving educational presentations, participating in continuing legal education activities, and volunteering for pro bono cases, is most effective when directed at attorneys. The more focused the audience of such promotional activities, the more fruitful they are likely to be. If one is interested in criminal defense cases, for example, then one can offer to make a presentation at a meeting of the local defense bar organization.

Web Sites

A Web site designed to assist potential clients in finding the beginning forensic psychiatrist is essential. Having an effective Web site is as important as having a telephone number and may be just as essential to communication. Attorneys are using the Internet more and more frequently to find experts. Most Web sites provide e-mail addresses that electronically link a potential client to the psychiatrist and facilitate initial contact. Although a Web site can serve as a kind of Internet "business card," psychiatrists should be aware that the versatility of a Web site can also create certain problems. Psychiatrists should be certain that their Web sites avoid the kind of material

or interactive options that can be used by attorneys to discredit them (see Chapter 22, "Forensic Psychiatry and the Internet," for a detailed discussion of these issues).

A psychiatrist's Web site represents the expert's professionalism, expertise, and qualifications, just as a CV does, but it also presents an opportunity to explore aspects of the expert's practice that may be of interest to a potential client. The Web site design and content should therefore be carefully considered. It should reflect the professional image that the psychiatrist wishes to project. A Web site that demonstrates a commitment to teaching, academic achievement, public service, or any other value that the forensic psychiatrist feels is integral to his or her public image can be of great assistance in establishing a forensic practice. On the other hand, a Web site that conveys a sense of being clever, playful, or unprofessional can harm the psychiatrist's reputation, image, and business.

Information that should be included in a Web site includes, of course, name, address, phone numbers, and e-mail. When considering what additional information to include, psychiatrists should bear in mind that information placed on a Web site is available to anyone and everyone, including patients. Psychiatrists should carefully consider how much information they want to make available to potential clients, opposing attorneys, evaluees, patients, and anyone else who might be interested. For example, even so straightforward and common a choice as including a photographic professional portrait or "head shot" will reveal gender, ethnicity, race, or age, which could affect potential referrals. Certainly, opposing attorneys will use any information that can make the psychiatrist look unprofessional or unscrupulous to attempt to discredit testimony or impeach the psychiatrist's reputation.

The choice of information to include on a Web site also depends on what sorts of referrals the psychiatrist desires. A forensic psychiatrist may wish to encourage referral of specific kinds of cases by stating parameters that encourage certain types of cases. For example, a psychiatrist can list areas of special interest or expertise, such as child custody evaluations. To this end, appropriate portions of a psychiatrist's CV can be and should be included. These include education, training, licensure, and board certification. Work experience in the forensic field might also be appropriate to include. Web sites should be updated regularly to reflect any changes in the CV or practice.

Case Lists

Forensic psychiatrists should keep a list of the cases in which they have been involved. When an attorney is interviewing a prospective expert witness, he or she may ask for a list of the cases on which the psychiatrist has worked

or provided testimony. Thus, such a list can be a useful marketing tool. In addition, Federal Rule of Civil Procedure 26(a)(2)(B) requires that a list of cases in which the expert has provided testimony in the past 4 years be submitted in any federal case, along with the expert's report, CV, and fee schedule. Therefore, the forensic psychiatrist should keep a list of cases going back at least 4 years. The list should include the name of the case, the court in which the case was heard, the date, and a two- to three-word description of the case. Examples of how a description might be listed include testamentary competence, child custody, and personal injury.

More information may also be included, such as whether the psychiatrist was retained by the prosecution or defense, the retaining attorney's name and contact information, and the case citation, as well as other potentially relevant information. Attorneys will often request this list as a way of obtaining "references." Attorneys can then contact the attorneys who previously retained the expert in similar cases.

Generally, however, the information on the case list should be limited to the minimum suggested here. Attorneys who request referrals can be provided that information directly by phone or e-mail. Printed information, as noted, is likely to be disseminated on the Internet. Psychiatrists then lose control over which attorneys they suggest as referrals or the potential use to which the case list may be put. Therefore, such lists should contain only the information necessary to satisfy the Rule 26 requirements. Psychiatrists can always provide additional information, such as names of retaining attorneys or the side for which they were retained, upon request (or at deposition) on a case-by-case basis.

Contracting With Clients

Utilizing business practices common to attorneys minimizes problems involved with collecting fees. Psychiatrists are generally unfamiliar with writing contracts for their services. In contrast, attorneys typically work on a contractual basis. Psychiatrists undertaking forensic work should be familiar with comparable acceptable and desirable billing practices that facilitate the ethical provision of forensic psychiatric services.

Case Vignette *(continued)*

Mr. W, the gentleman who contacted Dr. M to contract for a forensic evaluation for employment issues, does have an attorney, Mr. H. Mr. H contacts Dr.

M directly. Mr. H feels that Mr. W's negotiating position with his employer would benefit from having a forensic psychiatric evaluation. Mr. H explains that he does not want Dr. M to address causation of Mr. H's anxiety, but only to document the existence of an anxiety disorder for purposes of invoking the protection of the Americans with Disabilities Act. Mr. H proposes that Dr. M perform the evaluation, write a report, and suggest "reasonable accommodations." Mr. H offers to pay Dr. M half of a prenegotiated flat fee-for-service rate when Dr. M delivers the report, and the other half of the fee at the successful conclusion of the case. Assuming he has the appropriate training and expertise to undertake such an evaluation, should Dr. M agree to these conditions?

Retainer Agreements

Despite the fact that the contingency payment plan is being offered by an attorney instead of directly by the client, Dr. M should nevertheless refuse to accept this payment arrangement. Although not a problem for attorneys, contingency fees present a variety of ethical and practical problems for forensic psychiatrists (Gutheil and Simon 2002). The psychiatrist's objectivity and ability to render an unbiased opinion may be compromised if payment depends on agreeing with the client or on a positive outcome. For this reason, a contingency fee, that is, payment based on the retaining party collecting an award or damages, is considered unethical and should always be avoided (American Academy of Psychiatry and the Law 2005; see also Chapter 5, "Ethics in Forensic Psychiatry," this volume).

From a business perspective, payment on a contingency basis can create significant cash flow problems. Many legal cases take years to reach resolution. Dr. M is not likely to be able to go years without payment for time spent providing evaluations and reports, especially if significant time is spent on a case. A good business manager understands the necessity of managing cash flow; agreeing to wait until a case has concluded, regardless of whether payment is contingent on the outcome, is not good business practice. Payments, like services, should be rendered in a timely manner.

Attorneys typically have clients execute service agreements, also referred to as letters of understanding or retainer agreements, requesting advance payment as part of the contract for their services and detailing their fee schedule, which usually consists of billing by the hour or partial hour. Many of the forensic psychiatrist's clients are attorneys or entities familiar with the billing practices of attorneys and are not surprised when psychiatrists ask them to sign a retainer agreement or letter of understanding (Gutheil and Simon 2002). A retainer agreement establishes the contractual provisions for conducting and receiving payment for forensic services (Berger 1997; Granacher 2004). These agreements are contracts signed by both parties outlining the obligations of each. The

psychiatrist will evaluate the case and, if required, provide reports and testimony. The referral source will supply information, make arrangements, and provide payment for time the psychiatrist spends providing expert services.

One significant difference between an attorney's retainer agreement and a forensic psychiatrist's retainer agreement involves clarifying the identity of the client. Psychiatrists should understand that the attorney is the expert's client, and their retainer agreements should reflect this understanding. The retainer contract is between the psychiatrist and the retaining attorney. Although attorneys are paid by their clients and may execute a retainer agreement with their clients, the attorney is the party responsible by contract for paying the psychiatrist expert's fees.

Psychiatrists who plan to do a substantial amount of forensic work may want to have an attorney draft a retainer agreement that protects the psychiatrist's interests. Even with such agreements, misunderstandings regarding type and extent of services provided and problems collecting fees can and do arise. Having an agreement written by an attorney can minimize the occurrence of such problems. If a potential client is uncomfortable with certain terms in the standard retainer, the agreement can always be modified on a case-by-case basis. The retainer agreement in Figure 3–1 is offered as an example of a generic contract for forensic services.

Retainer agreements should set specific provisions for retainer fees and advance payments. Again, contrary to typical clinical practice, in which patients are billed after services are provided, in forensic work, fees should be paid in advance whenever possible and before undertaking work in any case. Advance payment supports and facilitates the ethical obligation to maintain honesty and strive for objectivity (American Academy of Psychiatry and the Law 2005) and avoids the ethical problems associated with payment of fees on a contingency basis.

Most forensic psychiatrists have a standard advance retainer fee, which they collect at the time that the retainer contract is signed. After the psychiatrist utilizes the time covered by that fee, he or she subsequently bills on a regular basis. Retainer agreements typically contain provisions requiring that all outstanding fees, including estimated fees for testimony, must be paid before testimony is provided, again, to avoid the appearance that the psychiatrist is being paid for testimony rather than time.

Certain exceptions to the general rule about requiring advance payment will arise. For example, insurance companies, government agencies, and courts typically do not provide advance payment but will pay a final bill based on a valid service agreement signed before work on the case begins. The psychiatrist may choose to waive or reduce retainer fees for clients with whom he or she has a long-standing working relationship and who have a track record of reliability in paying invoices regardless of the outcome of cases.

Thank you for referring your questions regarding the above named case to me for forensic psychiatric evaluation. I will be glad to offer my professional services regarding this case. Before I reserve time for this case, I ask that you send a retainer payment in the amount of $_____. No services will be provided until the retainer fee is remitted. In the event that time devoted to this case exceeds the retainer amount, I will bill you for further time. Payment will be expected promptly upon such additional billing.

My fee is $240.00 per 60-minute hour for reviewing records, performing examinations, preparing reports, conferring with attorneys, travel time, testifying time, waiting time, or time spent in any other way on this specific case. Billing is calculated in quarter hour increments. Depositions are scheduled for a minimum of 2 hours. Court appearances are scheduled for either a half day or full day. Full payment will be expected for appointments not kept, or for appointments not canceled 48 hours in advance. A charge may be made for deposition time, court time, or blocks of time longer than two hours, not canceled two weeks in advance. After you notify me that the case has been resolved, I will refund to you any unused retainer amount.

I recommend that you forward for my review all relevant medical reports, depositions, investigation reports, photographs, and other helpful information prior to my examination of the examinee. In order to make the most efficient use of my time, I suggest that you send all such records at least two weeks prior to the scheduled examination of the examinee.

Please sign below, indicating your acceptance of this service agreement and the contractual provisions contained herein and return it along with the requested retainer fee in the amount of $_____. Upon receipt of the signed document and retainer fee, I will countersign and send a completed contract back to you. If the signed service contract and retainer are not returned two weeks from the date of this letter, then my involvement in this case will stop, and my name may not be listed by you as a witness.

Please keep a copy of this service agreement for your records. Please contact me any time you have questions or further information. I look forward to working with you.

Contract accepted by:

_____ Date:_____

_____ Date:_____

FIGURE 3–1. Sample retainer agreement.

Preventive Contracting

Case Vignette *(continued)*

Dr. M has begun to establish a reputation in his community as an expert in a variety of cases involving juveniles and is beginning to receive a steady flow of referrals and cases. Attorney A represents a juvenile charged with a felony who will be tried as an adult. The case has received significant media attention. Attorney A asks for Dr. M's retainer agreement, which he executes, but Attorney A does not send the retainer fee. Dr. M understood from their initial phone contact that Attorney A would be making arrangements for an evaluation as soon as possible, given that the case was pressing. However, Dr. M receives no further contact from Attorney A, who will not even return Dr. M's phone calls.

A few weeks after receiving the executed retainer contract (absent the fee), the prosecuting attorney contacts Dr. M. The prosecutor also wants to retain Dr. M to evaluate the juvenile. The government contracts for psychiatric services and payment is made on a regular basis upon receipt of monthly invoices, although the government does not provide retainer fees. Dr. M does not know how to respond to the prosecutor. Has Attorney A retained him or not? He does not expect a retainer from the government. Is Attorney A's failure to pay a retainer fee any different? Does it mean Attorney A's signed retainer contract is invalid?

Attorneys sometimes use the tactic of preventive contracting to stop an expert witness from being retained by the opposing side of a case. Preventive contracting occurs when Attorney A contracts with the psychiatrist to evaluate a case but does not arrange for the evaluation to occur, because he never intended to have the psychiatrist evaluate the case. Having a contract with Attorney A, however, prevents the psychiatrist from contracting with Attorney B, the opposing attorney. In this way, Attorney A gains control over which experts are available to Attorney B.

In the case vignette above, Attorney A appears to have attempted to prevent the prosecutor from retaining Dr. M to evaluate his client. Assuming Dr. M has a retainer agreement that states that the fee as well as a signed contract are necessary to fully execute the agreement, Attorney A's failure to pay the retainer fee means that he has not retained Dr. M. If Dr. M had discussed waiving the retainer fee or had agreed that Attorney A could delay payment of the retainer, then Dr. M could have amended the retainer and had Attorney A sign an amended document. He would then be retained by Attorney A and not be available to provide services to the prosecution. However, Attorney A has not made such arrangements; he has simply ignored the fee requirement indicated in the retainer.

The fact that Dr. M would not receive a retainer fee from the prosecutor is not equivalent to Attorney A's failure to pay advance fees. It is not unethical or inappropriate to use different contracts that include different terms re-

garding advance fees for different clients. Forensic psychiatrists are free to make differing arrangements for payment, depending on the client and the circumstances. Dr. M may want to include in his retainer agreement an explicit statement indicating that the contract is not fully executed until all required signatures are obtained and advance payment is provided.

Psychiatrists can also limit their vulnerability to this legal maneuver by requiring prepayment, part of which can be nonrefundable after a certain point in time. A 2-week time limit is also commonly given for receipt of the prepayment. If prepayment is not received by the designated date, then the attorney is not allowed to name the psychiatrist as a witness. Another method of limiting this practice is to include a provision in the service agreement stating that unless the psychiatrist actually does some work on the case, the attorney is not allowed to name the psychiatrist as a witness.

Nuts and Bolts

Setting Up an Office

In the private sector, a forensic practice added onto a clinical practice is typically operated as part of a clinical practice that has infrastructure and procedures already in place. The psychiatrist uses the same office space to treat his or her clinical patients and to evaluate forensic clients' cases. In such a setup, the psychiatrist may not even need stationery or business cards that differ from the clinical stationery, if the printed material identifies the psychiatrist as both a clinical and forensic practitioner. As in a clinical practice, office equipment should allow fax, telephone, Internet, and scanning capabilities.

The psychiatrist can use a home office for many parts of forensic work, such as document review and report writing. However, interviewing forensic evaluees at home is not recommended. Forensic evaluees are typically engaged in an adversarial process and may identify the evaluating psychiatrist with their legal adversaries. Evaluees' emotions often run high, because litigation or even administrative proceedings often involve high personal and financial stakes. The psychiatrist has no way of conducting a risk assessment prior to the evaluation and thus may be taking unnecessary risks with personal or family safety by allowing evaluees into his or her home.

Home offices are also often not appropriate for depositions or meetings with attorneys, particularly opposing attorneys. Inviting attorneys into a home office should be considered a "forensic boundary violation" that po-

tentially compromises the forensic psychiatrist's effectiveness. The psychiatrist's home will inevitably offer insight into his or her personal life, tastes, financial status, and even academic interests. The most innocent personal items, such as books on display on a bookshelf, can and will be exploited by attorneys to compromise an expert's reputation or credibility. If the psychiatrist does not have access to office space appropriate for forensic activities such as depositions and meetings with clients, these can be scheduled at the client's office, a business center conference room, or a hotel conference room.

If the psychiatrist is a salaried employee, a sideline private forensic practice should probably be distinguished from the employment practice. For example, a separate mailing address, phone number, and business card might be necessary to distinguish the psychiatrist's position as medical director of an inpatient unit from his or her private forensic practice. Depending on the nature of the employment, the psychiatrist may also need a separate space for examining evaluees, or for all private forensic work. This can be arranged in a variety of ways, including renting a furnished and supported office space, subletting space in a colleague's office, negotiating use of the salaried employment office for use outside employment hours, or setting up a dedicated office outside the employment location.

The decision to obtain administrative assistance or to expand existing arrangements should be considered from a cost-benefit perspective. If the psychiatrist already has an administrative assistant attending to the clinical practice, this person can usually also absorb the administrative work involved in forensic practice. Depending on the needs of both the clinical and forensic practice, the psychiatrist may find the use of commercial companies who provide bookkeeping, transcription, billing, and other practice management services more time-effective and/or economical than hiring even a part-time administrative assistant. Regardless of the arrangement, the psychiatrist should bear in mind that he or she is ultimately responsible for the confidentiality of the material to which the administrative assistant or commercial company is privy, and breach of this confidentiality could create a professional and business disaster.

The written report is an essential marketing tool. The psychiatrist can generate reports using many technologies, from word processors to voice recognition software to dictation/transcription services. Regardless of how the report is generated, the psychiatrist should be certain that reports appear professional, competent, meticulous, and well written (Gutheil 2009; see Berger 2008 and Chapter 7, "The Forensic Psychiatric Examination and Report," this volume, for information on writing reports). The reports may be the only part of the psychiatrist's forensic evaluation actually seen by the client or a court. Both civil and criminal cases are more likely to be resolved

without a trial than with one. Thus, opportunities to testify as a means of demonstrating forensic skills are more limited than the opportunities to place a written product in front of a client, who often relies on such reports to help resolve cases without a trial.

Communications Systems

Communications systems in a wireless age comprise a variety of technologies. Clients may contact several experts when looking for psychiatric consultation. Attorneys are increasingly using e-mail to make first contact with psychiatrists who offer forensic services. Responding quickly, perhaps before the other psychiatrists contacted are able to respond, maximizes the chances of being retained in a case (Gutheil 2009). A communications system should therefore minimize response time from contacts to inquiries from potential referral sources. For example, a mobile phone that connects to the Internet and allows access to e-mail may be useful to the psychiatrist who practices in a variety of locations or whose work requires frequent travel.

Business Issues

Physicians, in general, are notorious for not understanding certain principles of business management; this is absolutely understandable. Few doctors obtain MBAs. They are, after all, immersed in the training needed to provide clinical care, not to manage complicated business tasks such generating aging accounts-receivable reports or designing billing practices that maximize collections. Physicians in large and small medical practices alike often hire staff to manage the business aspects of their practices. However, psychiatrists starting a forensic practice cannot afford to remain unaware of certain basic business issues or they will find more business-savvy clients will easily take advantage of them.

The Value of a Business Plan

Most business schools advocate developing a formal business plan when getting started in any business. For complex forensic practices, for example, those that involve a partnership or employment relationship between forensic service providers from multiple disciplines as well as support staff, a formal business plan may be useful and necessary (Granacher 2004). In contrast, a formal business plan is probably not going to be of assistance in achieving

practice goals for a solo practitioner who is adding some forensic cases to a clinical practice.

When setting out to start a forensic practice as a solo practitioner, the psychiatrist should spend some time considering some of the issues discussed previously, such as market position, and effective business organization and infrastructure. In addition, the psychiatrist should spend some time thinking about what percentage of time he or she wants to spend engaging in forensic versus clinical activities. This will indicate how actively he or she will need to be in marketing services and establishing a referral base.

The first goal of establishing a forensic practice should be to develop a steady stream of referred cases from clients. Typically, early-career forensic practitioners begin with a few cases and then decide whether they would like to obtain more cases and/or specialize in certain types of cases. If a small private forensic practice grows to become a large group practice with many employees and business goals, then the time and money needed to develop a business plan might be a useful tool for managing and developing practice goals.

To Incorporate or Not to Incorporate

A solo private practice physician can operate as a sole proprietorship or a professional corporation. Both arrangements have their advantages and disadvantages. Psychiatrists setting up a private practice that includes forensic work may wish to consult both an accountant or financial planner and an attorney to determine the costs and benefits associated with the decision of which business structure is most suited to their needs and goals. Little distinction between the professional's business and personal financial infrastructure exists for a nonincorporated sole proprietor. For example, a sole proprietor can use a personal bank account as both a business and personal account. Incorporating is an option for any solo practitioner, including one wishing to add forensic work to a clinical practice. However, a professional corporation requires separate bookkeeping, a distinct bank account, and its own tax return. A professional corporation must also be registered with the state as a corporation, complete with initial annual registration fees.

Billing and Bookkeeping

Forensic psychiatrists' billing practices typically mirror the billing practices of attorneys. Attorneys generally bill by the hour or fraction of the hour. This means billing by the quarter hour or tenth of an hour for time spent working on a case, including telephone time, waiting time, reading time, and travel time, as well as time spent examining, writing, and testifying. Statements should

be mailed regularly—at a minimum once a month. Accounts with large fees due may be billed once every 2 weeks.

Professional Liability Insurance

Professional liability for forensic services is relatively limited, but it does exist (Binder 2002; Gold and Davidson 2007). Psychiatrists adding forensic cases to their clinical practice should be certain that they understand their coverage. The two types of available malpractice insurance are occurrence and claims-made. *Occurrence insurance* covers events that allegedly occurred during a defined span of time, usually one contract year. The coverage is in place no matter when the claim is lodged. *Claims-made insurance* covers claims made during a defined span of time, regardless of when the alleged event occurred. Tail coverage must be purchased separately for claims-made coverage if coverage is to extend beyond the last year of the claims-made policy.

Regardless of whether psychiatrists have a claims-made or occurrence type policy, they need to specifically inquire as to whether the policy covers forensic practice. Some malpractice policies cover only treatment of patients, and not forensic work. Some policies require an extra premium to cover forensic work. If the psychiatrist's insurance does not cover forensic services or requires additional payment for such coverage, the psychiatrist should contact his or her professional liability insurance carrier to make appropriate arrangements.

Key Points

- The forensic psychiatrist's client is the attorney, court, insurance company, or employer who retains the psychiatrist to evaluate a case.
- A retainer agreement will contractually establish the responsibilities and obligations of both the psychiatrist and the retaining client and represents good business practices that avoid ethical problems associated with other types of fee arrangements.
- Thoughtful consideration of business models and practices will minimize problems that arise in nonclinical aspects of forensic practice.
- Forms of marketing should be carefully considered and pursued, if ethical and relevant.

Practice Guidelines

1. Establish procedures and infrastructure to support forensic psychiatry work, then expand and modify as the practice grows.
2. Obtain cases for a newly established forensic practice from existing contacts, even at lower fees, if necessary, to begin to establish a reputation and referral base.
3. Use a retainer agreement to contract with clients that includes arrangements for retainer fees as advance payment.
4. Be certain that every report represents your best work.
5. Consider consulting a financial advisor and attorney regarding financial and legal aspects of organizing a forensic practice.
6. Obtain appropriate professional liability insurance coverage.

References

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Bloomfield, CT, American Academy of Psychiatry and the Law, May 2005. Available at: http://www.aapl.org/pdf/ETHICSGDLNS.pdf. Accessed May 13, 2009.

American Board of Psychiatry and Neurology: Initial Certification in the Subspecialty of Forensic Psychiatry. Available at: http://www.abpn.com/fp.htm. Accessed July 5, 2009.

Berger SH: Establishing a Forensic Psychiatric Practice: A Practical Guide. New York, WW Norton, 1997

Berger SH: Template for quickly creating forensic psychiatry reports. J Am Acad Psychiatry Law 36:388–392, 2008

Binder RL: Liability for the psychiatrist expert witness. Am J Psychiatry 159:1819–1822, 2002

Federation of State Medical Boards: Expert Witness Qualifications. Available at: http://www.fsmb.org/pdf/grpol_expertwitness.pdf. Accessed July 14, 2009.

Gold LH, Davidson JE: Do you understand your risk? Liability and third-party evaluations in civil litigation. J Am Acad Psychiatry Law 35:200–210, 2007

Gold LH, Shuman DW: Evaluating Mental Health Disability in the Workplace: Model, Process and Analysis. New York, Springer, 2009

Granacher RP Jr: Starting a forensic practice, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 55–74

Greenberg SA, Shuman DW: Irreconcilable conflict between therapeutic and forensic roles. Professional Psychology: Research and Practice 28:50–57, 1997

Gutheil TG: The Psychiatrist as Expert Witness, 2nd Edition. Washington, DC, American Psychiatric Press, 2009

Gutheil TG, Simon RI: Mastering Forensic Psychiatric Practice. Washington, DC, American Psychiatric Press, 2002

Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–456, 1997

Suggested Readings

Berger SH: Establishing a Forensic Psychiatric Practice. New York, WW Norton, 1997

Gutheil TG: The Psychiatrist as Expert Witness, 2nd Edition. Washington, DC, American Psychiatric Press, 2009

Gutheil TG, Simon RI: Mastering Forensic Psychiatric Practice. Washington, DC, American Psychiatric Press, 2002

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Chapter 4

The Expert Witness

Thomas G. Gutheil, M.D.

Cross-examining attorney: Doctor, in your writings you have described the expert's "role." Are you admitting that you are faking your testimony?
Psychiatric expert witness *[baffled]:* I'm sorry, I don't understand the question.
Attorney: You repeatedly refer to the expert's "role," do you not?
Expert *[catching on]:* I see the problem! I'm not describing a role like that of an actor playing a part in a drama. I am describing the particular role function that an expert witness plays in the court system. I'm also indicating that your expert, who is also the plaintiff's treater, is in a role function incompatible with being an expert witness.

Every psychiatrist is expected to have some basic expertise in the field of psychiatry. Does that mean that every psychiatrist who ends up in a courtroom is consequently an expert witness? As the excerpt above, taken from an actual trial, suggests, the answer is "no," given that "expert witness" is the name of a particular role function within the legal system. Although this chapter applies specifically to the psychiatric expert witness, the basic principles are applicable to experts in all fields of endeavor who might be called into court to play that role.

I thank Robert Simon, M.D., members of the Program in Psychiatry and the Law, and James T. Hilliard, Esq., for useful comments.

The role of expert witness most closely resembles a consultation coupled with teaching. The psychiatrist provides a consult to the attorney, who draws on the psychiatrist's clinical knowledge to contribute to the psychiatric aspects of the legal case; the focus is on legal issues in legal—not clinical—contexts. In practical terms, this means that psychiatrists must become acclimatized to a system of thought composed of rules, assumptions about human nature, and basic philosophies often profoundly different from their own. Moreover, when psychiatrists enter the legal system, they play by the legal system's rules. This telegraphs the fact that often the task of the forensic psychiatrist is best understood as a translation process, bridging two disparate realms of discourse: psychiatry and law.

In fact, two separate translations occur in the practice of the expert witness. First, the psychiatric issue in the case, once identified, is translated into the relevant legal construct: does the psychiatric condition meet the legal criteria required, be they criteria for competence, responsibility, damages, or disability? Second, the answer to those questions (detailed in the section "The Opinion") is newly translated into common language that a lay jury or a psychologically unsophisticated judge might be expected to understand.

The consultation also draws on the witness's skills as a teacher. First, the witness teaches the lawyer the relevant psychiatry in the case. Later, if the case goes to trial, he or she teaches the jury. Obviously, both these teaching procedures require different approaches, imagery, and even vocabulary to be accomplished effectively in the respective contexts.

A second implication of the role of expert witness is that the forensic psychiatrist remains at heart a skilled and knowledgeable clinician even when translating data and concepts into those other realms. To function as an expert witness, the testifier need not be a forensic psychiatrist (though often such witnesses do have forensic training); what is required at a minimum is familiarity with the legal issues and context of the case, the ability to formulate a forensically relevant opinion, and the ability to testify usefully and to withstand cross-examination. All these qualities require that old standby—practice—and collaboration with the retaining attorney.

A *fact witness* is someone called into court to describe the observations of the five senses as they relate to a case; thus, the questions asked of that type of witness are variations on a theme, "What did you see (hear, smell, etc.)?" When a treating clinician is called to court to testify (as a fact witness) about a patient, the content of the testimony usually consists of direct observations of the patient and closely adherent concepts, such as diagnoses that the clinician reached or identification of the patient's behavior as a particular symptom or syndrome.

In contrast, an *expert witness,* after being qualified by the court, is entitled by that role to go beyond his or her own direct observations to draw in-

ferences and express opinions based on the observations of others (such as those contained in medical records or other documents, and observations of treaters or other witnesses) and to draw conclusions from those sources—conclusions that have legal significance, as the vignettes that follow will show.

Note that expert witnesses should be governed in their work by the ethical principles of honesty and striving for objectivity (American Academy of Psychiatry and Law 2005; see also Chapter 5, "Ethics in Forensic Psychiatry," this volume). *Honesty* as used here is another aspect of truth telling, regardless of whether one is under oath at the time. *Striving for objectivity* refers to the efforts made by the expert to minimize bias factors that may derive from a host of sources.

The psychiatrist usually enters the role of expert in two major ways. First, an attorney may ask the psychiatrist to serve in that role because of a recommendation from a colleague or friend, the psychiatrist's reputation, an article the psychiatrist wrote on the key subject, or some other unique qualification. This chapter is designed to make that transition both easier and more effective.

Second, you may decide on your own to step into this challenging field. Textbooks (see the references and suggested readings at the end of this chapter), courses, and fellowships are available to help you with your basic knowledge and skills in this new role.

Case Vignettes

Vignette 1

A patient on suicide watch on an inpatient unit screams something, then unexpectedly hurls himself through a window and dies from the fall. The family brings a malpractice suit against the treating psychiatrist, claiming that the suicide precautions were inadequate and that this inadequacy caused the suicide to be successful.

A different psychiatrist who happened to be passing nearby at the critical moment is called as a fact witness to tell the court what the man screamed, what his demeanor was, and who else was nearby. Here, the psychiatrist—though professionally trained in the field—is a bystander to the action and testifies as fact witness only on the data from her five senses.

The treating psychiatrist, now a defendant in the suit, is called as a fact witness to describe what the patient told her and explain her diagnoses, treat-

ment plan, and observations of the patient, as well as what precautions she had instituted.

Yet another psychiatrist, not associated with the treatment team or hospital, is called by the plaintiff's attorney as an expert witness to testify regarding the "standard of care." The standard of care is usually defined as being like "the care rendered by the average reasonable or prudent practitioner in similar circumstances"; the expert must be familiar with the exact wording of the standard for that jurisdiction. The standard of care in a malpractice context is the benchmark against which a particular patient's treatment is measured to determine whether the care was negligent—a conclusion drawn from all the data in the case. The defense attorney may retain a comparable expert to testify about how the care did not fall below that standard. The two experts, between them, in an adversarial proceeding, lay out for the jury the strengths and weaknesses of the psychiatric aspects of the malpractice case. The jury ultimately decides whether or not the care provided was up to the standard.

Vignette 2[1]

Dr. R helped Mrs. S leave her husband, whom she had described in treatment as abusive. In the custody battle following the divorce, Mrs. S's attorney asks for "a brief note on the therapy" to aid custody-related legal proceedings. Dr. R's note mentions the stress on Mrs. S of child-raising, her use of occasional diazepam for anxiety and to control excess alcohol use, and her efforts to leave a "sadomasochistic" relationship with her husband, labeled "a classic abuser." An unexpected subpoena designates Dr. R as "an expert," and during his "expert" deposition (examination under oath), the attorney reveals that his letter ("expert report") is interpreted as calling Mrs. S an inadequate mother, an abuser of alcohol and prescription drugs, and someone into "heavy S&M" paraphernalia. The attorney also notes that the husband is called a classic abuser without having been examined. Much is made of an ethics code from the American Academy of Psychiatry and Law, an organization about which Dr. R has never heard. Dr. R's reaction is, "That isn't what I meant at all!"

Here, Dr. R failed to grasp the basic paradigm shift involved in his transition from a treatment provider to his role as an expert witness. There are a number of reasons why treaters in general should not serve as experts; these reasons are extensively explored elsewhere (Strasburger et al. 1997; see also Chapter 2, "Introduction to the Legal System," this volume). The most crit-

[1]Modified from Gutheil and Hilliard 2001.

ical differences between treater and expert are that the clinician works only for the patient's welfare and the expert witness works for the truth, even if it might cause harm to the "examinee" (not "patient"); the expert warns the examinee about the lack of confidentiality in the examination and the need for objectivity under oath, come what may; and the empathic bond of treater with patient, so necessary for clinical work, would constitute a bias to the expert's forensically necessary objectivity.

Note also that the legal system may grasp for ethical standards from areas that the actual witness does not know. A consultation with a more experienced forensic psychiatrist might have averted some of these difficulties.

Vignette 3

A forensic psychiatrist had testified several years earlier in the trial of an alleged gangster as to his incompetence to be sentenced (a legal standard). On the basis of an extensive database and a direct interview, the expert had offered the opinion for the subject's attorney that the subject was psychiatrically incompetent.

Years later, in the context of an additional charge against the alleged gangster, the prosecution claimed to be calling the expert as a fact witness to certain data. The prosecutor played wiretapped tape recordings of the alleged gangster's recent conversations with family members and asked for the former expert's "reaction" to them. The former expert, now supposedly functioning as a fact witness, commented that the man sounded tired (data from the senses). The prosecutor pressed for more detailed responses. Sensing that the prosecutor was duplicitously seeking an essentially expert opinion (under fact-witness guise) about the mental condition of the alleged gangster, the expert replied that such an opinion would ethically require a present expert evaluation of the total clinical picture, medical records, tests, and so on—and that no fact witness could provide such an opinion. The prosecutor left disappointed.

Here, the contrast and tension between expert and fact witness roles constituted the crux of the psychiatrist's dilemma. The psychiatrist's challenge was to keep the narrow fact-witness role clearly in mind despite having previously served in the expert role, despite the temptation to give an expert's view again, and despite the attorney's attempt to distort that role.

In this connection, the expert's role has, on occasion, been described as "protecting the truth of the opinion from both attorneys." Behind this curious phrasing lies a useful truth. The retaining attorney has hired the expert and pays for the expert's time. Moreover, that attorney may be likeable and well-intentioned. These factors, no matter how welcome or refreshing, may constitute a potential bias, as will be discussed later in this chapter. The opposing attorney, on the other hand, exerts considerable effort through cross-

examination to challenge, refute, or invalidate the expert's opinion. Thus, the expert is called on to steer a straight course in presenting an expert opinion, based on appropriate expert function, between these two opposing pulls.

Vignette 4

A novice expert witness observed that early in her career she felt extremely triumphant when the side retaining her won the case and extremely crestfallen when her side lost. A senior forensic consultant pointed out that although this was a common early reaction, it constituted a form of bias by linking expert to outcome. In reality, he indicated, a case may be won or lost on a number of determinants, including jury demographics; opening statements; the nature, appearance, and demeanor of plaintiff, defendant, attorneys, or judge; and the simple facts of the case itself. The pitfall created by a personal investment in case outcome was the danger of slanting testimony to achieve a particular result—the attorneys win or lose, the expert just testifies. The novice expert felt relieved of excess pressure and worked toward a more realistic and dispassionate emotional position consistent with greater objectivity.

Vignette 5

An expert was asked in trial, "Do you know you are known as 'Dr. Ohfer'?" The expert was baffled and said no. The attorney explained that in the last two trials on this same issue the jury had ruled for the side opposing that expert; thus, the expert was "oh for two" in terms of "wins versus times at bat." The expert commented, "The trial outcome is not up to me; I just testify."

The Expert Witness Role: Two Fundamental Forensic Questions

The expert witness role differs in significant ways from that of the treating clinician.

Source of the Consultation

The first question an expert witness must ask is, for whom am I working? The treater works unambiguously for the patient and the patient's welfare. The expert witness, in contrast, works for the retaining person or agency. The latter is both the employer that gives the expert standing to present an opinion and a source of potential bias.

Scope of the Consultation

The second question for the expert witness is, what, if any, is the psychiatric aspect of this case? Or, what is the forensic psychiatric question I am being asked to answer? This question may be more difficult to answer than it first appears. Some attorneys are regrettably unclear regarding the nature of psychiatry and what a forensic consultation can reasonably provide. Attorneys may want psychiatrists to fulfill certain roles, such as that of lie detector, illness curer, mind reader, or mind changer, which lie outside the purview of even modern psychiatry.

The Issue of Bias

The bias issue is a vital element of expert witness work. Although no expert is bias-free in all circumstances, the expert's job description includes recognizing and overcoming any bias that may exist or arise. If the bias is insurmountable—for example, if the defendant is a relative—the expert should not accept the case.

Case vignette 4 describes the bias aspects of feeling that you win the case as an expert. On the popular Las Vegas–based television show *CSI: Crime Scene Investigation,* the lead character, Dr. Grissom, remarks, "Courts are like dice: they have no memory. What works this time may not work next time." Similarly, contextual factors in the courtroom will vary, and comparable expert testimony may be persuasive in one court and not the next.

What is the origin of bias? Working with an attorney may lead to liking or identifying with that attorney (or, for that matter, hating and being unable to identify with the attorney). These natural feelings may tempt the expert to slant his or her assessments for (or against) the attorney's position in the case (Gutheil and Simon 2002, 2004).

Because bias may derive from sources that are not conscious, it may not be possible to avoid or remove bias completely. A useful approach to the problem of bias may be to acknowledge it when asked, allowing the jury to make its own assessment of the impact of bias on the opinion. For example:

> "I assume [my bias is] that most persons are competent. However, in this case, based on the entire database, I believe this individual does not meet the pertinent criteria for competence."
>
> "I assume most physicians deliver reasonable care. However, in this case, based on the entire database, it is my opinion, I am sorry to say, that this physician fell below the standard of care."

Note that an expression of regret, such as in the last example, is not inappropriate when describing a colleague.

Money may serve as a bias, and perhaps the most critical one—the attorney who retained the psychiatrist wants to use the psychiatrist's services, and the psychiatrist wants to make a living and be retained again. These facts may create pressures to slant testimony—pressures the ethical expert must resist. The extreme proponent of this bias is the pejoratively labeled "hired gun." The hired gun sells testimony; he or she is willing to say whatever the attorney wants for the fee, rather than charging for the time it takes to perform the expert tasks.

Sometimes, expert witnesses may be retained directly by the court or judge. This neutral position tends to decrease somewhat the intensely adversarial nature of the process. Nevertheless, cross-examination by one side or the other is likely inescapable, and psychiatrists entering the legal arena should be prepared to defend their opinions in court.

The Expert's Database

The novice expert often falls into the common error of assuming that the clinical interview of the plaintiff or defendant or the current medical records are all that he or she needs to assess. Instead, in many cases, the database on which the opinion is based should extend beyond the immediate context. The term *database* refers to the totality of materials—records, legal documents, police and witness reports, and so forth—that is reviewed by the expert in assessing a case (Gutheil 2009).

The database may include interviews of litigants and, sometimes, psychological testing. Simon and Wettstein (1997) provide some useful guidelines for conducting forensic psychiatric examinations. Perhaps the most important step is to provide the examinee with warnings (Gutheil 2009) that distinguish the forensic proceeding, which takes place in an adversarial context, from the more familiar clinical interview, which is devoted to a patient's welfare. The examinee should be warned about the nonconfidentiality of the interview; the unpredictable, not necessarily favorable, effect of its conclusions; the freedom of the examinee to take breaks and to refrain from answering questions; and the freedom to consult with an attorney, as desired.

There are, of course, exceptions to so expansive a database. A defendant's competence to stand trial is based almost entirely on a here-and-now, present-state examination (see Chapter 7, "The Forensic Psychiatric Examination and Report," this volume), but the expert is usually obligated, as noted, to review comprehensively many data sources, depending on the nature of the

case. Such sources include past medical, school, and military records; legal documents such as deposition transcripts, interrogatories, and affidavits; witness and police reports; and similar materials. In addition, the expert should compare these items, one with another, to seek inconsistencies, contradictions, or corroborations that may emerge from such comparative processes.

The expert should insist on obtaining all relevant data. Regrettably, occasionally, an attorney will withhold even critical data for reasons of cost, expediency, or venality. Alternatively, shortcuts, such as a deposition or record summary instead of the whole document, will be offered. These maneuvers should be resisted and, if continued, may serve as grounds to withdraw from the case, because such maneuvers compromise the expert's necessarily comprehensive view of the case.

The Opinion

The development of the preliminary opinion about the merits of the case is the "go–no go" pivot point. After careful review of the entire database, the expert must decide whether, from a forensic psychiatric viewpoint, the case has merit for the retaining side. This may be a black-and-white issue or one of shades of gray. With strict candor, the expert shares that opinion in all its complexity with the retaining attorney. The attorney then makes an independent decision as to whether the expert can help the case. If not, the parties part in a friendly manner. If so, the expert may or may not write a report about the opinion, may or may not be deposed (examined under oath) by the opposing attorney or attorneys, and may or may not actually testify in court. This last task depends on the host of vicissitudes to which cases are subject, such as varying jurisdictional rules, attorney strategies, and successful challenges to the admissibility of the opinion, settlement, dismissal, mistrial, summary judgment, and the like.

In "gray-zone" cases, the expert and attorney may have to negotiate the extent, limits, and boundaries of the expert's opinions. This is the art of forensic work (Gutheil and Simon 2002). The expert often walks a tightrope between maintaining flexibility as to phrasing and emphasis and yielding to attorney pressures to alter substantive aspects of the opinion (Gutheil and Simon 1999; Gutheil et al. 2001). Probably no guiding factor is as critical here as actual experience.

This negotiation is especially common regarding expert reports, which provide a durable record of the expert's opinion and may be used at trial to assert a point or to challenge or impeach the report's author. Changes in wording (e.g., to precisely match statutory language) can usually be accepted

but may have to be acknowledged on cross-examination. Attempts by the retaining attorney to alter substantive elements of the report must be resisted. Persistent attempts to get the expert to change substantive wording may be grounds for withdrawing from the case (Gutheil et al. 2004).

Note that not all experts are chosen with the goal of ultimately testifying. The "consulting expert" may play several behind-the-scenes roles such as guiding the attorney's literature search, identifying impeaching data about the other side's expert opinion, and aiding in jury selection. For various reasons (Strasburger et al. 1997), the consulting expert should usually not move into the testifying role.

Qualification

Although any psychiatrist with adequate training and experience may demonstrate expertise in treatment, consultation, lectures, or articles, an expert witness is essentially defined by being so qualified by a court. One might informally say that an expert is anyone whom the court qualifies as an expert (Gutheil 2009). Support for this broad statement may be drawn from the fact that residents in training may be qualified as expert witnesses for hospital-based commitment hearings (though, of course, the functional role of supplying the court with observed data more closely resembles that of fact witness).

Qualification of an expert is a stage in court proceedings in which the attorney who retained the expert reviews before the court the expert's general and specific credentials and the experiences that suit the expert to render opinions in this particular case. After such review, the attorney formally or informally proffers the witness as an expert to the court. The attorney for the other side of the case may accept the witness, argue about accepting the witness, ask the witness questions to probe his or her credentials further, challenge the suitability of the witness or of the witness's methodology (see next section, "New Expert Thresholds"), and so on. The opposing attorney's approach, as described, is termed *voir dire* (loosely translated, "see what [the expert] will say"). The judge rules on the matter, and the expert either becomes or does not become an expert witness.

The judge's decision may be influenced by complex factors outside the expert's control. For example, Massachusetts had recently enacted a new "wrongful death" statute that articulated under eight headings the various deprivations that would accrue to survivors when someone died through presumed negligence. These deprivations included effects such as losses of income, consortium, companionship, and so on. An expert in a wrongful

death malpractice case, apprised of this new standard, spent considerable effort in identifying the various components of the case that would fit each of the elements of the new law. After painstaking presentation of these views in a jury-excluded voir dire, the judge commented, "Well, I am not going to make any new law." The expert was dismissed without giving trial testimony. Although frustrating, such vicissitudes must be accepted as outgrowths of court function to which the expert has submitted.

New Expert Thresholds

Forensic psychiatrists and courts have both been troubled by the arrival in courtroom testimony of what has been called "junk science" (Gutheil and Bursztajn 2003). This term refers to expert opinions that are based on specious, idiosyncratic, or unsupported testimony that does not draw on current scientific evidence but instead appears to flow from the expert's wish to persuade the jury, willy-nilly, about the point at issue.

An important series of decisions by the U.S. Supreme Court—*Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), *General Electric Co. v. Joiner* (1997), and *Kumho Tire Co. Ltd. v. Carmichael* (1999)—coupled with the Federal Rules of Evidence that govern federal courts, have addressed the thresholds for admissibility of expert testimony in the federal court system; a number of state courts have also adopted the general principles involved. The first such case, *Daubert v. Merrill Dow Pharmaceuticals, Inc.* (1993), designated trial judges as screeners (called "gatekeepers") of expert testimony before it is presented to the jury; the latter two cases, *General Electric Co. v. Joiner* (1997) and *Kumho Tire Co. Ltd. v. Carmichael* (1999), essentially refined the details. The requirements of the cases gave rise to the possibility of "*Daubert* hearings": preliminary hearings before the judge to determine whether the expert's testimony met the essential criteria of relevance and reliability. That is, the expert's opinion had to be based on science relevant to the case at hand, and the methodology used to reach the opinion had to be based on reliable science (Gutheil and Stein 2000). The court suggested some criteria for reliability, such as established professional opinion, peer-reviewed literature, known error rates, and the like (*Daubert v. Merrell Dow Pharmaceuticals, Inc.* 1993). Although not constituting a definitive checklist, these criteria may be useful for the expert to keep in mind in preparation of an opinion.

Like a number of useful principles, the use of a *Daubert* hearing can also be abused (Gutheil and Bursztajn 2005). The hearing may be used as a stalling tactic, as an opportunity to obtain a sneak preview of the expert's opinion

at court expense, and so on. Regardless, the expert must be prepared to present valid methodology in such a setting, as well as in court.

In this series of cases, in addition to defining the practice for federal courts, the U.S. Supreme Court set the conceptual bar for expert testimony and provided some guidance as to what level of support the expert's opinion must have before it is presented to any court. Experts are thus advised to be clear about their methodology in presenting an opinion.

Standard for Opinions

The expert expresses opinions to "a reasonable [degree of] medical certainty" (Rappeport 1985). This legal term does not mean "certainty" in its common usage. Rather, in many jurisdictions, what the expert expresses as an opinion must be true "more likely than not" (but psychiatrists should check the relevant standard in the jurisdiction in which they are operating.) Although "more likely than not" is the common phrasing, it may be expressed as "reasonable psychiatric (or psychological) certainty," "reasonable medical probability," or similar phrasings. The meanings are similar, but the expert should consult with the retaining attorney to clarify the local standard and its exact wording.

The expert's testimonial threshold (standard for testimony) of reasonable medical certainty should be distinguished from the standard of proof that a judge or jury must reach to render a verdict. Depending on jurisdiction and issue, the standard may be "preponderance of the evidence," "clear and convincing evidence," or "beyond a reasonable doubt." Thus, the jury is operating at a different, and legally driven, threshold from that of the expert.

As noted earlier, the third standard relevant to expert witness practice is the standard expressed in the criteria for the particular issue—for example, the standard for competence to stand trial. These criteria are usually established by legal statutes but may be formed in case law, the ultimate decision in a relevant legal case.

Common Pitfalls in Expert Witness Practice

Even experienced expert witnesses are vulnerable to the narcissistic pitfall of feeling that the case is in their hands, to win or lose at will, or that they are

somehow the center of the case. In reality, operating in a foreign environment such as the courtroom (Gutheil 1998), experts are lucky to be able to shape even their own testimony, given that admissibility considerations; vigorous cross-examination, accompanied by attempts to distort that opinion; and the limitations of the attorneys on both sides may conspire to make the expert's goal—teaching the jury something useful about the psychiatric aspects of the case—frustratingly incomplete. The true position of the expert was beautifully captured by Robert Simon (personal communication, December 1998), who noted that "the expert witness is a hood ornament on the vehicle of litigation, not the engine." Accepting this image should inspire proper expert humility.

A related pitfall is the illusion of control. Although an expert may use skill, training, and experience to provide a clear, data-based, and persuasive opinion in direct testimony, much of what happens in the courtroom beyond that point, including the jury's ultimate decision, is quite outside the expert's control. This reality limitation must be accepted if one wishes to work within the court system.

Beginning experts may encounter the "clinical pitfall" as well. Confronted with a strange setting in court, the novice expert may retreat to the belief that familiar clinical considerations will apply to this new world—that the court has a therapeutic purpose or intent; that the welfare of the patient, party, or examinee is paramount in everyone's mind; and that being helpful to a victim or a mentally ill person is the shared goal.

None of these principles apply. The legal system operates on time-honored precedents aimed at a perception of fairness and is not driven by primary clinical concerns such as doing no harm, even to ill persons. Furthermore, instead of operating as current clinicians do in an alliance-based collaborative team approach, the law operates within an adversarial system whose representatives attempt, in essence, to thwart—not aid—each other.

Perhaps the most subtle and challenging pitfall for the beginner is the failure to understand the fundamental and profound difference between the attorney's appropriate and unconflicted partisanship in a case—an essential element of the adversary model—and the expert's needed nonpartisan objectivity. Put another way, the attorney advocates for the retaining party and advocates energetically for that side to win the case. The expert, having painstakingly formed an opinion, advocates only for that opinion, and energetically attempts, within the limits of courtroom rules, to prevent that opinion from being inappropriately distorted, misrepresented, or obscured by cross-examination.

A clinician usually functions by scheduling various clinical activities, from patient appointments to grand rounds, in a regular and systematic manner. This may make the legal system's quite irregular approach confusing and demoralizing to the beginner. Beyond the classic "hurry up and wait" rhythm of the courtroom, the novice expert must learn to expect last-minute post-

ponements, continuances, precipitous calls into court on short notice, and other manifestations of chaos theory.

Out-of-State Practice and Its Vicissitudes

In assessing the standard of care, some states accept a national standard of care based on national meetings and journals; other jurisdictions subscribe to a locality rule, requiring the expert to be aware of the standard of practice in that particular locality. The expert must obtain from the retaining attorney the actual standard being used in that case.

As part of a multifocal effort to thwart "hired gun" testimony, in which out-of-state experts are viewed as coming into a state and testifying as to the standard of care to which local doctors must be held, some states and the American Medical Association have taken steps aimed at containing or controlling hired-gun practice. Some states demand that the expert be licensed in the state of testimony or that the expert have spent a specified percentage of time in defined clinical practice.

Experts, in dealing with this problem, have used several approaches. First, the expert may consult to a local physician, a procedure that may not require local licensure. Second, the expert may obtain temporary licensure in that jurisdiction or similar dispensation via the local board of registration in medicine. As a rule, the retaining attorney should take the lead in clearing the way for the expert to testify, whatever may be required.

In a curious move, the American Medical Association has taken the position that forensic work is the practice of medicine, with the apparent aim of permitting control of expert testimony through peer review or board of registration complaints (Zonana 1999). This organizational decision, of course, does not resolve the ethical, legal, or clinical dilemmas of an expert being considered a (treating) clinician (Simon and Gutheil 2003; Simon and Shuman 1999; Strasburger et al. 1997). In the same time frame, ethics complaints and attempted civil suits against experts have increased.

Conclusion

Despite its many pitfalls and the inherent challenge of shifting paradigms from a treatment context, the role of expert witness presents many opportu-

nities both to teach and to assist the legal system. The intellectual stimulation of attempting to translate among differing realms of discourse also provides great reward. When the task is properly and ethically undertaken, the expert witness can make a significant contribution to this specialized area of psychiatric practice.

Key Points

- The expert witness draws conclusions from the database; the fact witness reports on data from the five senses.
- The first forensic question is, "For whom am I working?"
- The second forensic question is, "What is the forensic psychiatric question I am being asked to answer?"
- The expert is qualified by the court to give testimony that is reasonable and reliable.
- The expert's opinion formulation requires objectivity and awareness of possible bias.
- The expert's opinion is given to reasonable medical certainty.
- The novice expert witness may encounter pitfalls of narcissism, illusions of control, clinical reasoning, and complexities of expert advocacy. Similar to countertransference, these should be countered.

Practice Guidelines

1. Understand the meaning of the expert's role functions in the legal system.
2. Thoroughly review the database, and request missing pieces from the attorney.
3. Derive an opinion supportable by the evidence in the database. This may mean telling the retaining attorney that you cannot support the case. Be morally, financially, and psychologically prepared to turn down a case that has no merit.
4. Strive to overcome bias or, failing this, pass on the case. The overarching principles of honesty and striving for objectivity should govern the process.

5. In "gray zone" cases, negotiate with the attorney about the limits and boundaries of the opinion, permitting flexibility but resisting attorney pressures for substantive changes.
6. Do not, with some exceptions, serve as expert witness for your own patients. In rare cases—geographic unavailability of other clinicians or unique training or knowledge—you may be drafted into the expert role, though this may alter the treatment relationship.
7. Accept and prepare for the chaotic time lines of the legal system.

References

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Bloomfield, CT, American Academy of Psychiatry and the Law, May 2005. Available at http://www.aapl.org/pdf/ETHICSGDLNS.pdf. Accessed January 6, 2010.

Daubert v Merrell Dow Pharmaceuticals, Inc, 509 U.S. 579 (1993)

General Electric Co v Joiner, 522 U.S. 136 (1997)

Gutheil TG: The Psychiatrist in Court: A Survival Guide. Washington, DC, American Psychiatric Press, 1998

Gutheil TG: The Psychiatrist as Expert Witness, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2009

Gutheil TG, Bursztajn H: Avoiding ipse dixit mislabeling: post Daubert approaches to expert clinical opinions. J Am Acad Psychiatry Law 31:205–210, 2003

Gutheil TG, Bursztajn HJ: Attorney abuses of Daubert hearings: junk science, junk law, or just plain obstruction? J Am Acad Psychiatry Law 33:150–152, 2005

Gutheil TG, Hilliard JT: The treating psychiatrist thrust into the expert role. Psychiatr Serv 52:1526–1527, 2001

Gutheil TG, Simon RI: Attorneys' pressures on the expert witness: early warning sings of endangered honesty, objectivity and fair compensation. J Am Acad Psychiatry Law 27:546–553, 1999

Gutheil TG, Simon RI: Mastering Forensic Psychiatric Practice: Advanced Strategies for the Expert Witness. Washington, DC, American Psychiatric Publishing, 2002

Gutheil TG, Simon RI: Avoiding bias in expert testimony. Psychiatric Annals 34:258–270, 2004

Gutheil TG, Stein MD: Daubert-based gatekeeping and psychiatric/psychological testimony in court: review and proposal. J Psychiatry Law 28:235–251, 2000

Gutheil TG, Commons ML, Miller PM: Withholding, seducing and threatening: a pilot study of further attorney pressures on expert witnesses. J Am Acad Psychiatry Law 29:336–339, 2001

Gutheil TG, Bursztajn H, Hilliard JT, et al: "Just say no": experts' late withdrawal from cases to preserve independence and objectivity. J Am Acad Psychiatry Law 32:390–394, 2004

Kumho Tire Co, Ltd v Carmichael, 119 S.Ct. 1167 (1999)

Rappeport JR: Reasonable medical certainty. Bull Am Acad Psychiatry Law 13:5–15, 1985

Simon RI, Gutheil TG: The forensic expert practicing on the road: new hazards along the way. Psychiatric Annals 33:302–306, 2003

Simon RI, Shuman DW: Conducting forensic examinations on the road: are you practicing your profession without a license? J Am Acad Psychiatry Law 27:75–82, 1999

Simon RI, Wettstein RM: Toward the development of guidelines for the conduct of forensic psychiatric examinations. J Am Acad Psychiatry Law 25:17–30, 1997

Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–456, 1997

Zonana H: Medical director's report. Newsletter of the American Academy of Psychiatry and the Law 24:3–4, 1999

Suggested Readings

Appelbaum PS: A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law 25:233–247, 1997

Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law, 4th Edition. Baltimore, MD, Lippincott, Williams & Wilkins/Wolters Kuwer, 2008

Berger S: Establishing a Forensic Psychiatric Practice. New York, WW Norton, 1997

Babitsky S, Mangravitti JJ: How to Excel During Cross-Examination: Techniques for Experts That Work. Falmouth, MA, SEAK, 1997

Brodsky SL: Testifying in Court: Guidelines and Maxims for the Expert Witness. Washington, DC, American Psychological Association, 1991

Candilis PJ, Weinstock R, Martinez R: Forensic Ethics and the Expert Witness. New York, Springer, 2007

Gutheil TG: The Psychiatrist in Court: A Survival Guide. Washington, DC, American Psychiatric Press, 1998

Gutheil TG: The Psychiatrist as Expert Witness, 2nd Edition. Washington, DC, American Psychiatric Press, 2009

Gutheil TG: The psychiatric expert witness. Psychiatric Times 19:37–39, 2002

Gutheil TG, Dattilio FM: Practical approaches to forensic mental health testimony. Baltimore, MD, Lippincott, Williams & Wilkins/Wolters Kluwer, 2007

Gutheil TG, Simon RI: Mastering Forensic Psychiatric Practice: Advanced Strategies for the Expert Witness. Washington, DC, American Psychiatric Publishing, 2002

Feder HA: Succeeding as an Expert Witness. Glenwood Springs, CO, Tageh Press, 1993

Melton GB, Petrilla J, Poythress NG, et al (eds): Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 1997

Poynter D: The Expert Witness Handbook: Tips and Techniques for the Litigation Consultant, 2nd Edition. Santa Barbara, CA, Para, 1997

Schouten R: Pitfalls of clinical practice: the treating clinician as expert witness. Harv Rev Psychiatry 1:645–665, 1993

Chapter 5

Ethics in Forensic Psychiatry

James L. Knoll IV, M.D.

***The term* ethics** can be described generically as a way of examining moral life. Whereas ethics often refers to theoretical perspectives, morality most often refers to actual conduct (Beauchamp and Childress 1989). In other words, "Ethics is the field of study and reflection concerned with morality" (Daly, personal communication, April 2, 2009). Although an ethical *conflict* is a serious disagreement regarding what ought to be done (or not done), which impedes the maintenance and development of the moral community, an ethical *dilemma* is a situation in which one must choose between or among equally demanding but incompatible courses of action. From a cultural perspective, one may think of "ethics" as a command of the extant superego of a civilization (Freud 1961). Physicians have used the term *medical ethics* to refer to "the principles of proper professional conduct concerning the rights and duties of the physician himself, his patients, and his fellow practitioners, as well as his actions in the care of patients and in relation with their families"(Stedman's Medical Dictionary 1990, p. 540). *Legal ethics* speak to moral obligations as well and have been defined as "the standards of minimally acceptable conduct within the legal profession, involving the duties that its members owe one another, their clients, and the courts" (Black's Law Dictionary 1999, p. 904). The unique discipline of forensic psy-

chiatry "operates at the interface" of these often "disparate disciplines—law and psychiatry—with differing objectives, philosophies, values, approaches, and methods" (Weinstock et al. 2003, p. 56). Thus, it is only to be expected that functioning at this interface will "frequently lead to ethical conflicts" (Weinstock et al. 2003, p. 56).

Turning to the concept of *justice,* it may be said that justice refers to the fair or proper ordering of resources and persons within a society (Black's Law Dictionary 1999). A closely related meaning involves conformity to truth, fact, or reason. In the commentary to the preamble of the American Academy of Psychiatry and the Law's (AAPL) ethical guidelines, AAPL notes the importance of balancing competing obligations to the individual and society. In seeking to maintain this balance, AAPL stresses that forensic psychiatrists should be bound by the following underlying principles, which include 1) respect for persons, 2) honesty, 3) *justice,* and 4) social responsibility (American Academy of Psychiatry and the Law 2005). Further, it has been noted that American forensic psychiatrists gear their ethical deliberations with a focus on upholding the ends of justice. In this justice paradigm, forensic psychiatrists are expected to act in accordance with respect for justice principles (Arboleda-Florez 2006).

Upon considering the iconic legal representation of justice—the famous statue of "Lady Justice"—one notices that "evil," in the archetypal form of a snake, is being held to the "letter of the law" (a legal book of societal laws). One also notices that Justice is "blind" (i.e., blindfolded) to all but the proper balance of her scales; this is the legal and criminal justice view. But, as with any great metaphor, there are alternate views. Another view, psychological in nature, is to see the snake as humanity's unrestrained instinctual impulses—its natural passions. This raw, animalistic desire is restrained against (and by) man's rules and regulations, or, in other words, his morality or conscience. Thus, Justice, in this view, is responsible for maintaining this position; but note carefully that she has given up some of her freedom in doing so. She no longer has a true free range of movement; she has made a *compromise,* which is essential for life in free society. In fact, her compromise formation has left her in a potentially dangerous situation. Should she ever become weary or distracted and let up on her foot, the backlash will be unpleasant. She is, in a sense, a prisoner to humanity's passions.

When performing the work of a forensic psychiatrist, the psychiatrist removes his or her clinical/treatment-oriented hat and dons the hat of the forensic scientist and expert witness (Strasburger et al. 1997). Stepping into the legal arena, and outside the comfort zone of the more familiar clinical setting governed by medical ethics, is the essential compromise in the practice of the forensic psychiatrist. In making this compromise, the forensic psychiatrist sacrifices the comfort of the doctor-patient relationship for the challenge

of justice and social responsibility. Indeed, it has been noted that "without information from well trained and competent forensic psychiatrists in certain cases, there is an increased likelihood of miscarriage of justice" (Dike 2008, p. 183). The general medical ethics principles of beneficence, confidentiality, and nonmaleficence (first do no harm) (Roberts and Dyer 2004) cannot follow the psychiatrist, as expert witness, into the courtroom without seriously compromising the accuracy and objectivity of the testimony provided. Thus, forensic psychiatrists "operate outside the medical framework" when they enter the legal realm, and the ethical principles by which their behavior is justified cannot be the same (Appelbaum 1990). The principles of beneficence and nonmaleficence lose their primacy to the principles of truth, honesty, and objectivity in a forensic legal setting. In the early 1980s, however, former American Psychiatric Association (APA) president and Harvard law professor Alan Stone took a different and distinctly critical view of forensic psychiatry, one that ultimately inspired American forensic psychiatry to set about the task of crafting a set of formal ethical guidelines.

Alan Stone and the History of American Forensic Psychiatric Ethics

On March 30, 1981, John Hinckley wrote a letter to actress Jodie Foster. The note, in part, read as follows:

> Jodie, I would abandon this idea of getting Reagan in a second if I could only win your heart.… I will admit to you that the reason I'm going ahead with this attempt now is because I just cannot wait any longer to impress you.… By sacrificing my freedom and possibly my life, I hope to change your mind about me.…please look into your heart and at least give me the chance, with this historical deed, to gain your respect and love. (Hinckley 1981)

Several hours later, Hinckley committed his "historical deed." In June of 1982, he was found not guilty by reason of insanity. In a sense, Hinckley's morbid infatuation with an American actress precipitated a series of events that would have a profound effect on American forensic psychiatry and the ethical guidelines that would later develop in the field. The verdict led to widespread discontent with the insanity defense, as well as with the reliability of psychiatric expert witness conclusions (Fulero and Finkel 1991). It was during the uproar and ferment surrounding the verdict and criticism of forensic psychiatry that Professor Stone delivered his 1982 AAPL address on the "ethical boundaries" of forensic psychiatry (Stone 1984).

It is important to note that at that time, there was intense derision of forensic psychiatry among the public and media (Bloom and Dick 2008). The Hinckley verdict appeared to increase the tension in an already strained relationship between organized general psychiatry and forensic psychiatry. Dr. Stone, representing the APA as a former president, delivered an unsettling but critical message to the profession of forensic psychiatry: immediate progress was required in terms of developing ethical standards and guidelines for the profession (Bloom and Dick 2008). In his address, Dr. Stone put forth four key issues that he believed rendered forensic psychiatry inherently unreliable and ethically untenable (Stone 1984):

1. Psychiatry may not have anything "true" to say that the court should listen to (i.e., does psychiatry possess enough scientific certainty and reliability to be proffered as evidence in court?).
2. There may be a risk that the psychiatrist will twist the rules of justice and fairness to help a "patient."
3. There may be a risk that the psychiatrist will deceive the "patient" in order to serve justice and fairness.
4. There may be a danger that the psychiatrist will prostitute the profession.

First, Stone questioned whether or not psychiatrists' testimony was "true" or certain enough for the courts to rely on. He was also worried about dual-agency concerns, such as a psychiatrist's allegiance to a "patient" causing him or her to "twist" testimony, either consciously or unconsciously, in the name of patient beneficence. After all, is it not a physician's highest ethical duty to do what is in the patient's best interest? Alternatively, there was the opposite risk—that the psychiatrist would use the disarming, "helper" mantel of the physician to better obtain information from a defendant that would ultimately be used to the defendant's detriment. Finally, were forensic psychiatrists to conduct themselves in an unscrupulous manner, following the credo of the "hired gun," would this not have the effect of prostituting the profession and ultimately denigrating it in the eyes of society (Mossman 1999)? Ultimately, Dr. Stone's opinion in 1982 was that "[f]orensic psychiatry is caught on the horns of an ethical dilemma. It is a painful position to be in, but the greater danger is to think that you have found a more comfortable position, that you can simply adjust to the adversarial system or remain true to your calling as a physician" (Stone 1984, p. 218).

To this day, many psychiatrists and forensic psychiatrists in the United Kingdom remain in firm agreement with Stone's early criticisms. In the United Kingdom, forensic psychiatry is more synonymous with correctional and forensic treatment, whereas, in the United States, it is most often associated with the role of expert witness (Arboleda-Florez 2006). From across the ocean

and this cultural divide, U.K. psychiatrists have observed that their "American brothers took a different path. Their mission was education, and they became scholars…rather than ministry to the sick. As befitted their scholastic pursuits, they named their order after the fruit of the tree of knowledge and became known as the Order of the Apple" (Grounds 2008, p. 1). Many psychiatrists in the United Kingdom hold the position that American forensic psychiatrists "mislead themselves…in thinking that beneficence and nonmaleficence could be so easily discarded (in the courtroom), because these principles defined their profession and were the basis on which they made judgments about treatment needs of defendants.…How can striving for truth and objectivity alone tell you what ought to be done?" (Grounds 2008, p. 3).

Despite these misgivings, the American brethren were not so easily discouraged. Paul Appelbaum, one of Stone's foremost pupils, who would later become an AAPL and APA president, took up the cause of laying out a well-reasoned ethical foundation from which American forensic psychiatry could begin to advance itself. Appelbaum (1990) pointed out that psychiatrists operate outside the medical framework when they choose to do work in the courtroom, and, thus, the ethical principles guiding their behavior cannot be the same. Appelbaum contended that the principles of beneficence and nonmaleficence lose their "primacy" to the legal principle of truth when a psychiatrist functions as expert witness in a courtroom setting. For example, one overriding principle for the forensic expert should be to gather and objectively present the maximum amount of relevant data so as to most accurately present opinions that answer the forensic-legal question the court is asking.

Approximately 25 years later, Stone's address continued to serve as a reminder of the importance of developing an ethical basis for the practice of forensic psychiatry in the United States. It has been noted that "[e]thics, neglected or ignored before Stone, are now center stage.…His critiques have not doomed forensic psychiatry; they have made it better intellectually and morally" (Miller 2008, p. 193). In 2007, at AAPL's 38th annual meeting, Dr. Stone returned to share his updated views on the ethics of forensic psychiatry (Stone 2007). In sum, Stone's position was still cautious, but slightly more optimistic about the possibility of developing an ethic (a system of ethics) for forensic psychiatry (Miller 2008). More recently, Appelbaum has observed that where forensic psychiatrists follow a responsible set of ethics principles (based on truth-telling and respect for persons), they are in a better position to "offer reliable and valid testimony" and avoid lapsing into an advocacy role (Appelbaum 2008, p. 195).

Professor Steven Morse, another of Stone's students, has argued that forensic psychiatrists are no different in terms of their ethical obligations than

any other experts who offer their services to the law. Although there may be a host of factors that lead forensic psychiatrists to act unethically, this is true of virtually all experts who render opinions for the court (Morse 2008). In sum, the current perspective would appear to be that the issue is "not so much about whether they [forensic psychiatrists] should avoid the courtroom, but how they should conduct themselves in it" (Dike 2008, p. 181). Over the past several decades, experts in the field have viewed the primary flaw in Stone's criticisms as relating to "his frequent characterization of individuals examined by forensic psychiatrists as *patients*…" (Dike 2008, p. 183; emphasis added). But in the forensic-legal setting, a *defendant* is "seeking to resolve a legal rather than a medical problem, the defendant is not a patient, nor indeed is the defendant the client; the client is the court" (Grubin 2008, p. 186). From this perspective, the problem that the forensic psychiatrist is resolving is not a medical matter, but a legal one. Others have noted that "without information from well trained and competent forensic psychiatrists in certain cases, there is an increased likelihood of miscarriage of justice" (Dike 2008, p. 183). Similarly, it has been argued that taking Stone's criticisms too literally (i.e., eliminating the role of forensic psychiatrist as expert witness) "would adversely affect the goals of achieving fairness and justice in our society" (Dike 2008, p. 184).

Basic Principles and Guidelines

The principle of "respect for persons" has been described as simply having respect for the human dignity of the evaluee. This guideline would proscribe engaging in "deception, exploitation, or needless invasion of the privacy of the evaluee" (Appelbaum 2008, p. 197). Respect for persons may also be used to refer to "not capitalizing on [the evaluee's] misunderstanding of [the forensic psychiatrist's role] and by keeping information confidential, except to the degree required by the legal process to fulfill the forensic function" (Weinstock et al. 2003, p. 57).

Morse (2008, pp. 206–207) has offered a solid, commonsense approach to the ethical practice of forensic psychiatry. He recommends a policy of forensic psychiatric ethics that is "deflationary and skeptical compared to what the law now permits, but still leaves forensic psychiatrists with a wide and important role to play." This approach proposes that "the forensic practitioner owes only the duty to act respectfully and honestly towards the subject and to perform his forensic functions with the highest level of professional skill" (Morse 2008, p. 208).

TABLE 5–1. Forensic psychiatry ethics guidelines

Confidentiality
Consent
Honesty and striving for objectivity
Qualifications

Source. American Academy of Psychiatry and the Law 2005.

When performing the role of expert witness in the courtroom, the forensic psychiatrist should have a solid understanding of the law's view of the psychology of the person. This view, sometimes referred to as the "folk psychological model," asserts that the individual is "a conscious (and potentially self-conscious) creature capable of practical reason, an agent who forms and acts on intentions that are the product of the person's desires and beliefs" (Morse 2008, p. 209). This is essentially why the law and morality are designed to be action-guiding. In other words, the law views the individual as being able to "act for and respond to reasons" (Morse 2008, p. 209).

In 2005, AAPL updated its ethics guidelines, which can be broken down into four basic tenets: 1) confidentiality, 2) consent, 3) honesty and striving for objectivity, and 4) qualifications (American Academy of Psychiatry and the Law 2005; Table 5–1). The full text of AAPL's Ethics Guidelines for the Practice of Forensic Psychiatry is provided in the appendix to this chapter.

Confidentiality

Protecting and maintaining patient confidentiality has been a fundamental and "enduring duty of physicians since the time of Hippocrates" (Roberts and Dyer 2004, p. 97). In contrast, in the forensic-legal setting, there are limits to confidentiality. The context of a forensic psychiatric evaluation constitutes one exception to the duty of confidentiality when the purpose of the evaluation is not treatment "but instead a forensic assessment that is intended to be shared with lawyers, judges, and/or jurors" (Simon and Shuman 2007, p. 39). Practically speaking, however, forensic psychiatrists are under an ethical obligation to keep information not relevant to the forensic-legal question confidential (American Academy of Psychiatry and the Law 2005). Evaluees should understand that forensic psychiatrists cannot guarantee confidentiality but will strive to maintain the confidentiality of nonrelevant information whenever possible.

It may help the forensic psychiatrist to clarify with the retaining attorney the limits of confidentiality in any individual case if uncertain. The extent of any limitations on confidentiality often varies with the particular legal sce-

nario. For example, in federal court, evaluations of a defendant's diminished capacity at the time of the offense may remain confidential in cases in which, pursuant to *Federal Rule of Criminal Procedure 12.2 (c)(2),* the report will be "sealed and must not be disclosed to any attorney for the government or the defendant unless the defendant is found guilty of one or more capital crimes and the defendant confirms an intent to offer during sentencing proceedings expert evidence on mental condition" (Federal Rules of Criminal Procedure, Rule 12.2 [c][2]). However, decisions regarding the extent of confidentiality are under the control of the court and legal rules, not the testifying expert.

The forensic psychiatrist should begin all examinations by giving warnings to examinees about the limitations on confidentiality, and about the differences between a forensic and a clinical examination. Table 5–2 gives a list of common nonconfidentiality disclosures that should be given to an evaluee prior to beginning an evaluation. At the outset of the interview, the defendant should be told about the purpose of the evaluation, the attorney or entity "for whom they are conducting the examination, and what they will do with the information obtained" (American Academy of Psychiatry and the Law 2005). Such disclosure is for the purpose of reinforcing the examinee's understanding that the encounter is not for therapeutic reasons and may potentially have harmful rather than helpful results.

Because of the tendency of some evaluees to "slip" back into a mode of relating to the examiner as a treating physician, it may be necessary to stop the interview and periodically repeat or reorient the evaluee to the fact that one's purpose is to conduct a forensic evaluation, not to function or be perceived as a treating physician. In a spirited debate at the APA's 150th annual meeting, one former APA president suggested, half jokingly, that forensic psychiatrists should wear police uniforms during evaluations to fully prevent such "slippage" into a doctor-patient mode of relating (Hartmann et al. 1997). Although extreme, his comment does raise a salient issue—that ethical forensic psychiatrists should remain vigilant throughout the evaluation for signs that the evaluee is slipping away from a proper understanding of the forensic psychiatrist's role.

Standard forensic evaluations should contain some form of a *statement of nonconfidentiality* to document that all of the required nonconfidentiality disclosures were made and understood (or not) by the evaluee. Such documentation in the forensic report typically takes the form of a statement similar to the following:

> Mr. Defendant was informed of the nonconfidential nature of the evaluation. He was informed that I was a psychiatrist who had been retained by the prosecution to evaluate him regarding his mental state at the time of the offense. He was told that although I was a psychiatrist, I would not be involved in his

TABLE 5–2. Nonconfidentiality disclosures

Purpose of the evaluation
Entity for whom you are conducting the examination
Clarification that you are not a "treating doctor" (reclarify as necessary)
What you will do with the information
Clarification that opinions formed may or may not be helpful
Ensure evaluee's understanding of all of the above

treatment in any way. I informed him that I would be writing a report based on my evaluation, and this report may be sent to the prosecutor, his defense attorney, and the court. He was told that my opinions in this matter may or may not be helpful to his case. He verbally acknowledged that he understood all of this information and agreed to proceed with the evaluation.

Case Vignette 1

Dr. A was performing an insanity defense evaluation at the request of the prosecutor. The defendant, who had a history of being in psychotherapy, was charged with murder. Dr. A evaluated the defendant at the local jail. He began the evaluation by giving her the standard warnings about the nonconfidential nature of the evaluation. About 2 hours into the evaluation, the defendant stated, "I probably shouldn't be telling you this part, but you are treating me with kindness and respect. You remind me of my past therapist. Do you ever do therapy with the people you evaluate after their court case is done?" Dr. A replied, "No. I'm sorry. That's generally not a good idea." Dr. A then proceeded to conduct the rest of the evaluation.

In this example, the defendant has clearly shown signs of potential "slippage" into relating to Dr. A as a treating psychiatrist. It is possible that Dr. A's empathic skills have enhanced the defendant's tendency to equate him with her previous therapist. This may cause her to temporarily forget the context of the evaluation and, most importantly, that Dr. A has been retained by the prosecution. In such a scenario, the defendant may tell Dr. A information that is either 1) against her best interests or 2) distorted in such a way as to "please" Dr. A because of her view of him as a "kind" physician. The defendant's remarks should have prompted Dr. A to temporarily stop the evaluation and revisit the issue of nonconfidentiality, as well as the fact that he is not acting in a treating role and may or may not be helpful to her case.

Not only does the forensic evaluation require notice to the evaluee of reasonably anticipated limitations on confidentiality, but the principle also applies to any persons contacted as collateral sources of information. Thus, a face-to-face or telephone interview of a defendant's family member, friend,

or employer will require a preliminary disclosure of the limits of confidentiality. After completion of the forensic evaluation, information that is not relevant to the forensic-legal question, especially sensitive information, should be excluded from the report. Further, such information should not be disclosed to colleagues or to the public, because it would constitute an ethical breach and may risk legal liability for the forensic psychiatrist (Binder 2002).

Consent

The right to consent, an attribute of personal autonomy, is a fundamental principle of medical ethics. The doctrine of informed consent requires that the individual possess 1) voluntariness of choice, 2) understanding and access to the relevant information, and 3) mental competence to make the decision at issue (Appelbaum 2007). Breach of informed consent under circumstances in which evaluation and treatment are provided may be actionable as malpractice. The term *informed consent* first received wide awareness and prominence in public health research, as well as in the practice of medicine, in 1972, in response to the public outcry regarding unethical practices in the Tuskegee syphilis research. Yet, even prior to this, the foundations for informed consent were articulated in the Nuremberg Code after World War II.

In obtaining true informed consent from an evaluee, it is important to assess whether he or she possesses the following abilities: 1) the ability to understand information relevant to the decision, 2) the ability to appreciate his or her situation and its consequences, 3) the ability to manipulate the relevant information rationally, and 4) the ability to express a stable, voluntary choice. These elements are further detailed elsewhere (Appelbaum 2007) and will not be expounded upon here.

In the case of a forensic evaluation, the informed consent of the evaluee should be obtained when necessary and feasible. In the event that the evaluee refuses to participate in the evaluation, he or she should be clearly informed that this fact may be included in a report or testimony. There may be times when it is clear that the evaluee is not competent to give consent, and in such cases the forensic psychiatrist should follow the appropriate laws of the jurisdiction. In many court-ordered evaluations (e.g., competency to stand trial, involuntary commitment), neither the evaluee's assent nor his or her informed consent is required. Nevertheless, for cases in which the evaluee was too impaired to give consent, this should be documented in the forensic report. At present, there does not appear to be a consensus opinion in terms of how much detail and supportive reasoning should accompany a

statement that an evaluee lacked competence to consent to the forensic evaluation.

In the absence of a specific order by the court, forensic psychiatrists retained by the prosecution should not evaluate a defendant if he or she has not yet consulted with his or her defense attorney. In the landmark U.S. Supreme Court case of *Estelle v. Smith* (1981), the Court held that the defendant's 6th Amendment rights were violated, because he was evaluated by the prosecution expert before he had a chance to be advised by counsel. This ethical principle becomes particularly important when a defendant 1) has been charged with a criminal act, 2) is being held in government custody or detention, or 3) is being interrogated for criminal or quasi-criminal conduct, hostile acts against a government, or immigration violations. In contrast, evaluations for the purpose of making diagnostic and treatment recommendations are not prohibited by these restrictions. Examples include civil commitment evaluations, risk management assessments, and conditional release evaluations from secure forensic facilities.

In considering informed consent, it is critical that the psychiatrist clearly distinguish the role of the forensic expert from the role of the treating forensic psychiatrist. Obtaining informed consent for a patient's treatment in a correctional or other criminal justice setting is quite different from consent for a forensic evaluation. For treating forensic psychiatrists, the usual rules of medical ethics apply, given that there is a clear doctor-patient relationship. In addition, AAPL ethics guidelines recommend that psychiatrists providing treatment in such settings should be familiar with the jurisdiction's regulations governing patients' rights regarding treatment (American Academy of Psychiatry and the Law 2005).

Honesty and Striving for Objectivity

The word *forensic* derives from the Latin word *forensis,* which translates to "before the forum" (American Heritage Dictionary 1985). This is derived from the fact that criminal cases during the Roman era were presented before a public forum. Both accused and accuser would give speeches and present their best "evidence" and arguments. At present, the term *forensics* is often used to refer generally to the application of a broad spectrum of sciences in an effort to answer questions of interest to the legal system. The task of the psychiatrist, in the role of expert witness, is to "shine the light" of psychiatric science and clinical knowledge on areas where the legal question and psychiatry overlap. Or, in the language of the Federal Rules of Evidence, which govern the admissibility of all types of evidence in federal cases, the role of the forensic psychiatrist is to "assist the trier of fact to understand the

evidence or to determine a fact in issue" (*Federal Criminal Code and Rules* 1995).

Forensic psychiatrists, as expert witnesses, subscribe to the principles of honesty and of striving for objectivity (American Academy of Psychiatry and the Law 2005). They are expected to use reliable methods, analyses, and reasoning to arrive at their opinions. As part of ongoing performance improvement, forensic psychiatrists should engage in continued monitoring of the quality and objectivity of their own work. For example, Appelbaum (2008) has recommended adoption of a peer review model, in addition to continuing training in ethics for forensic psychiatrists. In 2006, the U.S. Supreme Court considered a case that involved the insanity defense, *Clark v. Arizona* (2006). Although the Court did not make any substantive rulings about the criteria for an insanity defense, it provided some important insights into its current attitude on the difficulties inherent in bringing forensic psychiatric opinions into the courtroom. The Court recognized that forensic psychiatrists must move from methods and concepts designed for *treatment* to *legal* concepts (i.e., those relevant to sanity). This "leap" from one discipline to another requires cautious, objective judgment. If a leap is to be made, the forensic psychiatrist owes a duty to the court that it is sure-footed. For example, facts should be distinguished from impressions, relevant collateral data should be reviewed, and opinions should be well-supported with factual data.

AAPL ethical guidelines note that the forensic psychiatrist's honesty and objectivity "may be called into question" if an expert opinion is given without first performing a personal examination in cases that require one (American Academy of Psychiatry and the Law 2005). Although malpractice cases may be primarily record reviews, examinations of competency or sanity generally require a face-to-face evaluation. The guidelines state that at the very least, appropriate efforts should be made to conduct an evaluation. There may be some instances in which this is not possible; however, the forensic psychiatrist is obligated to "clearly state" the lack of a personal evaluation as a limitation to opinions given.

Prior to formally beginning a case, the issue of fees should be clearly understood. The ethical psychiatric expert's fee should never be contingent on the outcome of a case, because the expert is charging for time spent on the case, regardless of the judicial decision. Contingency fees are clearly unethical, because this type of payment arrangement exerts a biasing pressure on the forensic psychiatrist that is not present when fees are unassociated with final opinions or outcomes of the case.

On occasion, forensic psychiatrists may be labeled, either rightly or wrongly, by legal professionals as either prosecution/plaintiff- or defense-oriented. The ethical expert witness should make reasonable efforts to be open

to working for either side. In circumstances in which the forensic psychiatrist is "offering an unbiased opinion (which we usually assume to be the case), then one can work for either side" (Sadoff and Dattilio 2008, p. 170).

Many forensic psychiatrists will come to the field with their own personal biases already well entrenched. For example, like any other members of society, psychiatrists may hold personal beliefs consistent with the "law-and-order camp" or the "liberal/sympathy" camp. Psychiatrists offering legal opinions who hold sociopolitical biases should endeavor to be aware of their views and how they might potentially bias expert opinions (Gold 2004). The time-tested aphorism "know thyself" will ultimately help the forensic psychiatrist remain vigilant on issues of objectivity and bias.

Truth and Advocacy

In the United States, trials are conducted on the basis of an adversarial model in which attorneys are taught and encouraged to be "zealous advocates" of the causes and/or clients they represent. This may be a startling paradigm shift for the novice psychiatric witness. The paradigm shift involves a transition from the partisan clinical stance (which may even be encouraged by the ethical and practical stance of the attorneys) to the neutral stance required of the forensic psychiatrist. To maintain ethical standards, the forensic psychiatrist must resist the temptation to accept an advocate's role (American Academy of Psychiatry and the Law 2005; McGarry and Curran 1980).

Two general models have been described regarding ethical expert testimony: 1) the advocate for truth, and 2) the honest advocate (Gutheil 1998). In the *advocate for truth model,* the expert becomes a completely neutral observer and adheres to absolute truth during testimony. In contrast, the *honest advocate model* holds that it is acceptable to be a persuasive advocate, after forming an objective opinion, when operating in an adversarial system. However, the expert must be honest about the limits of testimony and remain truthful on cross-examination. In actual practice, most experts adopt a combination of these two models.

Although some forensic psychiatrists may take the position that advocacy is always unethical, AAPL has, in fact, "followed the view that advocacy is permissible and advocacy for an opinion may even be desirable. Identification with a cause and even bias are not unethical in and of themselves and some emotionality and bias may be inevitable. However, bias must be openly acknowledged and not lead to distortion, dishonesty, or failure to strive to reach an objective opinion" (Candilis et al. 2007, p. 47). For better or worse, such emotionality is often a matter of individual testimonial style. However, the important distinction to be made is that the expert is advocating "for an opinion, rather than a client…" (Candilis et al. 2007, p. 88).

The novice forensic psychiatrist, attempting to achieve this neutral stance, finds that "attorneys frequently expect outright cheerleading from their expert" (Candilis et al. 2007, p. 88). How the forensic psychiatrist conducts himself or herself in precisely such situations demonstrates integrity and commitment to the ethics of the field. Thus, it is a skill and a virtue to be able to be self-reflective and to analyze one's conduct when under the pressure of a zealous attorney. Surely, here is an occasion in which consultation with an experienced colleague may be very useful.

It is unrealistic to assume that the forensic psychiatrist can be absolutely impartial. To guard against or minimize partiality, the forensic psychiatrist should strive to initially approach a case with an impartial attitude. Once a comprehensive analysis has produced a well-reasoned, objective opinion, it becomes natural to identify with that opinion. Upon taking the witness stand, the expert must strive to impartially preserve the truth. Relevant information may not be kept secret (Halleck et al. 1984). The expert should guard against a sense of "loyalty" to the retaining attorney, which might cause a shift from objective expert to advocate. Blatant advocacy is easily recognized by the trier of fact, and the expert should not go beyond the available data or the scholarly foundations of his or her testimony (Brodsky and Poythress 1985; Gutheil and Dattilio 2008). An ethical forensic psychiatrist can enhance his or her credibility by appropriately acknowledging facts of the case that are unfavorable to his or her opinion, the limitations of the opinion, and hypothetical situations under which the opinion would be different (Gutheil 1998).

Perhaps the most unpleasant and offensive stigma associated with forensic psychiatry is the perception of the expert witness as a "hired gun." This pejorative term evokes the image of the unscrupulous Wild West gunslinger, willing to "sell out" to whoever paid the highest price. This issue has long been considered one of the foremost problems associated with the practice of forensic psychiatry. At times, the issue of being a "hired gun" has seemed to threaten the credibility of the entire profession, especially when the term is raised in the wake of high-profile cases (Mossman 1999).

Yet in certain cases it may be "difficult to distinguish honest bias, sometimes even unconscious, from a 'hired gun'" (Weinstock et al. 2003, p. 64). For example, commonly observed reasons for why psychiatrists intentionally or unintentionally demonstrate bias can include the desire for a "just" outcome or having an "agenda" of bringing public attention to the mental condition at issue. Nevertheless, under AAPL's ethical tenet of honesty and striving for objectivity, the deliberate distortion of data would be considered clearly unethical. The renowned forensic psychiatrist and psychoanalyst Bernard Diamond, M.D., held that the forensic psychiatrist "must clearly distinguish between his own idiosyncratic views and that of the scientific community" (1994, p.124).

Boundaries and Limitations

Striving for objectivity and accuracy mandates a careful assessment of the boundaries of psychiatric knowledge and the limits of the current science. The progress of psychiatric science results in an ever-shifting boundary between disease and deviance (Rosenberg 2006). The legitimacy of many disease categories not uncommonly remains the subject of "professional ferment" for extensive periods. For this reason, forensic psychiatrists must strive not only for accuracy in diagnosis but also honesty about the limitations of their field. For example, there is growing interest in applying brain science, particularly brain imaging, to the issue of sanity. However, presently, the implications of neuropsychiatric imaging for the law are still unclear (Morse 2004; Reeves et al. 2003; Shuman and Gold 2008). Neuroscience is continually identifying potential *associations* between biology and violence, but the courts deserve to be informed of their preliminary and hypothetical nature (Eastman and Campbell 2006). Other areas in which the psychiatrist must currently acknowledge clear limitations include such subjects as involuntary conduct, dissociative states, and other mental conditions or "syndromes" that do not clearly meet the *Daubert* standard.

Case Vignette 2

Dr. B was retained by the federal defender in a credit card fraud case in which the defendant was using the federal diminished capacity defense in an attempt to obtain a downward departure in his sentence. Dr. B had evaluated and diagnosed the defendant with pathological gambling and opined in her report that the defendant committed credit card fraud while suffering from a significantly reduced mental capacity that significantly impaired his ability to control his behavior. Dr. B then testified that the defendant's pathological gambling was so severe that he had become completely bankrupt and had no reasonable alternatives to pay off his gambling debts to organized crime, or to continue his gambling habit. When challenged on cross-examination with evidence that the defendant demonstrated substantial caution and patience with regard to his offenses of credit card fraud, Dr. B testified that "no one" with pathological gambling as severe as the defendant's would be able to refrain from breaking the law in order to "feed their addiction."

In this example, Dr. B confidently offers the court her opinion but does so in an area of significant professional uncertainty—psychiatry's ability to accurately assess volitional control. In such situations, it is critical that the forensic psychiatrist be honest about the current limitations of psychiatric science. Thus, Dr. B should be forthright about the limitations inherent in making determinations about the defendant's ability to control his criminal conduct. In addition, Dr. B should not put forth such *ipse dixit* testimony.

Rather, she should offer behavioral evidence from the time of the crime to support her conclusions and ascertain the defendant's capacity to be deliberate and purposeful with regard to the crime, as well as his capability for resisting impulses in other areas of life. In sum, Dr. B should strive for *enhanced* rigor and scrutiny when evaluating a defendant's ability to refrain from committing the offense.

One method that may help hold the forensic psychiatrist to the limitations of psychiatric science is by asking oneself what the ideal forensic *pathologist* would do in a similar situation (Dietz 1996). This question helps to focus one's testimony on the objective and technical matters of the field and may help steer one away from inferences that exceed the limits of the current science. When the forensic psychiatrist strays too far from this touchstone of the forensic scientist, the risk begins to increase that the objective focus will be lost and that the forensic psychiatrist will lose sight of the fact-value distinction (Stone 1984).

Forensic Psychiatry and Moral Decision Making

Psychiatrists are often in the position of having to make moral value judgments, either implicitly or explicitly. However, as the forensic psychiatrist moves away from evidence-based science and objective reasoning and toward value-laden inferences, the line between fact and value becomes increasingly blurred. Arguably, the area in which objective focus may be most easily lost is in the murky terrain of moral decision making.

It was not until the famous *M'Naghten* case that juries were asked to address the concept of moral versus legal wrongfulness. However, this moral determination was properly the charge of the jury. At present, many jurisdictions accept both moral and legal wrongfulness considerations in a defendant's insanity defense. Forensic psychiatrists are currently taught and expected to be able to form objective opinions on the issue of a defendant's understanding of the moral wrongfulness of his or her act. Add to this determination an even more complex layer of "subjective" moral wrongfulness, and the terrain becomes even less clear. Subjective moral wrongfulness refers to the defendant who commits an offense with knowledge that the act is illegal but believes it is *personally* morally justified. In contrast, objective moral wrongfulness refers to the defendant who, as a result of a psychiatric disorder, lacked the capacity to know that *society* considered the act to be wrong.

To illustrate the complexity of finely "splitting the moral wrongfulness hair," let us consider the high-profile case of Andrea Yates, who was charged with drowning her five children in 2001. Both prosecution and defense had retained two of the most preeminent and accomplished forensic psychia-

trists in the United States. In the Yates case, the legal test for insanity in Texas was as follows: "at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong" (Texas Penal Code, Section 8.01). In the Yates trial, both defense and prosecution experts agreed on three issues. They agreed that 1) Mrs. Yates suffered from a mental disease, 2) Mrs. Yates knew that her conduct was against the law, and 3) there was a subjective moral wrongfulness issue to be considered (Resnick 2007). This final point referred to the evidence that Mrs. Yates suffered from a delusional belief that her children were not being raised "righteously," that she would "burn in hell," and that she had to choose the "lesser of two evils" by drowning them in order "to save their souls." This was precisely where the legal battle lines were drawn—at the intersection of severe mental illness and Mrs. Yates's appreciation of the subjective moral wrongfulness of her acts.

Once the forensic analysis turns away from a determination of *legal* wrongfulness (a relatively concrete concept) and toward one involving *moral* wrongfulness (a more abstract, subjective concept), the door is opened more widely for the forensic psychiatrist's own personal biases to creep into the analysis. Although both experts in the Yates case did an exemplary job of splitting the wrongfulness hair in an objective manner, this issue has not yet received the attention in the field that it deserves, leaving many forensic psychiatrists to approach such determinations in a variety of ways. It is possible that in the future, courts will begin to narrow the meaning of moral wrongfulness to exclude "subjective" wrongfulness and limit the standard to strict "objective societal or public standards" (see *U.S. v. Ewing* 2007, a 7th Circuit Court of Appeals decision).

One might be inclined to wonder what the clinical science of psychiatry has to offer on the issue of subjective morality, an area rife with potential biases. Morally motivated decision making has been increasingly studied in the social sciences, with distinctive patterns emerging. Emotions naturally and involuntarily come into play in certain circumstances. In the midst of a moral dilemma, subjects tend to adopt a utilitarian frame of reference as long as their choices have only an indirect or secondary effect on mortality. In contrast, most subjects begin to have serious moral reservations as their decisions come closer to directly affecting a human life (Bartels and Medin 2007; Nichols and Mallon 2006).

Brain imaging studies appear to support the hypothesis that difficult moral judgments elicit greater activity in areas associated with *emotion*. When 24 subjects were presented with moral and nonmoral scenarios, the moral dilemmas were associated with more activity in the orbitofrontal cortex and temporal pole and less activity in other areas associated with cognition (Borg et al. 2006). In another study, subjects again showed greater activation in ar-

eas associated with emotional processing when their considerations came closer to directly affecting a human life (Greene et al. 2001). These findings suggest that emotional processing is heavily involved in certain types of moral decision making. This raises potentially important questions not only about a defendant's state of mind at the time of an offense but also about the objectivity of the forensic psychiatrist as his or her analysis comes closer to the "fire" (i.e., sentencing, or competence to be executed) in capital cases.

Unless or until the courts achieve unanimity on this issue, such forensic determinations will continue to challenge the ethical forensic psychiatrist. One reasonable approach is to simply list one's opinion on all the factors supporting the conclusion that the defendant *did* understand the moral wrongfulness, and also give a list of all the factors supporting the conclusion that the defendant *did not* understand the moral wrongfulness. The forensic psychiatrist then facilitates the decision-making function of the trier of fact. This approach redirects the analysis back toward a more objective stance in which the expert elucidates evidence weighing on each side of the moral wrongfulness question and simply leaves the final determination of moral issues to the finder of fact.

Dual-Agency Concerns

One of Stone's primary concerns about the ethics of forensic psychiatry involved the dilemma of dual agency, that is, the tension between the psychiatrist's obligation of beneficence toward patients and the conflicting obligations to the legal system (Stone 1984). This dilemma of competing and sometimes conflicting ethical obligations is not confined to forensic psychiatry but also commonly occurs in general psychiatry and involves competing interests to the community, third parties, other health care workers, and the pursuit of knowledge in the form of research (Robertson and Walter 2008; Stone 1984). In the practice of forensic psychiatry, the problems associated with dual agency would appear to be most acute. This is particularly the case for situations in which the psychiatrist acts as both treating physician *and* forensic evaluator (Greenberg and Shuman 1997; Strasburger et al. 1997). The AAPL ethical guidelines warn that treating psychiatrists should "generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes" (American Academy of Psychiatry and the Law 2005). The special problem of distinguishing treatment from evaluation as it pertains to death row inmates will be discussed in a later section.

Attorneys and even judges often believe that the treating psychiatrist is in the single best position to serve as an expert witness. This mistaken assumption commonly rests on the notion that the treating psychiatrist has spent the most time with the individual and would therefore be expected to

TABLE 5–3. Treating psychiatrist versus expert witness: areas of role conflict

Treating psychiatrist	Expert witness
Natural bias in favor of patient's best interests	Trained to maintain neutral, factual position
Possible reduced objectivity due to bias in favor of patient	Maximized objectivity, as required by ethical guidelines
Less likely to seek multiple sources of data due to issues of confidentiality	Required to seek multiple sources of data
Less likely to challenge patient's self-report or version of events	Very likely to challenge evaluee's self-report and version of events based on collateral data
Potential breach of patient confidentiality	Evaluee clearly informed about the lack of confidentiality
Adverse effects on therapeutic relationship	No therapeutic relationship to compromise

"best" understand why the defendant acted as he or she did. However, this assumption contains many fallacies of which legal professionals are typically unaware. For example, the treating psychiatrist must necessarily accept the patient's subjective psychic reality and work with it for the benefit of the patient. The treating psychiatrist will not usually threaten the therapeutic relationship by gathering collateral data from the patient's friends, family, and coworkers. In addition, the treating psychiatrist sees and evaluates the patient in a single setting—the psychiatrist's therapy chair. In contrast, the forensic psychiatrist will have the opportunity to obtain data about the evaluee in multiple settings.

Table 5–3 summarizes the areas of role conflict that occur when a treating psychiatrist functions as an expert witness. As a result of these important differences, an independent forensic evaluator is typically better suited than a treating psychiatrist to evaluate an individual for forensic-legal purposes.

Despite these caveats, occasions arise when an attorney will seek to have a treating psychiatrist who was to appear as "fact" witness sworn in or "tendered" as an expert witness. The AAPL ethical guidelines caution that the treating psychiatrist should remain vigilant for this scenario, because it may result in the unnecessary disclosure of private information or the possible misinterpretation of testimony as "expert" opinion (American Academy of Psychiatry and the Law 2005).

Moreover, when the treating psychiatrist testifies in court, even as a fact witness, the role conflict inherent in this situation might ultimately be detrimental to the patient (Greenberg and Shuman 1997; Greenberg et al. 1987; Strasburger 1999, 1999; Strasburger et al. 1997). The treating psychiatrist has formed a relationship with the patient based on the understanding that the information provided by the patient will be confidential. The treatment relationship may be seriously and irrevocably damaged should confidential information be revealed in court by the patient's treating psychiatrist (Perlin et al. 2008). Another potentially adverse outcome can arise if the patient does not obtain a favorable outcome, becomes upset, and blames the treating psychiatrist. In such a scenario, the therapeutic relationship is likely to be destroyed. AAPL ethical guidelines acknowledge that in some limited circumstances, the dual role may be unavoidable. For example, in rural or semirural areas, a lack of availability of forensic services may necessitate a forensic evaluation by the treating psychiatrist (American Academy of Psychiatry and the Law 2005). Other examples in which the dual role may be permissible, but not ideal, include workers' compensation cases, disability evaluations, civil commitment cases, and guardianship hearings.

Qualifications

Prior to accepting a case, the forensic psychiatrist should determine whether he or she has the proper "knowledge, skill, experience, training, or education" required for the particular forensic-legal question under consideration (Federal Rule of Evidence 702) (Federal Criminal Code and Rules 1995). The forensic psychiatrist will invariably be "qualified" from the outset of the direct examination, given that the retaining attorney must tender the expert to the court. However, the expert's qualifications can be, and often are, vigorously challenged during cross-examination by opposing counsel (Babitsky et al. 2000; Shuman 2001). In addition to routine probing questions about the expert's curriculum vitae, licensing, education, training, and publications, opposing counsel is likely to ask the expert about his or her actual experience dealing with the subject matter at issue. This may present a significant problem if the expert's recent day-to-day experience does not "match up with what's at issue in the case" (Babitsky et al. 2000, p. 74). Table 5–4 lists some basic questions to assist the expert in determining whether he or she is qualified for a particular case.

A finding by a court that a psychiatrist is "not qualified" for a particular case becomes a matter of public record, which may then be used against the expert in future cases. To avoid this problem and abide by the AAPL ethical guideline of claiming expertise "only in areas of actual knowledge, skills, training, and experience" (American Academy of Psychiatry and the Law 2005),

TABLE 5–4. Are you qualified?

Is the case actually within your area of expertise?
How much clinical experience do you have with the subject matter under consideration?
Do you have the proper training and certification?
Do you understand the legal question and legal standards at issue?
Have you published in the area under consideration?
Does the state you are testifying in have any statutes outlining the percentage of time an expert is allowed to perform expert witness work, and do you meet the criteria?
Do you have any critical biases or conflicts of interest?

experts should take care to stay within their true areas of expertise when accepting a case. Although this recommendation may be more obvious for cases that clearly involve special expertise (e.g., evaluation of children, correctional mental health issues, or evaluation of persons of foreign cultures), it may be less clear for cases in which the expert has had some amount of involvement with the issue in question, but the involvement was somewhat limited. In such instances, it may be prudent to refer the case to a colleague who does possess the necessary expertise.

Forensic experts without proper training and qualifications will inevitably be ferreted out by attorneys who realize only too well that juries will easily be able to distinguish those experts who are qualified from those who are not by the manner in which they testify. Attorneys and the legal system are advised to pay close attention to verifying experts' educational and training credentials, even before retaining their services on a case. Psychiatrists should make certain that their credentials accurately reflect their expertise, because attorneys are advised to routinely 1) verify the accuracy of the expert's curriculum vitae, 2) inquire about the expert's membership in professional organizations, 3) verify accreditation and reputation of any institution from which an expert's degree has been claimed, and 4) contact the state licensing board to verify the expert's license issue date, status, and credentials (Sadoff and Dattilio 2008).

Death Penalty Concerns

In 2001, the AAPL Executive Council formally adopted a moratorium on capital punishment "at least until death penalty jurisdictions implement pol-

icies and procedures that A) ensure that death penalty cases are administered fairly and impartially in accordance with basic due process; and B) prevent the execution of mentally disabled persons and people who were under the age of 18 at the time of their offenses" (American Academy of Psychiatry and the Law 2001).

Despite this official position, there remain diverse opinions about the ethical permissibility of psychiatrists' participation in death penalty cases. The American Medical Association (AMA) has taken the unequivocal position that it is unethical for any physician to directly participate in an execution (American Medical Association 1993). This position, taken literally, does not seem to pose a problem. However, for the forensic psychiatrist who either provides treatment or performs evaluations on death row, the ethical dilemmas become significantly more challenging. Even the purely clinical function of treatment of death row inmates thrusts the psychiatrist into a highly complex ethical arena (Matthews and Wendler 2006).

The role of the forensic evaluator who performs competence-to-be-executed evaluations presents even more complex ethical issues with even less consensus to use as a guide. A research survey of 290 forensic psychiatrists revealed that many did not share the views of their professional organizations. Only 8.5% believed that it was never acceptable to evaluate a condemned prisoner (Leong et al. 2000). About one-half believed that an inmate who is incompetent to be executed should be treated for the purpose of restoring competence. Most of the respondents supported a role for psychiatric evaluations of death row inmates, but they were divided on whether incompetent death row inmates should be treated if it would result in restoring the defendant's competence to be executed.

In *Ford v. Wainwright* (1986), the U.S. Supreme Court ruled that the 8th Amendment prohibits the execution of a prisoner who is insane. In *Ford,* the Court gave some guidance in terms of a "test" for competence to be executed, which involves whether the prisoner is aware of 1) his impending execution and 2) the reason for it. It should be noted that some lower courts have required the higher standard of the defendant being able to consult with his attorney in matters related to appeals. After *Ford,* the lower courts struggled with these minimalist standards, and the U.S. Supreme Court remained reluctant to establish a rule governing all competence-to-be-executed determinations. This was demonstrated best in *Panetti v. Quarterman* (2007).

However, in *Panetti* the Court did clarify that "a prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it" (*Panetti v. Quarterman*, p. 4). Therefore, it may be argued that a mentally ill death row inmate's concrete awareness of a state's reason for execution may nevertheless be inadequate for cases in which the inmate suffers

from a "delusion that the stated reason is a sham." In other words, the defendant must possess a rational, not merely a factual, understanding of the *Ford* criteria. In *State v. Perry* (1992), the Louisiana Supreme Court ultimately held that the State may not forcibly medicate a defendant found incompetent to be executed. However, this court did leave open the possibility for Louisiana to reinstate a defendant's execution, should the inmate become competent to be executed without the use of medication.

Treatment Versus Evaluation on Death Row

For forensic psychiatrists working on death row, one of the main principles to attend to is the distinction between treatment and evaluation roles. Although this distinction is given primacy in all of forensic psychiatry, it takes on particular importance in the death row setting. It is critical to make a clear distinction between providing *treatment* to inmates on death row and performing a *forensic evaluation* of a death row inmate for the courts. The AMA's Council on Ethical and Judicial Affairs has concluded that evaluating an inmate's competence to be executed is permissible, given that the physician is acting as an advocate of the justice system and not as part of the process of punishment (American Medical Association 1995).

It is recommended that a treating psychiatrist should never offer a forensic opinion on a patient's psychiatric competence to be executed (Burns 2007). When the inmate has been adjudicated incompetent to be executed, two important questions typically arise (Scott 2006): 1) Should the psychiatrist continue to treat with medications when this may result in restoration of competence and, therefore, execution? and 2) Can the inmate who refuses medication be *involuntarily* medicated to restore competence to be executed?

Professional ethical guidelines may be helpful in answering the first question. The AMA has clearly stated that psychiatrists should never treat an inmate for the purpose of restoring competence to be executed. Thus, treatment expressly for the purpose of restoring psychiatric competence to be executed is ethically suspect because the psychiatrist could be viewed as facilitating the state's interest in executing the inmate (Matthews and Wendler 2006). Table 5–5 provides a list of ethical guidelines for treating death row inmates, derived from published guidelines and professional literature (American Medical Association 1993; Bonnie 1990a; Scott 2006).

The second question—how to approach the psychiatric treatment of the incompetent death row inmate—may be guided by the traditional medical ethic of *primum non nocere* (first, do no harm). In this context, the psychia-

TABLE 5–5. Psychiatric treatment on death row: ethical guidelines

Primum non nocere—first, do no harm.
Do not treat for the purpose of restoring competence to be executed.
Treat all death row inmates undergoing extreme suffering.
Allow the inmate to make a decision about further treatment after a rational mental capacity has been restored.
Ensure that reevaluations of competence are performed by an independent, nontreating psychiatrist.
As treating psychiatrist, never offer a forensic opinion on patients' competence to be executed.
Obtain consultation on difficult cases.

Source. American Medical Association 1993; Bonnie 1990a; Scott 2006.

trist's treatment efforts are focused *solely* on reducing the pain and suffering caused by the inmate's serious mental illness. Once the suffering has been reasonably alleviated, and some individualized degree of rational mental capacity has been restored, it may then be possible for the inmate to make his or her own decision about receiving further treatment. Such an approach leaves open to interpretation the question of whether treatment is ultimately beneficial or harmful to the patient (Bonnie 1990b). Should an inmate make it clear that treatment is not desired, the psychiatrist may then abstain from treatment on ethical grounds, as well as on the basis of the patient's informed decision.

Forensic psychiatrists should also consider whether they can remain clinically objective while treating or evaluating death row inmates. The moral burden of providing treatment in these difficult circumstances is likely to be most difficult for psychiatrists who have the greatest personal moral doubts about the death penalty (Bonnie 1990b). Research suggests that moral opposition to the death penalty is associated with a reluctance to participate in evaluations of competence to be executed (Deitchman et al. 1991). Legal scholars are only now beginning to acknowledge that the persistence and resilience of the death penalty in the United States may be explained by its strong emotional variables, which may be argued as representing the scaffolding undergirding all so-called rational debate (Bandes 2008). Because such emotional variables cannot be simply ignored, forensic psychiatrists should thoughtfully acknowledge their own emotional responses to working on death row, and how their responses may affect treatment and/or evaluative decisions.

Special Populations and the Death Penalty

The U.S. Supreme Court has addressed the death penalty in special populations, such as the developmentally disabled and youthful offenders. In *Atkins v. Virginia* (2002), the U.S. Supreme Court held that executing an intellectually disabled criminal was cruel and unusual punishment prohibited by the 8th Amendment. The Court cited evolving standards of decency, as well as the fact that a significant number of states had concluded that death is not a suitable punishment for an intellectually disabled criminal. This position is supported by the social science research finding that juries were less likely to view mentally retarded and mentally ill offenders as death-worthy (Boots et al. 2003).

For youthful offenders, the U.S. Supreme Court overruled previous decisions (*Stanford v. Kentucky* 1989; *Thompson v. Oklahoma* 1988) in *Roper v. Simmons* (2005), holding that the Eighth and Fourteenth Amendments forbid imposition of the death penalty for offenders who were under the age of 18 years when their crimes were committed (*Roper v. Simmons* 2005). The sensible-sounding, yet ill-defined, "evolving standards of decency" test was invoked in *Roper,* and the majority cited sociological and scientific research findings that juveniles may lack mental maturity and sense of responsibility as compared with adults. The implications of the *Roper* ruling were immediately felt in Virginia as they related to the case of the D.C. Beltway snipers in 2002. The younger codefendant, Lee Boyd Malvo, who was 17 years old at the time of the offenses, was therefore no longer eligible for the death penalty for his role in the sniper attacks and killings.

Additional Suggested Guidelines

Other ethical recommendations, which are not currently part of the official AAPL guidelines, have been suggested by leaders in the field. These guidelines include a prohibition on sex between a forensic psychiatrist and an evaluee, a prohibition against giving an opinion in a death penalty case without having personally examined the defendant, and the general principle that the forensic psychiatrist may owe some responsibility to both society and the evaluee, regardless of who is paying for the expert services (Weinstock et al. 2003).

In addition, Morse (2008, pp. 214–216) has offered a sensible list of "forensic do's and don'ts" that the forensic psychiatrist may find helpful, not only in terms of general practice, but also for additional ethical guidance. These suggestions include the following:

- Strive to provide the court with the most legally useful information, and remain within the bounds of your expertise.
- Whenever possible, observations of the defendant by others who had an opportunity to observe him or her should be sought to enhance accuracy and objectivity. (In other words, one should "triangulate" by checking the defendant's self-report.)
- Make clear the database from which statements (used as evidence) are derived (i.e., the principle of attribution).
- If your position is in conflict with the literature and/or the orthodox position, clearly explain why you accept one position and why you reject the larger database.
- When addressing behavioral control issues, proceed with great caution.
- Consider avoiding the subject of "free will" in reports or testimony. (Morse's position is that free will is nowhere mentioned in legal criteria and has nothing useful to add to the courts' deliberations.)

Evolving Areas of Ethical Inquiry: Interrogations

Some subjects of ethical debate in forensic psychiatry are relatively new and will doubtless experience the same disciplined, principled evolution that has characterized progress in the field thus far. For example, on the subject of interrogation, AAPL ethical guidelines have made it clear that it is unethical for a psychiatrist to participate in procedures that constitute torture. However, it can be argued that the issue of intelligence interrogations can be viewed on a continuum, with a multitude of shades of gray that are deserving of substantial future ethical discourse (Arboleda-Florez 2006; Thompson 2005). Both the APA and AMA have issued position statements that prohibit psychiatrists from "direct participation" in interrogations (American Medical Association 2009; American Psychiatric Association 2006). The American Psychiatric Association defines participation as being present, asking or suggesting questions, or offering advice to interrogators.

Military forensic psychiatrists who consult in the area of interrogations may have different mandates per the U.S. Department of Defense (Marks and

Bloche 2008) and might consider consulting with colleagues and/or the AAPL ethics panel on cases in which military and APA and AMA ethical guidelines present a dilemma. Such conflicts are not likely to be easily resolved in cases for which the U.S. Department of Defense has endorsed a Behavioral Science Policy that appears to support psychiatrists providing advice to interrogators (Marks and Bloche 2008). In those cases, the ethical conflict for the military psychiatrist would involve an order to provide interrogation assistance that the military has deemed to be a compelling matter of national security versus the APA and AMA positions, which prohibit direct participation.

To further illustrate the conflict, one might argue that the "broader ethical/moral concerns would trump those" of professional ethics, and that it would be acceptable to "obtain information from a detainee that would prevent the deaths of others" (Meyers 2007, p. 137). In contrast, some have maintained that the fundamental ethics of forensic psychiatry (honesty, striving for objectivity, and respect for persons) would militate against participation in interrogations (Janofsky 2006). Finally, it has been pointed out that psychiatrists' participation in interrogation of detainees, such as prisoners at Guantánamo Bay, may violate not only APA and AMA ethics but also the Geneva Convention and Ethics Codes of the World Medical Association (Halpern et al. 2008). The difficult quandary of the dual responsibilities of the military psychiatrist is likely to persist. However, it has been suggested that the U.S. Department of Defense might alleviate some ethical problems by initiating "independent medical reviews of the physical and mental health conditions" of detainees, and by establishing an independent commission to review the role of physician participation in interrogation of terror suspects (Rubenstein and Annas 2009, p. 355).

Conclusion

Since Alan Stone's wakeup call in 1984, forensic psychiatry has crafted a system of ethics, the evolution of which has been both disciplined and principled (Candilis et al. 2007). Indeed, "mindful and intelligent evolution is in the best tradition of academic scholarship. It is a method for fine-tuning arguments, receiving feedback, and contributing to the evolution of professional discourse" (Candilis et al. 2007, p. 176). Rather than vilifying Stone, those involved in the discipline of forensic psychiatry carefully listened, analyzed, and deliberated before proceeding to outline a clear and reasonable set of ethical principles. Most forensic psychiatrists "are grateful to Stone for

identifying and continuing to comment intelligently on the ethics of forensic psychiatry" (Miller 2008, p. 193).

Stone and others forced forensic psychiatrists to ask the question: "Is it ethical to permit oneself to deviate from the physician/healer role at all?" (Diamond 1994, p. 239). On careful reflection, refusal to deviate from that role ultimately becomes an untenable position. The fact that our legal system has a clearly stated need for competent, ethical forensic psychiatrists makes it "irresponsible not to respond to that need" (Diamond 1994, p. 239).

The forensic psychiatric expert, like any other forensic expert, "functions within a social context that is influenced by time and place" (Grubin 2008, p. 186). And, at present, forensic psychiatrists have more useful knowledge to offer the courts than ever before (Appelbaum 2008). In bringing this knowledge to elucidate complex mental health issues for the legal system, forensic psychiatry may continue its technical and ethical evolution "by advocating education, peer review, consultation,…familiarity with ethical framework.…transparency in testimony, open and honest analysis of the strengths and weaknesses of one's own view, avoidance of the ultimate question, and separation of legal and scientific questions" (Candilis et al. 2007, p. 177). But, with such high aspirations, the best assurance of ethical conduct will always be "the integrity of the professional persons themselves who, in forensic psychiatry, face the challenge of confronting and balancing many conflicting values" (Weinstock et al. 2003, p. 71).

Key Points

- Serious conflicts of interest arise when a psychiatrist acts as both forensic evaluator and treating psychiatrist. If at all possible, this type of dual agency should be avoided.
- For the forensic psychiatric expert, the medical ethical principles of beneficence and nonmaleficence lose their primacy to the legal ethical principles of truth, honesty, and objectivity. In the forensic-legal setting, the evaluee is not a patient but an individual seeking to resolve a legal, not a medical, issue.
- The forensic psychiatrist should adhere to the following underlying principles: 1) respect for persons, 2) honesty, 3) justice, and 4) social responsibility.
- The forensic psychiatrist should never distort data and should concede the current limits of the psychiatric science at issue.
- Regarding work on death row, the psychiatrist should make a

clear distinction between providing treatment to inmates and performing a forensic evaluation for the courts.

Practice Guidelines

1. Become familiar with American Academy of Psychiatry and the Law (AAPL) and American Psychiatric Association ethical guidelines, and adhere to them in practice.
2. Begin all examinations by giving warnings to evaluees about limitations on confidentiality, and about the differences between a forensic and a clinical examination.
3. Treat all evaluees with respect and dignity.
4. Never accept contingency fees.
5. In the absence of a specific order by the court, forensic psychiatrists retained by the prosecution should not evaluate a defendant if he or she has not yet consulted with his or her defense attorney.
6. When striving for accuracy and objectivity, do not rely on the evaluee's self-report alone, but seek out collateral data.
7. Prior to accepting a case, determine whether you have the proper "knowledge, skill, experience, training, or education" (Federal Rule of Evidence 702) required for the particular forensic-legal question under consideration.
8. Do not treat for the purpose of restoring competence to be executed. However, treat all death row inmates undergoing extreme suffering.
9. As treating psychiatrist, never offer a forensic opinion on a patient's competence to be executed.
10. Obtain consultation on difficult cases.

References

American Academy of Psychiatry and the Law: Position statement on the death penalty, 2001. Available at: http://www.aapl.org/positions.htm. Accessed May 17, 2009.

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Bloomfield, CT, American Academy of Psychiatry and the Law, May 2005. Available at: http://www.aapl.org/pdf/ETHICSGDLNS.pdf. Accessed May 13, 2009.

American Heritage Dictionary, 2nd College Edition. Boston, MA, Houghton Mifflin Company, 1985

American Medical Association, Council on Ethical and Judicial Affairs: Physician participation in capital punishment. JAMA 270:365–368, 1993

American Medical Association: Report 6-A-95: Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed: Treatment to Restore Competence to be Executed. House of Delegates Proceedings of the 144th Annual Meeting, Council on Ethical and Judicial Affairs, American Medical Association, 1995

American Medical Association: Physician participation in interrogation, in report 10-A-06 on the Council on Ethical and Judicial Affairs (2009). Available at: http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_10a06.pdf. Accessed May 18, 2009.

American Psychiatric Association: Psychiatric participation in interrogation of detainees: position statement (2006). Available at: http://archive.psych.org/edu/other_res/lib_archives/archives/200601.pdf. Accessed May 18, 2009.

Appelbaum PS: The parable of the forensic psychiatrist: ethics and the problem of doing harm. Int J Law Psychiatry 13:249–259, 1990

Appelbaum PS: Clinical practice: assessment of patients' competence to consent to treatment. N Engl J Med 357:1834–1840, 2007

Appelbaum PS: Ethics and forensic psychiatry: translating principles into practice. J Am Acad Psychiatry Law 36:195–200, 2008

Arboleda-Florez JE: The ethics of forensic psychiatry. Curr Opin Psychiatry 19:544–546, 2006

Atkins v Virginia, 536 U.S. 304 (2002)

Babitsky S, Mangraviti J, Todd C: The Comprehensive Forensic Services Manual: The Essential Resources for All Experts. Falmouth, MA, SEAK, 2000

Bandes S: The heart has its reasons: examining the strange persistence of the American death penalty. Studies in Law, Politics and Society 42 (1), 2008

Bartels D, Medin D: Are morally motivated decision makers insensitive to the consequences of their choices? Psychological Science 18:24–28, 2007

Beauchamp T, Childress J: Principles of Biomedical Ethics, 3rd Edition. New York, Oxford University Press, 1989

Binder RL: Liability for the psychiatrist expert witness. Am J Psychiatry 159(11):1819–1825, 2002

Black's Law Dictionary, 7th Edition. Saint Paul, MN, West Group, 1999

Bloom JD, Dick DW: Commentary: 1982 was AAPL's year of living dangerously. J Am Acad Psychiatry Law 36:175–180, 2008

Bonnie R: Dilemmas in administering the death penalty: conscientious abstention, professional ethics and the needs of the legal system. Law Hum Behav (14):67–90, 1990a

Bonnie R: Healing-killing conflicts. Hastings Center Report, May/June:12–18, 1990b

Boots D, Cochran J, Heide K: Capital punishment preferences for special offender populations. J Criminal Justice (31):553–565, 2003

Borg J, Hynes C, Van Horn J, et al: Consequences, action and intention as factors in moral judgments: an fMRI investigation. J Cogn Neurosci 18(5):803–817, 2006

Brodsky SL, Poythress NG: Expertise on the witness stand: a practitioner's guide, in Psychology, Psychiatry, and the Law. Edited by Ewing CP. Sarasota, FL, Professional Resource Exchange, 1985, pp 389–411

Burns K: The red zone—boundaries of clinical vs. forensic work in correctional settings, in Correctional Psychiatry: Practice Guidelines and Strategies. Edited by Thienhaus O, Piasecki M. Kingston, NJ, Civic Research Institute, 2007

Candilis P, Weinstock R, Martinez R: Forensic Ethics and the Expert Witness. New York, Springer Science, 2007, pp 47, 88, 176

Clark v Arizona, 548 U.S. 735 (2006)

Deitchman MA, Kennedy WA, Beckham JC: Self-selection factors in the participation of mental health professionals in competency for execution evaluations. Law Hum Behav 15:287–303, 1991

Diamond B: The Psychiatrist in the Courtroom: Selected Papers of Bernard L. Diamond, M.D. Hillsdale, NJ, Analytic Press, 1994

Dietz PE: The quest for excellence in forensic psychiatry. Bull Am Acad Psychiatry Law 24:153–163, 1996

Dike CC: Commentary: is ethical forensic psychiatry an oxymoron? J Am Acad Psychiatry Law 36:181–184, 2008

Eastman N, Campbell C: Neuroscience and legal determination of criminal responsibility. Nat Rev Neurosci 7:311–318, 2006

Estelle v Smith, 451 U.S. 454 (1981)

Federal Criminal Code and Rules: Testimony by Experts, Rule 702. Saint Paul, MN, West Publishing, 1995

Federal Rules of Criminal Procedure: Rule 12.2 (c)(2). Available at: http://www.lawcornell.edu/rules/frcrmp/Rule12)2.htm#Rule12_2(b)(2). Accessed May 8, 2009.

Ford v Wainwright, 477 U.S. 399 (1986)

Freud S: Civilization and Its Discontents. New York, WW Norton, 1961

Fulero S, Finkel N: Barring ultimate issue testimony: an insane rule? Law Hum Behav 15:495–507, 1991

Gold LH: Sexual Harassment: Psychiatric Assessment in Employment Litigation. Washington, DC, American Psychiatric Publishing, 2004

Greenberg SA, Shuman DW: Irreconcilable conflict between therapeutic and forensic roles. Prof Psychol Res Pr 28:50–57, 1997

Greenberg SA, Shuman DW, Strasburger LH: Crudely, without any finesse: the defendant hears his psychiatric evaluation. Bull Am Acad Psychiatry Law 15:229–233, 1987

Greene JD, Sommerville RB, Nystrom LE, et al: An fMRI investigation of emotional engagement in moral judgment. Science 293(5537):2105–2108, 2001

Grounds A: The end of faith in forensic psychiatry. Crim Behav Ment Health 18:1–13, 2008

Grubin D: Commentary: mapping a changing landscape in the ethics of forensic psychiatry. J Am Acad Psychiatry Law 36:185–190, 2008

Gutheil T: The Psychiatrist as Expert Witness. Washington, DC, American Psychiatric Press, 1998

Gutheil T, Dattilio F: Practical Approaches to Forensic Mental Health Testimony. Philadelphia, PA, Lippincott Williams & Wilkins, 2008

Halleck SL, Appelbaum P, Rappeport JR, et al: Psychiatry in the Sentencing Process. Washington, DC, American Psychiatric Association, 1984

Halpern A, Halpern J, Doherty S: "Enhanced" interrogation of detainees: do psychologists and psychiatrists participate? Philos Ethics Humanitarian Medicine 25(3):21, 2008

Hartmann L, Freedman A, Appelbaum P, et al: Debate on ethics of conducting competence to be executed examinations at the 150th Annual Meeting of the American Psychiatric Association, San Diego, CA, May 1997

Hinckley J: Letter to Jodie Foster, March 30, 1981. Available at: http://www.law.umkc.edu/faculty/projects/ftrials/hinckley/jforstercommun.htm. Accessed May 6, 2009.

Janofsky J: Lies and coercion: why psychiatrists should not participate in police and intelligence interrogations. J Am Acad Psychiatry Law 34:472–478, 2006

Leong GB, Silva JA, Weinstock R, et al: Survey of forensic psychiatrists on evaluation and treatment of prisoners on death row. J Am Acad Psychiatry Law 28:427–432, 2000

Marks JH, Bloche MG: The ethics of interrogation—the U.S. military's ongoing use of psychiatrists. N Engl J Med 359(:1090–1092, 2008

Matthews D, Wendler S: Ethical issues in the evaluation and treatment of death row inmates. Curr Opin Psychiatry 19:518–521, 2006

McGarry AL, Curran WJ: Courtroom presentation of psychiatric and psychological evidence, in Modern Legal Medicine, Psychiatry and Forensic Science. Edited by Curran WJ, McGarry AL, Petty CS. Philadelphia, PA, FA Davis, 1980, pp 963–987

Meyers J: Letter to the Editor. J Am Acad Psychiatry Law 35(1):137, 2007

Miller GH: Alan Stone and the ethics of forensic psychiatry: an overview. J Am Acad Psychiatry Law 36:191–194, 2008

Morse SJ: New neuroscience, old problems: legal implications of brain science. Cerebrum 6(4):81–90, 2004

Morse SJ: The ethics of forensic practice: reclaiming the wasteland. J Am Acad Psychiatry Law 36:206–217, 2008

Mossman D: "Hired guns," "whores," and "prostitutes": case law references to clinicians of ill repute. J Am Acad Psychiatry Law 27:414–425, 1999

Nichols S, Mallon R: Moral dilemmas and moral rules. Cognition 100:530–542, 2006

Panetti v Quarterman, 551 U.S. 930 (2007)

Perlin M, Bursztajn H, Gledhill K, et al: Psychiatric ethics and the right of person with mental disabilities in institutions and the community, in Informed Consent to Conflicts of Interest to Informed Consent. Haifa, Israel, UNESCO Chair in Bioethics, 2008, pp 113–115

Reeves D, Mills MJ, Billick SB, et al: Limitations of brain imaging in forensic psychiatry. J Am Acad Psychiatry Law 31:89–96, 2003

Resnick P: The Andrea Yates case: insanity on trial. Cleveland State Law Review (55):1–10, 2007

Roberts L, Dyer A: Concise Guide to Ethics in Mental Healthcare. Washington, DC, American Psychiatric Publishing, 2004

Robertson MD, Walter G: Many faces of the dual-role dilemma in psychiatric ethics. Aust N Z J Psychiatry 42:228–235, 2008

Roper v Simmons, 543 U.S. 551 (2005)

Rosenberg CE: Contested boundaries: psychiatry, disease, and diagnosis. Perspect Biol Med 49:407–424, 2006

Rubenstein L, Annas J: Medical ethics at Guantanamo Bay detention centre and in the U.S. military: a time for reform. Lancet 74(9686):353–355, 2009

Sadoff R, Dattilio F: Crime and Mental Illness: A Guide to Courtroom Practice. Mechanicsburg, PA, PBI Press, 2008

Scott CL: Psychiatry and the death penalty. Psychiatr Clin North Am 29(3):791–804, 2006

Shuman DW: Expertise in law, medicine, and healthcare. J Health Polit Policy Law 26:267–290, 2001

Shuman DW, Gold LH: Without thinking: impulsive aggression and criminal responsibility. Behav Sci Law 26:723–734, 2008

Simon R, Shuman D: Clinical Manual of Psychiatry and Law. Washington, DC, American Psychiatric Publishing, 2007

Stanford v Kentucky, 492 U.S. 361 (1989)

State v Perry, 610 So.2d 746 (La. 1992)

Stedman's Medical Dictionary, 25th Edition. Baltimore, MD, Williams & Wilkins, 1990

Stone A: Ethics in forensic psychiatry: re-imagining the wasteland after 25 years. Presentation at the 38th annual meeting of the American Academy of Psychiatry and the Law, October 2007

Stone AA: The ethical boundaries of forensic psychiatry: a view from the ivory tower. Bull Am Acad Psychiatry Law 12(3):209–219, 1984

Strasburger LH: The litigant-patient: mental health consequences of civil litigation. J Am Acad Psychiatry Law 27:203–211, 1999

Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154(4):448–456, 1997

Thompson SK: The legality of the use of psychiatric neuroimaging in intelligence interrogation. Cornell Law Rev 90(6):1601–1637, 2005

Thompson v Oklahoma, 487 U.S. 815 (1988)

U.S. v Ewing, 484 F3d 607 (7th Cir. 2007)

Weinstock R, Leong G, Silva J: Ethical Guidelines, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner E. New York, Hodder Arnold, 2003, pp 56–72

Suggested Readings and Relevant Web Sites

Ake v Oklahoma, 470 U.S. 68, 105 S.Ct. 1087 (1985)

American Psychiatric Association: The Principles of Medical Ethics With Annotation Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Association, 2001

Candilis PJ: The revolution in forensic ethics: narrative, compassion, and a robust professionalism. Psychiatr Clin North Am 32:423–435, 2009

Case of the Quarter: Treating psychiatrist cannot be considered impartial. Rx For Risk, 17:13–14, 2009 [Discussion of Weiler v Weiler, 169 A.D.2d 1029 (1991)]

Cohen F: The Mentally Disordered Inmate and the Law, 2nd Edition, Vols I and II. New York, Civic Research Institute, 2008

Gawande A: When law and ethics collide—why physicians participate in executions. N Engl J Med 354:1221–1229, 2006

Human Rights Watch, http://www.hrw.org/

Melton G, Petrila J, Poythress N, et al: Constitutional, common-law, and ethical contours of the evaluation process: the mental health professional as double agent, in Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007, pp 69–100

Rosenbaum R: Travels with Dr. Death. Vanity Fair, May 1990, pp 141–173

Appendix: AAPL Ethics Guidelines for the Practice of Forensic Psychiatry[1]

I. Preamble

The American Academy of Psychiatry and the Law (AAPL) is dedicated to the highest standards of practice in forensic psychiatry. Recognizing the unique aspects of this practice, which is at the interface of the professions of psychiatry and the law, the Academy presents these guidelines for the ethical practice of forensic psychiatry.

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Commentary

Forensic Psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. These guidelines apply to psychiatrists practicing in a forensic role.

These guidelines supplement the Annotations Especially Applicable to Psychiatry of the American Psychiatric Association to the Principles of Medical Ethics of the American Medical Association.

Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings and abuses.

Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility. However, when a treatment relationship exists, such as in correctional settings, the usual physician-patient duties apply.

II. Confidentiality

Respect for the individual's right of privacy and the maintenance of confidentiality should be major concerns when performing forensic evaluations. Psychiatrists should maintain confidentiality to the extent possible, given the legal context. Special attention should be paid to the evaluee's understanding of medical confidentiality. A forensic evaluation requires notice to the evaluee and to collateral sources of reasonably anticipated limitations on confidentiality. Information or reports derived from a forensic evaluation are subject to the rules of confidentiality that apply to the particular evaluation, and any disclosure should be restricted accordingly.

Commentary

The practice of forensic psychiatry often presents significant problems regarding confidentiality. Psychiatrists should be aware of and alert to those issues of privacy and confidentiality presented by the particular forensic situation. Notice of reasonably anticipated limitations to confidentiality should be given to evaluees, third parties, and other appropriate individuals. Psychiatrists should indicate for whom they are conducting the examination and

what they will do with the information obtained. At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluee that the psychiatrist is not the evaluee's "doctor." Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluee may develop the belief that there is a treatment relationship. Psychiatrists should take precautions to ensure that they do not release confidential information to unauthorized persons.

When a patient is involved in parole, probation, conditional release, or in other custodial or mandatory settings, psychiatrists should be clear about limitations on confidentiality in the treatment relationship and ensure that these limitations are communicated to the patient. Psychiatrists should be familiar with the institutional policies regarding confidentiality. When no policy exists, psychiatrists should attempt to clarify these matters with the institutional authorities and develop working guidelines.

III. Consent

At the outset of a face-to-face evaluation, notice should be given to the evaluee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible. If the evaluee is not competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction.

Commentary

Informed consent is one of the core values of the ethical practice of medicine and psychiatry. It reflects respect for the person, a fundamental principle in the practices of psychiatry and forensic psychiatry.

It is important to appreciate that in particular situations, such as court-ordered evaluations for competency to stand trial or involuntary commitment, neither assent nor informed consent is required. In such cases, psychiatrists should inform the evaluee that if the evaluee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony.

Absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons are: known to be charged with criminal acts; under investigation for criminal or quasi-criminal conduct; held in government custody or detention; or being interrogated for criminal

or quasi-criminal conduct, hostile acts against a government, or immigration violations. Examinations related to rendering medical care or treatment, such as evaluations for civil commitment or risk assessments for management or discharge planning, are not precluded by these restrictions. As is true for any physician, psychiatrists practicing in a forensic role should not participate in torture.

Consent to treatment in a jail or prison or in other criminal justice settings is different from consent for a forensic evaluation. Psychiatrists providing treatment in such settings should be familiar with the jurisdiction's regulations governing patients' rights regarding treatment.

IV. Honesty and Striving for Objectivity

When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.

Commentary

The adversarial nature of most legal processes presents special hazards for the practice of forensic psychiatry. Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.

Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data. They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical "facts," "inferences," and "impressions."

Psychiatrists should not distort their opinion in the service of the retaining party. Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination. For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychia-

trists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions clearly state that there was no personal examination, and note any resulting limitations to their opinions.

In custody cases, honesty and objectivity require that all parties be interviewed, if possible, before an opinion is rendered. When this is not possible, or is not done for any reason, this should be clearly indicated in the forensic psychiatrist's report and testimony. If one parent has not been interviewed, even after deliberate effort, it may be inappropriate to comment on that parent's fitness as a parent. Any comments on the fitness of a parent who has not been interviewed should be qualified and the data for the opinion clearly indicated. Contingency fees undermine honesty and efforts to attain objectivity and should not be accepted. Retainer fees, however, do not create the same problems in regard to honesty and efforts to attain objectivity and, therefore, may be accepted.

Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes.

Treating psychiatrists appearing as "fact" witnesses should be sensitive to the unnecessary disclosure of private information or the possible misinterpretation of testimony as "expert" opinion. In situations when the dual role is required or unavoidable (such as Workers' Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important. When requirements of geography or related constraints dictate the conduct of a forensic evaluation by the treating psychiatrist, the dual role may also be unavoidable; otherwise, referral to another evaluator is preferable.

V. Qualifications

Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience.

Commentary

When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely. As a correlate of the

principle that expertise may be appropriately claimed only in areas of actual knowledge, skill, training and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise.

VI. Procedures for Handling Complaints of Unethical Conduct

The American Academy of Psychiatry and the Law does not adjudicate complaints that allege unethical conduct by its members or nonmembers. If received, such complaints will be returned to the complainant for referral to the local district branch of the American Psychiatric Association, the state licensing board, and/or the appropriate national psychiatric organization of foreign members. If the American Psychiatric Association or the psychiatric association of another country expels or suspends a member, AAPL will also expel or suspend that member upon notification of such action. AAPL will not necessarily follow the American Psychiatric Association or other organizations in other sanctions.

Commentary

General questions regarding ethical practice in forensic psychiatry are welcomed by the Academy and should be submitted to the Ethics Committee.

The Committee may issue opinions on general or hypothetical questions but will not issue opinions on the ethical conduct of specific forensic psychiatrists or about actual cases.

The Academy, through its Ethics Committee, or in any other way suitable, is available to the local or national committees on ethics of the American Psychiatric Association, to state licensing boards or to ethics committees of psychiatric organizations in other countries to aid them in their adjudication of complaints of unethical conduct or the development of guidelines of ethical conduct as they relate to forensic psychiatric issues.

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Chapter 6

Psychiatric Diagnosis in Litigation

Robert I. Simon, M.D.

Liza H. Gold, M.D.

***The* Diagnostic and Statistical Manual** *of Mental Disorders* (DSM) (American Psychiatric Association 1994, 2000) contains current standard psychiatric diagnostic nomenclature used for clinical diagnosis, treatment, and research. The development and adoption of DSM diagnoses have been accompanied by a great deal of controversy. This controversy continues as the fifth edition of DSM is being prepared for publication in 2012.[1] Nevertheless, DSM diagnoses are generally accepted and relied on in clinical and research venues, as well as many other venues for which the nomenclature was not intended, including insurance companies, managed care companies, and the courts (Gold 2002; Greenberg et al. 2004; Shuman 1989).

[1]See Gallatzer-Levy and Gallatzer-Levy 2007 for an excellent review of past and present controversies associated with DSM, and Widiger and Clark 2000 for diagnostic issues regarding the development of DSM-V.

Concerns raised by the use of DSM in the courts are significant for both psychiatry and the law. The drafters of DSM have consistently expressed these concerns about the use of DSM in litigation. DSM-IV (American Psychiatric Association 1994) and its text revision, DSM-IV-TR (American Psychiatric Association 2000), state, "When the DSM-IV categories, criteria, and textual descriptions are 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 information contained in a clinical diagnosis" (American Psychiatric Association 2000, pp. xxxii–xxxiii). This caveat regarding the use of DSM diagnoses in forensic contexts is intended to remind everyone that the information presumably conveyed by a diagnosis may not be the information courts require to come to legal decisions, and it is likely to remain unchanged in the forthcoming fifth edition of DSM. This imperfect fit between diagnostic nomenclature and functional abilities sometimes results in both psychiatric and legal overemphasis on diagnosis rather than assessment of function.

Although issues of the scientific reliability of DSM diagnoses sometimes arise (Gold 2002; see also, e.g., *Ryder v. State* 2004), the acceptability of DSM in court seems to be so settled that courts do not even treat it as an issue. The standards regarding the judicial determination of scientific reliability were set forth in the Supreme Court decisions of *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993). Reliance on DSM to satisfy the *Daubert* criteria appears to be so widely accepted that courts treat it as a foregone conclusion. DSM diagnoses rarely fail to meet *Daubert* criteria for reliability, validity, and, therefore, admissibility (Shuman 1989). In fact, legal arguments regarding *Daubert* and DSM in published opinions center on contesting admission of evidence on the grounds that it did not rely on DSM and, thus, did not satisfy *Daubert* (see, e.g., *Mancuso v. Consol. Edison* 1997).

The more significant question raised by the acceptance and reliance of the legal system on DSM is whether DSM diagnoses provide an adequate understanding of psychological states for forensic purposes. Legal determinations, whether civil or criminal, typically revolve around issues of impairment. A DSM diagnostic category is not directly relevant to such determinations. For example, in criminal matters, defendants acquitted through a "not guilty by reason of insanity" verdict are typically evaluated on the basis of their ability to distinguish right from wrong or to resist their impulses. These verdicts are not rendered simply on the basis of whether defendants meet DSM criteria for certain diagnoses such as schizophrenia or bipolar disorder. Nor will specific diagnoses qualify a defendant for a not-guilty-by-reason-of-insanity verdict when others will not. In personal injury litigation, functional impairment is the critical issue for determining damages (Simon 2002). The legal question

in such litigation is not whether the plaintiff has a psychiatric diagnosis but how the plaintiff's pre- and post-incident conditions differ, and whether that difference can be attributed to the defendant's wrongful conduct.

The use of DSM diagnoses in forensic settings can create confusion by encouraging misguided attempts to utilize diagnoses as a proxy for impairment or for legally relevant behavior (Greenberg et al. 2004). When categorical DSM diagnoses are used for purposes other than clinical treatment or research, misconceptions about the role and importance of these diagnoses result in the "imperfect fit" that concerned the framers of DSM. These misconceptions may be held both by the legal system and, at times, by psychiatrists providing forensic evaluations in litigation.

Diagnosis and impairment are not equivalent. No diagnosis carries specific information regarding level of impairment or information about whether an impairment associated with that diagnosis is relevant to the legal issue under examination by the court. The use of categorical DSM diagnosis in litigation may result in the examiner missing the most important aspect of the forensic evaluation: the assessment of impairment or legally relevant behavior.

The legal system is rarely concerned with the imperfect fit between diagnosis and legal concerns. Attorneys and judges usually focus on the presence or absence of the diagnosis. Courts and attorneys may require psychiatrists to provide DSM diagnoses or insist that they do so. This, in turn, may lead psychiatrists to give undue importance to diagnosis in forensic evaluations and to miss the essential assessment of impairment in function. Even when a diagnosis is appropriate and accurate, the categorical nature of DSM's nosology is such that necessary dimensional information may be overlooked or misinterpreted. These issues will be addressed by examining the use of the diagnosis of subthreshold posttraumatic stress syndrome (PTSD). Although discussed only in the context of personal injury litigation, the "imperfect fit" of categorical DSM diagnosis applies across the spectrum of civil and criminal litigation.

Case Vignette

Ms. J, a 36-year-old chief financial officer of a large corporation, was returning home aboard a jet aircraft when it skidded off the runway in a snowstorm. The aircraft entered a bordering harbor and came to a stop in 5 feet of icy water. Ms. J was momentarily dazed when her head struck the seat in front of her. She was terrified that she would drown, as she had never learned to swim. She escaped the aircraft by sliding down an emergency chute and was able to walk ashore.

Ms. J twisted her ankle as she emerged from the water. She was taken to a local emergency room, where her examination showed an abrasion on her forehead and swelling of her left ankle but no serious injuries. After receiving

appropriate treatment in the emergency room, she was released from the hospital. The accident occurred on a Friday night before a 3-day weekend. Ms. J returned to work on the following Tuesday.

One year later, Ms. J filed a personal injury suit against the airline, demanding $500,000 in damages. She claimed that negligence on the part of the airline caused physical and psychological injuries. Soon after she filed her suit, a psychiatrist retained by her attorney examined Ms. J. Ms. J reported that shortly following the accident, she experienced occasional nightmares of falling or drowning. She had daily recollections of the accident, psychological and physical reactivity to situations that reminded her of the accident, and difficulty in concentration. She denied insomnia, irritability, and depression. Ms. J reported that over the course of the subsequent year, her work function seemed to be particularly affected by the events. She stated that she developed difficulty "staying focused" at work and managing a substantial increase in her workload. She claimed that her lack of concentration caused "a lot of serious mistakes," which resulted in her being passed over for promotion. Ms. J had not lost time from work.

Ms. J's work required frequent travel, which she had always enjoyed. After the accident, she developed significant anxiety related to flying. Her primary care physician prescribed a minor tranquilizer for use as needed for flying-related anxiety. She was able to fly, but she had to take medication to do so. Although this tranquilizer provided some relief, Ms. J was still uncomfortable whenever she traveled by plane. She claimed that both the stress of flying and the effects of the tranquilizer left her physically and emotionally depleted. She resisted her primary care physician's recommendation to seek psychological help. She feared reexperiencing the trauma and the worsening of her symptoms, stating, "I just want to forget it."

Ms. J continued to see some of her friends and her fiancé, but her plans to marry were placed on hold. The marriage plans had been interrupted once before the accident because of "storminess" in the relationship. Sexual intimacy had also waxed and waned throughout the relationship. Nevertheless, Ms. J reported that the relationship with her fiancé became more "troubled" and unstable following the accident. Ms. J's unwillingness to take vacations with her fiancé that would require flying led to discord and more frequent arguments. Her fiancé threatened to leave. In addition, although she maintained close relationships with some friends, Ms. J stated that she avoided casual friends who asked questions about the accident and the lawsuit.

Ms. J's history revealed that she was the only child of a troubled marriage. Her parents fought frequently. Her father was an alcoholic who was physically and verbally abusive to both Ms. J and her mother. Ms. J was an outstanding student in high school and college. At age 28, she married a much older business executive. The couple had no children. They were divorced after 2 years of marriage because of "incompatibility." Ms. J denied any history of significant psychological symptoms or treatment for a psychiatric condition. She had no significant medical problems and no history of drug or alcohol abuse.

The plaintiff's expert determined that Ms. J exhibited symptoms of subthreshold PTSD following the life-threatening airplane accident. She met only four of six minimal symptom criteria necessary for a DSM-IV diagnosis

of PTSD and had only two of three criterion C symptoms: efforts to avoid thoughts, feelings, or conversations associated with the trauma and efforts to avoid activities, places, or people that arouse recollections of the trauma. In addition, she manifested only one of two criterion D symptoms: difficulty concentrating. This psychiatrist considered but rejected other DSM-IV diagnoses as incorrect, including generalized anxiety disorder, anxiety disorder not otherwise specified, and adjustment disorder, chronic. He considered but resisted the temptation to diagnose anxiety disorder not otherwise specified merely to gain the imprimatur of DSM-IV in court. The examiner made the diagnosis of subthreshold PTSD because the minimal DSM-IV symptom criteria for PTSD were not met.

The plaintiff's attorney was uncomfortable with the diagnosis of subthreshold PTSD. She expressed concern that the defense attorney would attack subthreshold PTSD as a suspect non-DSM diagnosis. The attorney was also concerned that the judge and jury would become confused and reject a diagnosis not found in DSM-IV. The examining expert experienced considerable pressure from the attorney to "consider the possibility of an official diagnosis." The expert did believe that Ms. J could be legitimately diagnosed as having PTSD on the basis of meeting clinical significance criteria: "The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (criterion F in posttraumatic stress disorder). Although this reasoning was clinically valid, the expert was certain that opposing counsel would accuse him of circumventing DSM-IV criteria by invoking "clinical significance criteria" to reach a diagnosis of PTSD. He anticipated the cross-examination: "Isn't it true, Doctor, that she does not meet the DSM-IV criteria for PTSD, does she? Let's go over each of the criteria," and so forth.

Categorical and Dimensional Diagnosis

General Issues

A *categorical* system of classification is most efficient when all members of a diagnostic class are homogeneous, when the boundary between classes is clear, and when the classes are mutually exclusive. Categorical classification assists clinicians by providing a pragmatic tool to facilitate diagnosis and to treat illnesses. Medical students are taught the principle of *parsimony*—that is, to think of a single disorder that can explain a patient's multiple symptoms. Throughout the history of medicine, there has been a continuing quest for a coherent classification of mental disorders. Many methodologies have been proposed, but little agreement has existed on which mental disor-

ders to include and the best way to organize them (Sadler et al. 1994). During the nineteenth century, psychiatry began developing a categorical system of classification similar to that long favored by medical tradition.

In a categorical diagnostic system, the patient either meets the diagnostic criteria for a disorder or does not. For example, a brain tumor either is or is not present. In a pure categorical diagnosis, all the diagnostic criteria for the disorder must be met. DSM-IV recognizes the heterogeneity of clinical presentations by establishing polythetic criteria sets in which the individual may meet only a subset of diagnostic criteria from a longer list. For example, the diagnosis of borderline personality disorder can be made with only five of nine inclusion criteria. Unlike medical diagnoses, DSM-IV psychiatric diagnoses usually do not inform about the etiology and pathogenesis of a disorder.

Individuals with a specific diagnosis are often heterogeneous regarding the diagnostic criteria, as stated in DSM-IV:

> In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. (American Psychiatric Association 2000, p. xxxi)

As a consequence, DSM-IV uses a modified categorical diagnostic system.

In a dimensional classification system, no discrete categories are present. Individuals are classified along a continuum. A dimensional system classifies clinical presentations based on quantitative or qualitative factors or attributes rather than establishing diagnostic categories. The dimensional system is most useful in describing conditions or levels of severity that are distributed continuously, without clear boundaries. For example, Axis V in DSM-IV, the Global Assessment of Functioning (GAF) Scale, is numerically coded from 0 to 100. Qualitative dimensional approaches found in DSM-IV include severity specifiers such as mild, moderate, and severe. Anxiety, depression, obsessions, and compulsions, formerly considered to fit into neat categorical diagnoses, are now recognized as spectrum disorders—a qualitative dimensional classification.

Categorical and dimensional diagnostic systems often coexist. For example, the diagnosis of a brain tumor is categorical (present or absent), but the extent and severity of the disease (staging) helps inform treatment decisions and prognosis. Rating scales for severity of illness, such as the Hamilton Rating

Scale or the Brief Psychiatric Rating Scale, measure severity and change in an illness that is diagnosed categorically (Bogenschutz and Nurnberg 2000).

Implications for Forensic Psychiatry

DSM-IV relies on a system of diagnosis that establishes categorical boundaries, using both inclusion and exclusion criteria. The categorical nature of DSM diagnoses can create problems for psychiatrists providing assessments in litigation. This categorical diagnostic model does not accommodate dimensional posttraumatic stress spectrum syndromes such as the subthreshold PTSD diagnosed in Ms. J's case (Kinzie and Goetz 1996). Mental conditions such as subthreshold PTSD, which exhibit symptoms that fall outside the DSM-IV diagnostic criteria, are thereby excluded. A dimensional system of diagnosis avoids categorical boundaries, permitting stress spectrum syndromes to be recognized along with associated impairments (Maser and Patterson 2002).

The question of whether mental disorders are discrete clinical conditions or arbitrary distinctions along dimensions of functioning is a long-standing issue (Widiger and Samuel 2005). DSM-IV readily acknowledges the importance of dimensional diagnosis in increasing reliability while also communicating more clinical information. However, DSM-IV cautions that dimensional systems have serious limitations and have been less useful than categorical systems in clinical practice and in stimulating research. For example, dimensional systems lack agreement on the choice of operational dimensions for classification purposes. Moreover, numerical dimensions are less familiar to clinicians than are categorical descriptions of mental disorders.

DSM-IV itself suggests a flexible approach to diagnosis. It fairly states the limitations of a categorical approach while at the same time providing cautionary warning about idiosyncratic use of diagnoses, as described below:

> The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication. (American Psychiatric Association 2000, p. xxxii)

Diagnosis is relevant to the treatment instituted by clinicians to restore the plaintiff to his or her pre-accident condition, but it does not play the same role

in determining the plaintiff's right to compensation. For example, "pain and suffering" can exist in the absence of a mental disorder. Insisting on the provision of categorical diagnoses does not necessarily provide more useful information for the decision-makers or provide a useful incentive for litigants. In certain cases, dimensional diagnosis may permit consideration of spectral, subthreshold disorders that are more meaningfully related to associated impairments. Nevertheless, categorical psychiatric diagnosis will remain an important feature of forensic practice. The imperfect fit between the use of diagnoses for clinical purposes and their use in litigation makes the prominent role played by categorical diagnoses in forensic settings problematic.

Lawyers, judges, and juries much prefer categorical diagnoses because of their seeming clarity. In litigation, decisions must be made at the time of trial. The assessment of an individual over time that occurs in clinical settings is a luxury not available to judicial decision-makers. However, categorical diagnostic models exclude conditions that fall outside preestablished inclusion criteria and may be better described by a dimensional or spectrum framework. Disorders classified prototypically and categorically, such as PTSD, have dimensions that complicate psychiatric diagnosis and can lead to a lack of clarity in the courtroom that can complicate judicial decision making.

Dimensional Diagnosis in Litigation: Subthreshold Posttraumatic Stress Disorder

Subthreshold PTSD is an example of a disorder with dimensional features that has not received official diagnostic recognition yet clearly exists and frequently causes significant functional impairment. Subthreshold PTSD can be conceptualized as a dimensional entity that manifests categorical characteristics (defined symptoms causing impairment) and is a good example of such a model (Frank et al. 1998; Maser and Patterson 2002; Ruscio et al. 2002).

The diagnosis of PTSD may present clinically with significant variations from the prototype. Subthreshold PTSD, although not a formally recognized DSM diagnosis, has been recognized in the professional literature (Schützwohl and Maercker 1999; Stein et al. 1997). It is common in Vietnam veterans (Warshaw et al. 1993; Weiss et al. 1992) and Iraq and Afghanistan war veterans (Jakupcak et al. 2007) and is highly represented among sexual abuse survivors and in other traumatized persons (Blanchard et al. 1996; Carlier and Gersons 1995). The number of PTSD symptoms present gener-

ally correlates with the severity and chronicity of the disorder (Breslau and Davis 1992; Green et al. 1990; Marshall et al. 2001).

Subthreshold conditions in medicine and psychiatry are common and often cause significant impairment. For example, in medicine, a patient may have some, but not all, of the clinical symptoms necessary for a clinician to make a diagnosis of migraine headache but is, nonetheless, debilitated by the pain. Subthreshold psychiatric conditions may not fit into categorical diagnostic classifications but may also be debilitating (Maser and Akiskal 2002). Subsyndromal symptoms of major depression can be disabling (Broadhead et al. 1990; Judd et al. 1998; Pincus et al. 2003). Subthreshold social phobia can be associated with severe limitations (Davidson et al. 1994; Schneider et al. 2002).

Subthreshold PTSD may be a longitudinal variant of full PTSD. Like most disorders, PTSD develops over time. Likewise, it may remit with or without treatment over time. A diagnosis of subthreshold PTSD may apply to persons who are newly diagnosed and to those in the process of recovery. Like full PTSD, however, the subthreshold variant may become chronic and persist for years (Moreau and Zisook 2002). Across study groups, the percentage of participants meeting the DSM-IV reexperiencing criterion or the hyperarousal criterion is much greater than the percentage that meets the avoidance criterion. This implies that those who have genuine PTSD symptoms are often excluded from the diagnosis of PTSD because of the absence of the requisite three avoidant symptoms (Mylle and Maes 2004; Schützwohl and Maercker 1999). Some authors have therefore argued for the development of a posttraumatic stress spectrum disorder (Moreau and Zisook 2002).

Persons with subthreshold PTSD exhibit clinically significant levels of functional impairment associated with their symptoms. Such findings can be relevant when assessing damages in forensic evaluations. Research has demonstrated that persons with subthreshold PTSD report significantly more interference with work or education than do traumatized persons with fewer symptoms, though they report significantly less interference than persons with the full disorder (Breslau et al. 2004; Grubaugh et al. 2005; Jakupcak et al. 2007; Stein et al. 1997; Zlotnick et al. 2002). An examination of comorbidity, impairment, and suicidality in a cohort of adults with subthreshold PTSD indicated that impairment, number of comorbid disorders, rates of comorbid major depressive disorder, and current suicidal ideation increased linearly and significantly with increasing number of subthreshold PTSD symptoms (Marshall et al. 2001). A community-based population study of elderly patients with PTSD and subthreshold PTSD revealed that both groups had significant impairment and disability compared with a non-PTSD control group (van Zelst et al. 2006).

The accompanying schematic figures illustrate dimensional models of psychological trauma. In Figure 6–1, a one-to-one linear relationship between

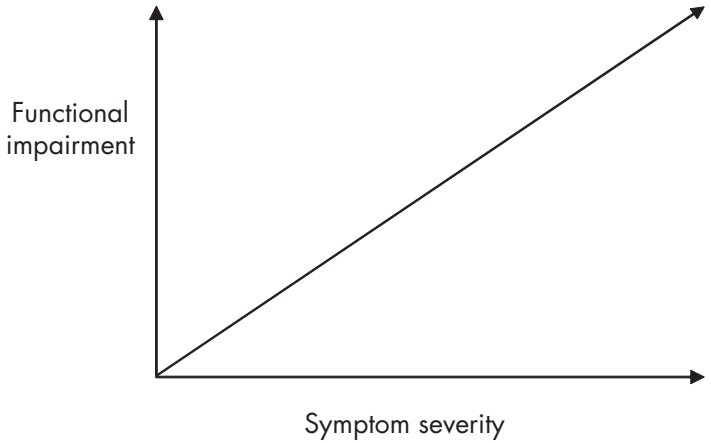

FIGURE 6–1. Hypothetical dimensional model of functional impairment and symptom severity.

symptom severity and functional impairment is presented for heuristic purposes only. Although a correlation usually exists between symptom severity and functional impairment, rarely, if ever, is the correlation a one-to-one linear relationship (Mezzich and Sharfstein 1985). Figure 6–2 demonstrates possible categorical diagnoses that may occur on a dimensional axis of increasing severity of psychological trauma.

In clinical practice, the fact that a patient's symptoms do not meet all the criteria of a diagnostic category may not be critically significant. Diagnosis in a clinical setting guides treatment. Treatment of a patient with all the symptom criteria of depression, social phobia, or PTSD, in most cases, will not differ significantly from treatment of a patient with a moderate to severe subthreshold form of these disorders. The threshold for treatment intervention generally is severity of symptoms or impairment in function, not whether every diagnostic criterion has been met. If treatment does differ, the clinician has the option over time to change treatment recommendations in response to the evolution or remission of the patient's disorder.

In contrast, in a forensic setting, the difference between a DSM diagnosis and no diagnosis or between a DSM diagnosis and a non-DSM diagnosis may be significant, regardless of degree of impairment. In the vignette, Ms. J's degree of functional impairment causally related to the accident, as indicated by a comparison of her pre- and post-incident functioning, should be the most significant factor in the award of damages. However, the expert psychiatrist's diagnosis of subthreshold PTSD in the case of Ms. J demonstrates the

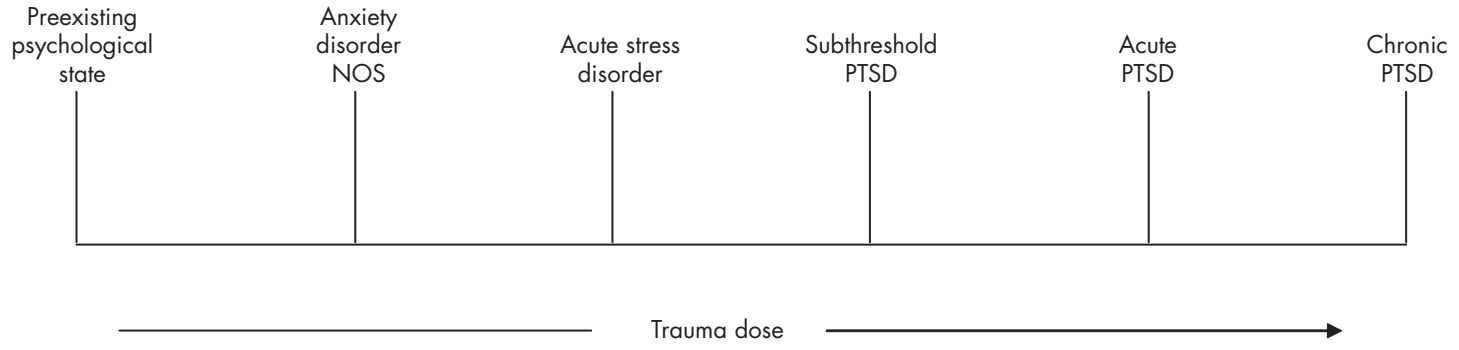

FIGURE 6–2. Categorical diagnoses on a dimensional axis of psychological trauma.

difficulties that can arise between the legal system's desire for a categorical diagnosis and the dimensional presentation of a subthreshold syndrome.

Plaintiff's Case

During trial (see case vignette earlier in this chapter), the plaintiff's expert testified that he relied on the psychiatric literature to make the diagnosis of chronic subthreshold PTSD. He pointed out the persistent decrements in Ms. J's quality of life following the airplane accident. The plaintiff's attorney elicited testimony from the expert about the professional literature support for the diagnosis of subthreshold PTSD and its association with clinically significant impairment in social and occupational functioning. The plaintiff's expert explained that PTSD is a spectrum or dimensional disorder rather than an all-or-none categorical diagnosis. He emphasized that "pain and suffering" can also exist in the absence of a DSM diagnosis of mental disorder. The attorney was convinced by this argument and felt she could successfully present it to the court.

In anticipation of the defense argument that DSM-IV is the "bible" for the diagnosis of mental illness, the plaintiff's attorney stated during closing arguments that DSM-IV is a work in progress. She quoted directly from DSM-IV:

> It must be noted that DSM-IV reflects a consensus about the classification and diagnoses of mental disorders derived at the time of initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in DSM-IV will require reconsideration in light of evolving new information. (American Psychiatric Association 2000, p. xxxiii)

The attorney argued that since 1994, when DSM-IV was published, new research has recognized the existence and importance of subthreshold PTSD in causing functional impairments.

The plaintiff's attorney also quoted the "Cautionary Statement" in DSM-IV, which warns, "These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts" (American Psychiatric Association 2000, p. xxxvii). Finally, the plaintiff's attorney noted that the manual itself stated that it was not to be applied mechanically by untrained individuals in "cookbook fashion." She advised the jury, quoting from DSM, that the diagnostic criteria "are meant to be employed by individuals with appropriate clinical training and experience in diagnosis" (American Psychiatric Association 2000, p. xxxii). She pointed out the

expert's qualifications and experience and again emphasized that the literature demonstrates that subthreshold PTSD, though not an "official" DSM diagnosis, can be associated with significant impairments. She reminded the jury of Ms. J's functional impairments resulting from her condition.

Defense's Case

Prior to trial, the defense attorney filed a motion *in limine* requesting that the judge not allow the plaintiff's expert's use of a non-DSM, subsyndromal diagnosis, which he argued lacked credibility. The judge rejected the motion and allowed the testimony. During trial, on cross-examination, the defense attorney produced DSM-IV and pointedly asked the plaintiff's expert, "Doctor, isn't DSM-IV the bible of authoritative diagnosis that psychiatrists rely on in their clinical practice?" The expert responded, "DSM-IV is an official guide to psychiatric diagnosis but is not the last word. All patients with psychiatric conditions do not necessarily meet DSM-IV diagnostic criteria." The defense attorney then proceeded to demonstrate how the expert had departed from customary diagnostic practice to arrive at an idiosyncratic diagnosis that served the plaintiff's purpose in litigation. He produced an enlarged chart of the diagnostic criteria of PTSD and specifically challenged the expert on each symptom. The expert had to acknowledge that all the symptom criteria required for a diagnosis of PTSD had not been met.

The attorney then tried to get the plaintiff's expert to agree that when fewer PTSD symptoms are present, there is little or no functional impairment. The plaintiff's expert replied that this can be true in some instances but that persons with fewer PTSD symptoms may nevertheless have significant impairment based on comorbidity and predispositional factors. The defense attorney retorted, "Well, Doctor, didn't you just tell this jury that Ms. J did not have any prior psychiatric conditions? You also told the jury that she does not currently suffer from any psychiatric condition other than subthreshold PTSD, is that correct?" The plaintiff's expert conceded this point. The defense attorney continued, "Isn't it true, Doctor, that Ms. J did not seek treatment?" The expert testified that although this was true, over one-half of individuals with PTSD or subthreshold PTSD do not seek professional help for their condition in order to not reexperience the trauma and exacerbate their symptoms.

The defense expert testified that little or no functional impairment was actually caused by the airplane accident. He stated that the absence of treatment supported this conclusion. The defense expert testified that Ms. J's symptoms of anxiety and lack of concentration were related to work stress and preexisting difficulties in her relationship with the fiancé. In closing arguments, defense counsel used this testimony to support his arguments regarding lack of damages. He contested the claim that the litigant's subthreshold PTSD "causes

clinically significant distress or impairment in social, occupational, or other areas of functioning." The defense attorney asserted that many individuals experience stress at work that causes suboptimal performance. He argued to the jury that many people fly despite their fear of flying. Moreover, he continued, the person alleging symptoms of PTSD or subthreshold PTSD has a duty to mitigate his or her symptoms by seeking treatment.

In closing arguments, the defense attorney attacked the diagnosis of subthreshold PTSD as a nonexistent "designer disorder" not recognized in DSM-IV. The defense attorney stated that DSM-IV is the psychiatric diagnostic authority, arguing to the jury that diagnostic criteria be strictly interpreted. He also quoted from DSM-IV, citing the admonition concerning the "excessively flexible and idiosyncratic application of DSM-IV criteria" (American Psychiatric Association 2000, p. xxxii). When a diagnosis of PTSD is made in the absence of meeting the diagnostic criteria, the defense attorney argued, the PTSD diagnosis is forced so that the plaintiff can provide an incident-specific trauma to establish proximate causation. In doing so, the attorney said, the plaintiff is attempting to exclude other, more likely causes of Ms. J's psychiatric condition.

The case was settled at the end of closing arguments for $50,000. Although Ms. J appeared to make a favorable impression on the jury during her testimony, her attorney was afraid that Ms. J's avoidance of treatment coupled with an unofficial subthreshold diagnosis could lead to a favorable defense verdict. Also, the jury appeared to have difficulty grasping the concept of subthreshold disorders. The defense attorney was inclined to settle because of the plaintiff's continued work impairment and difficulties in her relationship with her fiancé following the accident. Monetary damages awarded by a jury might be considerable because of Ms. J's loss of promotion opportunity. Although these impairments could be ascribed to other causes, no work impairment was discovered before the accident.

Psychiatric Diagnosis in Litigation: Square Pegs in Round Holes

DSM-IV, with its system of diagnostic categorization, was intended to encourage greater precision in communication among mental health practitioners for purposes of treatment and research. However, the problems of diagnostic categorization noted in the previous section reinforce the importance of DSM's admonition about its limitations as a vehicle to communicate with greater precision in the forensic setting (American Psychiatric Association 2000). The use of categorical DSM diagnosis risks encouraging legal deci-

sion-makers to attempt to fit diagnostic categories into legal categories for which they were not intended. If it cannot be assumed that all individuals described as having the same diagnosis are alike in important ways, then the likelihood that the use of a categorical diagnosis will encourage greater precision in communication in the forensic setting is diminished.

A dimensional model of psychological trauma informs the court much more effectively than categorical diagnosis about the relationship between the severity of symptomatology and the degree of functional impairment. Nevertheless, the use of dimensional diagnosis in litigation does not resolve all the problems created by the imperfect fit of psychiatric diagnoses in the law. Dimensional diagnoses also have limitations. For example, the use of subthreshold diagnoses in court might allow psychiatrists to legitimize their pet diagnoses. Jurors not familiar with psychiatric diagnosis may have even greater difficulty understanding the significance of non-DSM-defined terms.

A dimensional diagnostic system may also be misleading in the specific and relevant assessment of functional impairment unless additional information is provided. For example, according to DSM-IV, the determination of the level of functional impairment is coded on Axis V by use of the GAF scale. Moderate impairment in either social or occupational functioning may provide similar GAF scores, but each is likely to have very different implications for compensation. A narrative assessment that explains the individual's specific areas of functional impairment to the trier of fact is required.

The use of the "not otherwise specified," or NOS, diagnostic categories of classification, which are designed to catch psychiatric symptom clusters that constitute atypical disorders, also does not resolve the problems of the imperfect fit of DSM diagnoses in litigation. For example, anxiety disorder NOS can be used for an individual with subsyndromal PTSD. In this instance, one of the PTSD-specific rating scales, such as the Clinician-Administered PTSD Scale, can complement the NOS diagnosis. However, forcing subsyndromal disorders into catchall NOS diagnoses substitutes a categorical but vague diagnosis for a dimensional diagnosis that could better inform the court about the relationship between symptom severity and functional impairment.

Role of Psychiatric Diagnosis in Litigation

The categorical diagnostic system of DSM was not intended to be used as a tool for legal purposes, as DSM makes clear. Alternative dimensional models of diagnosis also do not fit neatly into legal considerations. The DSM's fram-

ers' reservations regarding the use of psychiatric diagnoses in the legal arena have already been reviewed earlier in this chapter. In an unpublished opinion, a New Jersey appeals court stated, "[W]e caution trial judges to be circumspect in allowing use of the DSM-IV in a forensic setting for which the manual was not designed" (*New Jersey v. Tirado* 2006). The Supreme Court, in *Clark v. Arizona* (2005) expressed the same reservations, referring to DSM's own caveat:

> There is the potential of mental-disease evidence to mislead jurors (when they are fact-finders) through the power of this kind of evidence to suggest that a defendant suffering from a recognized mental disease lacks cognitive, moral, volitional, or other capacity, when that may not be a sound conclusion at all. Even when a category of mental disease is broadly accepted and the assignment of a defendant's behavior to that category is uncontroversial, the classification may suggest something very significant about a defendant's capacity, when in fact the classification tells us little or nothing about the ability of the defendant to form mens rea or to exercise the cognitive, moral, or volitional capacities that define legal sanity.

The objectives of medical evaluation are either treatment or research. In these contexts, diagnosis is essential. A DSM diagnosis is a translation of thoughts, feelings, and behaviors into a set of criteria that communicates, however imperfectly, information to practitioners. In the courtroom, these diagnoses must then be translated back into thoughts, feelings, and behaviors that judges and jurors can understand. Because any translation is necessarily imprecise, the danger exists that psychiatric and psychological testimony may take the form of diagnostic conclusions rather than clinical descriptions. For these reasons, some legal experts have suggested that the use of diagnostic labels in forensic settings be done away with altogether (Schopp and Sturgis 1995) or unless absolutely required by law (Greenberg et al. 2004).

If diagnoses do not address the needs of the legal system, why should they be used in court at all? For one thing, the allure of categorical diagnoses is such that the use of diagnoses in the legal system and in forensic mental health evaluations is unlikely to disappear. Categorical models of classification often appear easier to use. One diagnostic label can convey a considerable amount of relevant and useful clinical information in a succinct manner. Dimensional models are inherently more complex than diagnostic categories because they generally require a more rigorous description that includes specific, and sometimes more technically precise, information (Widiger and Samuel 2005).

DSM-IV is the de facto official code set for various federal agencies and for virtually all states. Over 650 federal and state statutes and regulations rely

on or directly incorporate DSM's diagnostic criteria. For example, the Department of Veterans Affairs disability program uses the diagnostic criteria in DSM-IV to assess whether an applicant qualifies for disability on the basis of a mental disorder (38 CFR § 4.125). In California, Medicaid reimbursement to hospitals is keyed to DSM-IV (9 CCR §§ 1820.205[a][1][B] and 1830.205[b][1][B]). The Americans with Disabilities Act and the Social Security Act make diagnosis an essential element of a claim.

Diagnoses are also often threshold requirements needed to meet specific legal sanctions or determinations. These threshold requirements limit legally sanctioned excuses, entitlements, and curtailments of liberty to persons who suffer from mental illness. For example, in criminal law, every legal test for criminal responsibility specifies that the legally relevant impairment must be the result of "mental disease or defect." Many standards for incompetence to stand trial, including those of the Model Penal Code, require that the defendant's limitations be the result of mental disorder. For example, the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008 authorizes a variety of interventions for law enforcement agencies responding to incidents involving mentally ill offenders. The Act defines "serious mental illness" as a disorder meeting the diagnostic criteria specified in DSM-IV.

In civil law, the existence of a mental disorder may be necessary to establish that a party was incompetent to contract or unable to write a valid will (Halleck et al. 1992; Shuman 2002). In some cases, the law makes the presence of a mental disorder an element of a party's *prima facie* case or defense (Greenberg et al. 2004). Even when not specifically required to prove a case, both lawyers and forensic evaluators often think they must have a diagnosis for credibility (Greenberg et al. 2004).

Thus, DSM-IV seeks to warn about the risks of misunderstanding and misuse of psychiatric diagnoses for forensic purposes:

> In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. (American Psychiatric Association 2000, p. xxxiii)

If psychiatrists and other mental health practitioners regularly testify to diagnostic categories without thorough exploration and explanation of relevant functional impairment, DSM's admonition about the risks of misunderstanding and misusing psychiatric diagnoses is unlikely to be appreciated by judges, lawyers, and jurors.

Nevertheless, despite all these limitations, diagnostic considerations can be relevant in forensic evaluations. Although not dispositive, some degree of association clearly exists among DSM diagnoses, impaired mental capacity, and impaired functioning. As noted, formal mental disorders are threshold requirements in a number of legal statutes. In general, mental disorders serve these threshold functions because they are believed to be meaningfully associated with diminished abilities or functional impairments. Even though a diagnosis does not specify the nature of this association in regard to a specific functional capacity or a specific legal standard, psychiatrists' assessment of a relevant impairment may be informed or guided by a psychiatric diagnosis. When mental disorder is a threshold requirement for certain legal determinations, the diagnostic requirement is meant to serve as a validator of the main legal contention that certain relevant impairments are present (Halleck et al. 1992).

Diagnoses also serve the valuable purposes of directing inquiry and restraining ungrounded assertions regarding symptoms and functional impairment. As a result of their specialized knowledge, psychiatrists providing forensic evaluations can draw reasonable connections between or refute unreasonable claims about symptoms associated with a diagnosis and impaired functions associated with those symptoms. Thus, diagnosis may direct evaluators toward closer examination of the range of symptoms associated with that diagnosis and with the functional impairments and specific capacities that are legally relevant. Similarly, the use of diagnosis can limit unsupportable conclusions regarding an individual's past mental status or degree of functional impairment.

In addition, diagnoses allow psychiatrists to make knowledgeable observations about the longitudinal course of a disorder and symptoms that may have affected relevant legal capacities. The identification of a chronic, episodic, or progressively deteriorating course of mental illness associated with various diagnostic categories provides forensic examiners with a framework for identifying the course of a particular individual's illness and the likelihood of symptoms creating functional impairments at a certain point in time. In addition, the natural history of a disorder often provides clues to the possible duration of such impairments that may be legally relevant.

Finally, the use of a diagnosis can serve as a point of reference that enhances the value and reliability of psychiatric testimony, even though it may not be the determinative factor for the trier of fact. When a diagnosis is established, an extensive body of literature and research important in rendering legal determinations can be introduced to the court. The subject of the evaluation can be assessed in relation to others of the same diagnostic category aided by the cumulative experiences and research of the fields of psychiatry and psychology.

Making a diagnosis is only the beginning of any assessment, whether clinical or forensic. In clinical practice, more information must be gathered to understand the patient's psychological state and to devise and implement an appropriate treatment plan. For example, a diagnosis of major depression does not convey any specific information regarding a patient's risk of suicide. An individual with active suicidal ideation, a plan, means, and intent would be provided with vastly different treatment than an individual with no suicidal ideation, even though both may have the same categorical DSM diagnosis.

Similarly, in forensic evaluations, the legal system's reliance on DSM diagnoses should not lead psychiatrists to simply provide categorical diagnosis without further information. As expressed by Stuart Greenberg and colleagues, "Experts should always address legally relevant behaviors, capacities and functioning" (2004). Evaluation of the relevant functional impairment or changes resulting from the mental disorder should be specific and explicit and, where appropriate, should include a dimensional model of description. Otherwise, clinicians run the risk of providing information that is more misleading than helpful to the trier of fact.

Conclusion

Psychiatrists and other mental health practitioners who offer expert testimony should take steps to prevent categorical diagnosis from casting a spell of certitude on the court. This requires appreciating and avoiding the misuse and misunderstanding of psychiatric diagnosis in forensic settings. Impairment, not diagnosis, is the central issue in most types of litigation. Subthreshold diagnoses such as subthreshold PTSD illustrate the significant differences between the application of DSM categorical diagnosis and that of dimensional diagnosis in litigation. Dimensional diagnosis permits consideration of subsyndromal conditions and their associated impairments along a continuum of symptom severity rather than on all-or-none categorical terms.

The law's reliance on "official" DSM diagnosis, however, makes the use of a dimensional model problematic. Attorneys and judicial decision-makers clearly prefer categorical DSM diagnoses. Unfortunately, "gray" medical and psychiatric conditions may not conform to preestablished "black-and-white" categorical diagnoses and may require forensic psychiatrists to provide an appreciation of the dimensional nature of diagnosis. Overreliance on categorical diagnoses in litigation can result in the use of diagnoses to convey or imply information that they were not designed to encompass.

Psychiatrists providing forensic evaluations and expert testimony should make certain that the law's emphasis on categorical diagnosis does not result in failure to specifically assess functional impairment. In assessing impairment, expert testimony should provide a qualitative or quantitative dimensional context. Such a context requires the use of clinically based data, severity of illness assessments, and the pertinent psychiatric literature to help the fact-finder assess the functional effect of the evaluee's symptom on the relevant capacity or behavior in question.

Key Points

- There is an "imperfect fit" between categorical DSM diagnosis and the legal process across the spectrum of civil and criminal litigation.
- Subthreshold diagnosis illustrates the significant differences between the application of DSM categorical diagnosis and dimensional diagnosis in litigation.
- Regardless of the legal system's desire or requirement for a formal DSM diagnosis, legal determinations often hinge on relevant impairment, not diagnostic category.
- No diagnosis implies any specific level of impairment.

Practice Guidelines

1. Identify the necessity for inclusion or exclusion of psychiatric diagnosis in accordance with the relevant legal statute.
2. Identify the functional capacity directly relevant to the legal issue in question and evaluate functional impairment, if any.
3. Explain the relationship between the diagnosis and the relevant functional capacity. If an unreasonable or invalid inference of functional impairment is being made on the basis of any given diagnosis, explain the lack of correlation between or incorrect reasoning about the diagnosis and functional capacity in question.
4. Do not substitute the formulation of a DSM diagnosis for a careful forensic evaluation of the relevant functional capacity in question. A narrative summary may be necessary to explain the litigant's specific functional impairments.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Blanchard EB, Hickling EJ, Barton KA, et al: One-year prospective follow-up of motor vehicle accident victims. Behav Res Ther 10:775–786, 1996

Bogenschutz MP, Nurnberg HG: Classification of mental disorders, in Comprehensive Textbook of Psychiatry, 7th Edition. Edited by Sadock BJ, Sadock VA. Philadelphia, PA, Lippincott Williams & Wilkins, 2000, pp 824–839

Breslau N, Davis GC. Posttraumatic stress disorder in an urban population of young adults: risk factors for chronicity. Am J Psychiatry 149:671–675, 1992

Breslau N, Lucia VC, Davis GC: Partial PTSD versus full PTSD: an empirical examination of associated impairment. Psychol Med 34:1205–1214, 2004

Broadhead WE, Blazer DG, George LK, et al: Depression, disability days, and days lost from work in a prospective epidemiological survey. JAMA 264:2524–2528, 1990

Carlier IVE, Gersons BPR: Partial posttraumatic stress disorder (PTSD): the issue of psychological scars and the occurrence of PTSD symptoms. J Nerv Ment Dis 183:107–109, 1995

Clark v Arizona, 548 U.S. 735 (2006)

Daubert v Merrell Dow Pharmaceuticals, Inc, 509 U.S. 579 (1993)

Davidson JRT, Hughes DC, George LK, et al: The boundary of social phobia: exploring the threshold. Arch Gen Psychiatry 51:975–983, 1994

Frank E, Lassano GB, Shear MK, et al: The spectrum model: a more coherent approach to the complexity of psychiatric symptomatology. CNS Spectr 3:23–34, 1998

Gallatzer-Levy IR, Galatzer-Levy RM: The revolution in psychiatric diagnosis. Perspect Biol Med 50:161–180, 2007

Gold LH: Psychiatric diagnoses and the retrospective assessment of mental states, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 335–367

Green BL, Grace MC, Lindy JD, et al: War stressors and symptom persistence in posttraumatic stress disorder. J Anxiety Disord 4:31–39, 1990

Greenberg SA, Shuman DW, Meyer RG: Unmasking forensic diagnosis. Int J Law Psychiatry 27:1–15, 2004

Grubaugh AL, Magruder KM, Waldrop AE, et al: Subthreshold PTSD in primary care: prevalence, psychiatric disorders, healthcare use, and functional status. J Nerv Ment Dis 193:658–664, 2005

Halleck SL, Hoge SK, Miller RD, et al: The use of psychiatric diagnoses in the legal process: task force report of the American Psychiatric Association. Bull Am Acad Psychiatry Law 20:481–499, 1992

Jakupcak M, Conybeare D, Phelps L, et al: Anger, hostility, and aggression among Iraq and Afghanistan war veterans reporting PTSD and subthreshold PTSD. J Trauma Stress 20:945–954, 2007

Judd LL, Akiskal HS, Maser JD, et al: A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. Arch Gen Psychiatry 55:694–700, 1998

Kinzie JD, Goetz RR: A century of controversy surrounding posttraumatic stress-spectrum syndromes: the impact on DSM-III and DSM-IV. J Trauma Stress 9:159–179, 1996

Mancuso v Consol. Edison, 967 F. Supp. S.D.N.Y. (1997)

Marshall R, Olfson E, Hellman F, et al: Comorbidity, impairment and suicidality in subthreshold PTSD. Am J Psychiatry 158:1467–1473, 2001

Maser JD, Akiskal HS (eds): Spectrum concepts in major mental disorders. Psychiatr Clin North Am 25 (4) (entire issue), 2002

Maser JD, Patterson T: Spectrum and nosology: implications for DSM-V. Psychiatr Clin North Am 25(4):855–886, 2002

Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008, H.R. 3992 (Publ No 110-416, 122 Stat. 352), October 14, 2008

Mezzich JE, Sharfstein SS: Severity of illness and diagnostic formulation: classifying patients for prospective payment systems. Hosp Community Psychiatry 36 (suppl 7):770–772, 1985

Moreau C, Zisook S: Rationale for posttraumatic stress disorder spectrum. Psychiatr Clin North Am 25(4):775–790, 2002

Mylle J, Maes M: Partial posttraumatic stress disorder revisited. J Affect Disord 78:37–48, 2004

New Jersey v Tirado, WL 3736049, N.J. Super. A.D. (2005)

Pincus HA, McQueen LE, Elinson L: Subthreshold mental disorders: nosological and research recommendations, in Advancing DSM: Dilemmas in Psychiatric Diagnosis. Edited by Phillips KA, First MB, Pincus HA. Washington, DC, American Psychiatric Publishing, 2003, pp 129–144

Ruscio AM, Ruscio J, Keane TM: The latent structure of posttraumatic stress disorder: a taxometric investigation of reactions to extreme stress. J Abnorm Psychol 111:290–301, 2002

Ryder v State, 83 P.3d 856, 869 fn.3, Okla. Crim. App. 2004, cert. denied, 125 S.Ct 215 (2004)

Sadler JZ, Wiggins OP, Schwartz MA (eds): Philosophical Perspectives on Psychiatric Diagnostic Classification. Baltimore, MD, Johns Hopkins University Press, 1994

Schneier FR, Blanco C, Antia SX, et al: The social anxiety spectrum. Psychiatr Clin North Am 25(4):757–774, 2002

Schopp RG, Sturgis BJ: Sexual predators and legal mental illness for civil commitment. Behav Sci Law 13:437–458, 1995

Schützwohl M, Maercker A: Effects of varying diagnostic criteria for posttraumatic stress disorder are endorsing the concept of partial PTSD. J Trauma Stress 12:155–165, 1999

Shuman DW: The Diagnostic and Statistical Manual of Mental Disorders in the courts. Bull Am Acad Psychiatry Law 17:25–32, 1989

Shuman DW: Retrospective assessment of mental states and the law, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 21–46

Simon RI: Toward the development of guidelines in the forensic psychiatric examination of posttraumatic stress disorder claimants, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002, pp 41–90

Stein MB, Walker JR, Hazen AL, et al: Full and partial posttraumatic stress disorder: findings from a community survey. Am J Psychiatry 154:1114–1119, 1997

van Zelst WH, de Beurs E, Beekman AT, et al: Well-being, physical functioning, and use of health services in the elderly with PTSD and subthreshold PTSD. Int J Geriatr Psychiatry 21:180–188, 2006

Warshaw MG, Fierman E, Pratt L, et al: Quality of life and dissociation in anxiety disorder patients with histories of trauma or PTSD. Am J Psychiatry 150:1512–1516, 1993

Weiss DS, Marmar CR, Schlenger WE, et al: The prevalence of lifetime and partial post-traumatic stress disorder in Vietnam theater veterans. J Trauma Stress 5:365–376, 1992

Widiger TA, Clark LA: Toward DSM-V and the classification of psychopathology. Psychol Bull 126:946–963, 2000

Widiger TA, Samuel DB: Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders–5th Edition. J Abnorm Psychol 114:494–504, 2005

Zlotnick C, Franklin CL, Zimmerman M: Does "subthreshold" posttraumatic stress disorder have any clinical relevance? Compr Psychiatry 43:413–419, 2002

Suggested Readings

Gold LH: Psychiatric diagnoses and the retrospective assessment of mental states, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 335–367

Greenberg SA, Shuman DW, Meyer RG: Unmasking forensic diagnosis. Int J Law Psychiatry 27:1–15, 2004

Sadler JZ, Wiggins OP, Schwartz MA (eds): Philosophical Perspectives on Psychiatric Diagnostic Classification. Baltimore, MD, Johns Hopkins University Press, 1994

Shuman DW: The Diagnostic and Statistical Manual of Mental Disorders in the courts. Bull Am Acad Psychiatry Law 17:25–32, 1989

Shuman DW: Retrospective assessment of mental states and the law, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 21–46

Widiger TA, Samuel DB: Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders–5th Edition. J Abnorm Psychol 114:494–504, 2005

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Chapter 7

The Forensic Psychiatric Examination and Report

Robert M. Wettstein, M.D.

The forensic evaluation is unlike a mental health evaluation for clinical or treatment purposes in several respects (Heilbrun 2001). The sharply contrasting roles of the forensic evaluator have significant implications for the conduct of the forensic interview and evaluation. Clinical evaluators serve the health care needs of the individual patient and share mutual goals of beneficence and nonmaleficence. They typically rely on the patient's self-report in their decision making, and, in most cases involving nondemented adult patients, they need not obtain information from family or other collateral data sources.

Forensic evaluators, however, are retained by third parties (e.g., attorney, court, or agency) whose goals are not clinical but legal or financial. Those third parties may have goals adverse to the evaluee's legal or financial interests, such as prosecution, incarceration, and loss of child custody. Forensic evaluators adopt an objective and skeptical approach to the evaluee's self-report and presentation and seek input from collateral sources of information as well as testing. They reach their opinions with a reasonable degree of

clinical certainty and are not allowed to engage in speculation, which is permitted in a clinical evaluation.

Forensic mental health evaluations involve several phases: preparation for the case, data collection, data analysis, and forensic report writing (Heilbrun 2001).

Case Vignettes

Vignette 1

A psychiatrist in a general office practice had been treating a 30-year-old female nurse, Ms. D, who had difficulty functioning at work, for anxiety and depressive symptoms. Six months ago, on her way to work, the public bus on which Ms. D was riding was involved in a head-on collision with an oncoming truck. She was emotionally shaken but not physically injured and continued her trip to work at an urban public health clinic. Later that evening, while at work, Ms. D was sexually assaulted by a male patient at the clinic. As a teenager, Ms. D had been sexually abused for 3 years by an uncle.

She informed the psychiatrist that she filed a civil lawsuit against the public transportation agency and a workers' compensation claim against her employer, seeking monetary damages and expenses for the psychiatric treatment in both suits. Ms. D reported that her attorney wanted the psychiatrist to assist her in this litigation, and she asked the psychiatrist to contact her attorney. The psychiatrist had no experience or training in forensic psychiatry, although some of his patients had been involved in civil litigation in the past.

Vignette 2

Dr. S, a psychiatrist in general practice, received a telephone call from his golfing partner, an attorney, who was representing a young man charged criminally with the homicide of his wife. Dr. S maintained a busy office psychiatric practice and had no experience evaluating criminal defendants charged with major crimes. He agreed to conduct the evaluation as a favor to his friend. Based on what his friend told him about the defendant, Dr. S was confident that he could properly evaluate the defendant and assist in lowering the defendant's criminal charges and sentence at the attorney's request.

Vignette 3

The county public defender's office contacted Dr. C, a forensic psychiatrist, to conduct a pretrial evaluation of a defendant accused of performing oral and anal intercourse, which occurred in a particularly sadistic manner, on a

TABLE 7–1. Preparation of the case

Identify the referral issue.
Clarify role with the retaining party.
Decide whether to accept the case.
Accept referrals only within expertise.
Establish fee and expense agreement.
Other tasks
Know the relevant legal and forensic literature.
Inform retaining party of anticipated course of evaluation.
Obtain relevant documents.
Schedule interviews and testing.

5-year-old boy. Dr. C had some experience with violent and sexual offenders but had not previously encountered such violent sexual activity perpetrated against a young child. Dr. C had two preschool-age sons and experienced intense feelings of revulsion and anger as the defense attorney introduced the case to him. He discussed his feelings about the defendant and the alleged crime with his wife, who encouraged Dr. C to accept the referral because it would be good for his practice and income.

Preparation for the Case

The forensic evaluator should address several issues before beginning work on the case (Table 7–1).

Identify Forensic Issue and Clarify Expert Role

Once the forensic evaluator has been contacted by an attorney, court, or agency, the evaluator, like any consultant, must specifically identify the referral question. Some referral sources are not initially clear about the forensic issue; others may not know how a forensic mental health expert could assist them if they have not previously retained such experts. The evaluator should determine in what role he or she is being solicited. Three possible roles are 1) forensic evaluator and court witness for the litigants or the court itself, 2) court mediator between the litigants, and 3) nonwitness consultant to the retaining party (i.e., attorneys or court).

These differing forensic roles entail correspondingly distinct clinical and ethical responsibilities and obligations. Expert evaluators who conduct interviews of the litigant and render expert forensic opinions in the case do so while striving for objectivity (American Academy of Psychiatry and the Law 2005). In contrast, a mental health consultant to the retaining attorney who does not interview the litigant or testify in the case may serve as part of the legal "team" and thus advocate for that party's legal interests. That expert's role may include assisting in jury selection, testing mock trials, preparing witnesses to testify, or assisting with the preparation of cross-examination of the opposing experts (Strier 1999). Individuals should serve only one role in a given forensic case.

Decide Whether to Accept the Case

The evaluator should consider several issues before deciding to accept the forensic referral. The evaluator should have the expertise and training to work on the case. For example, a psychiatrist without child psychiatry training or supervised experience is unlikely to be able to appropriately perform a child custody evaluation involving young children. Likewise, a general psychiatrist without forensic training and experience, as in Case Vignettes 1 and 2, may not be able to competently perform the forensic evaluation, at least not without considerable supervision from an experienced forensic expert. In such situations, the general psychiatrist is advised to refer the matter to an appropriate forensic expert or to at least collaborate with such a colleague.

Some states have enacted statutes setting minimum requirements for mental health professionals to conduct competency-to-stand-trial and criminal responsibility evaluations (Farkas et al. 1997). In these states, there may be training and experience requirements as well as an examination and certification process that must be followed. These requirements were established as a result of concerns about the quality of existing pretrial evaluations.

Forensic evaluators bring their individual perspectives and biases to the task, and the sources of potential bias are many (Gutheil and Simon 2004). The evaluator should not be so biased regarding the psychiatric or forensic issues of the case that an objective and fair evaluation cannot be performed. In Case Vignette 3, Dr. C was aware of intense negative feelings toward the defendant and the alleged crime, and he may have had difficulty putting those feelings aside. Similarly, previous contact or work with the retaining or opposing attorney, especially if extensive, should be considered a potential source of conflict and a barrier to objectivity in conducting the evaluation. The evaluator should be alert to such influences and be able to decide

to refuse the case if these barriers are substantial (Simon and Wettstein 1997). An example of potentially conflicting influence is illustrated in Case Vignette 2, in which Dr. S felt pressured to accept a referral as a favor to his attorney friend, though he was likely not to have the requisite training and experience to conduct the evaluation. Dr. S also may have had difficulty performing an objective evaluation if there was a perception of pressure or coercion to reach an opinion favorable to his friend.

A previous personal or professional relationship with the evaluee is similarly grounds for recusing oneself from the forensic evaluation (Strasburger et al. 1997). A treating psychiatrist may know his or her patient well and, therefore, be approached by the patient's attorney for participation in the litigation as a forensic expert. That psychiatrist, however, is well advised to refer the patient to another psychiatrist to perform the forensic evaluation. Avoiding potential bias may preserve the treatment relationship with the patient and ensure that a competent forensic evaluation is performed. Treating psychiatrists do not typically bring the necessary skepticism, objectivity, and evaluation approach to their patients to be able to conduct a comprehensive and impartial forensic evaluation. In addition, attempting to perform a forensic evaluation of a current patient risks jeopardizing that treatment relationship, especially if the clinician is unable to support the patient's legal case.

Establish Fee and Expense Agreement

The evaluator should secure agreement with the retaining attorney, court, or agency with regard to the evaluator's fees and expenses to conduct the evaluation. Such agreements are optimally secured in written form, either with a formal contract provided by the evaluator or retaining party or in summary form through correspondence. Evaluators' hourly or total fees may be limited by policy of the court or insurance carrier, and such resource limitations should be discussed in advance with regard to whether a proper evaluation can nevertheless be conducted. It is unethical for evaluators to contract with the retaining party (i.e., attorney, court, or expert witness agency) on a contingency basis.

Expenses for consultants to conduct specialized medical or psychological testing may add considerably to the evaluator's fees and should be disclosed to the retaining party, to the extent foreseeable. Fees for court testimony, waiting time, and travel time should also be formalized in advance. Court testimony is notoriously difficult to schedule in advance, and testifying psychiatrists who maintain a significant clinical practice will frequently suffer disruptions to their patient care activities. Some evaluators routinely set higher fees for

courtroom testimony as opposed to the forensic evaluation itself; such an increment, however, if done, could give the appearance of impropriety and needs to be appropriately justified.

Data Collection

General Issues

The forensic evaluation must be a comprehensive review of the relevant clinical and legal information regarding the evaluee and the legal issue in question. It is typically essential for the forensic evaluator to obtain information from a variety of sources rather than solely from the evaluee (Heilbrun et al. 1994). Relevant records should be obtained and reviewed, preferably before the interview with the evaluee (Table 7–2). Clinical records are typically obtained from retaining or opposing counsel.

Sometimes, clinical records or summaries of records obtained from counsel are incomplete. Attorneys have been known to selectively provide information to their own expert witnesses, either inadvertently or with the intent of manipulating the evaluator (Gutheil and Simon 1999). In some cases, it will be important to obtain copies of an entire hospital or clinic chart rather than just a discharge summary. Evaluators may then need to obtain written consent from the evaluee for the complete record and request those records from the original source (e.g., a hospital or clinic). Retaining counsel should be aware that the evaluator is attempting to independently obtain such records and may later request a copy of them for their files once they reach the evaluator. Attorneys will ordinarily be the source of legal documents such as the litigation complaint or criminal affidavits, interrogatories, discovery depositions, hearing transcripts, and investigation and police reports.

It is usually necessary for the forensic interview to occupy far more time than a clinical evaluation. The evaluator may need multiple forensic interviews and testing sessions with the evaluee (Simon and Wettstein 1997). Substantial contact with the evaluee often permits a more accurate assessment of an evaluee, whose mental status could change over time because of a mood or other mental disorder. In rare cases, a face-to-face interview with an evaluee will not be possible, such as when the legal discovery deadline has passed, the court will not grant access to the litigant, or the litigant is deceased. Collateral interviews may nevertheless be feasible, in addition to review of records. Any forensic opinions offered by the evaluator without a personal interview of the litigant must be explicitly qualified by that limitation.

TABLE 7–2. Collateral document sources

Previous psychiatric evaluations and treatment
Previous psychological testing
Hospital, office, laboratory, and pharmacy records
Academic records
Occupational evaluations and employment documents
Financial records
Social Security disability records
Military records
Discovery regarding the legal case
Diaries, journals, and electronic data written by the evaluee

The evaluator must attend to the conditions of the evaluation. Lengthy interviews can be stressful to the evaluee as well as the evaluator, and opportunities for bathroom use or other interruptions should be available. Day-long interviews may be necessary if there is great distance between the evaluator and evaluee. The presence of third-party witnesses or taping equipment potentially increases the adversarial nature of the evaluation process, distracts the individuals involved in the evaluation, and distorts the results, but such procedures are sometimes compelled by applicable law (American Academy of Psychiatry and the Law 1999). But the attendance of witnesses or the use of audiotaping and videotaping can help to ensure a complete and accurate record and may serve to challenge any misrepresentations by the evaluator (Simon 1996). The presence of interested observers potentially distorts standardized testing procedures such as neuropsychological testing (Cramer and Brodsky 2007; McSweeny et al. 1998). Nevertheless, some forensic evaluators routinely videotape or audiotape their evaluations and make the tape available for use at trial. Opposing experts may then have an opportunity to review the tape or transcripts of the interviews and to identify distortions, errors, and omissions in the interviews.

Some forensic evaluation facilities employ a multidisciplinary staff to collect relevant information. Thus, a psychiatrist will obtain psychiatric data, a psychologist will perform psychological testing, a social worker will obtain family and social history, and an internist will perform medical and laboratory testing. Evaluators in solo practice usually obtain most information on their own, albeit with the use of consultants or medical specialists, as needed for additional testing (e.g., magnetic resonance imaging scan of the head, electroencephalogram, thyroid function tests, psychological testing, and neuropsychological testing). Team evaluations permit a greater number of forensic evaluations, but they create problems in areas such as

scheduling coordination, the need for meetings to discuss and evaluate data, uncertainty regarding responsibility for the work product, and potential for inconsistency in the court testimony of the team (Bow et al. 2002).

Forensic evaluators are ethically responsible for initially informing the evaluee regarding the nature, purpose, and nonconfidentiality of the evaluation process (American Academy of Psychiatry and the Law 2005). This notification procedure is distinguishable from the informed consent process conducted in a typical clinical evaluation or treatment session in that the forensic evaluation is usually a third-party evaluation, may be court ordered, and is undertaken ordinarily as a nonconfidential evaluation. Relevant information can be provided to the evaluee in writing, orally, or both. Forensic evaluees may misunderstand the evaluator's role, ethical and legal obligations, the evaluation itself, and evaluation procedures. Thus, beyond providing relevant information, the evaluator should attempt to rectify the evaluee's misunderstanding of these matters whenever they arise. In this regard, the evaluator should collaborate with the evaluee's attorney, who bears the primary responsibility for educating the evaluee about the legal considerations relevant to participating in the evaluation and providing legal advice to the evaluee (Connell 2006; Foote and Shuman 2006). Some evaluators request that evaluees acknowledge in writing that they have received the relevant information, but evaluees in court-ordered evaluations ordinarily do not need to provide a release-of-information form to the evaluator.

Forensic interviews are readily distinguished from clinical interviews with regard to general approach; technique; content areas; voluntariness; threats to validity, pace, and setting; and skepticism on the part of the evaluator (Melton et al. 2007, p. 44). Although clinical interviews focus on such here-and-now issues as coping strategies used by the patient, ego strengths and weaknesses, and defense mechanisms, forensic interviews are directed toward the assessment of cognitive or volitional capacities of the evaluee in the past, present, or future (Scheiber 2003). Forensic evaluations are focused on the particular forensic mental health issue in the case. The assessment of psychiatric symptoms and disorders is an essential component of both types of evaluations. Forensic evaluators maintain a skeptical attitude about self-reported data and are wary of the influence of others (e.g., attorneys, family, and other jail or prison inmates) on the evaluee (Williams et al. 1999).

Forensic Practice Guidelines

As in clinical psychiatry, practice guidelines for forensic evaluations can be useful to evaluators, especially because they have been developed by colleagues

who are experts in the given area. These guidelines are typically considered aspirational rather than mandatory, and in psychiatry they are often vague (Recupero 2008). Guidelines include clinical, forensic, legal, and ethical issues relevant to that particular forensic evaluation. Existing forensic practice guidelines include those for evaluations of child custody (American Academy of Child and Adolescent Psychiatry 1997b; American Psychological Association 2009), conduct disorder (American Academy of Child and Adolescent Psychiatry 1997a), juvenile sex offenders (American Academy of Child and Adolescent Psychiatry 1999), criminal responsibility (American Academy of Psychiatry and the Law 2002), competency to stand trial (American Academy of Psychiatry and the Law 2007), and psychiatric disability (American Academy of Psychiatry and the Law 2008). Research data on forensic evaluators' adherence to professional guidelines have been published (Bow et al. 2002).

Forensic Instruments

Forensic evaluators often use a nonstandardized, unstructured interview format, covering relevant content areas. Open-ended rather than "yes–no" or leading questions are appropriate for exploring the forensic content in the interview, such as the criminal defendant's account of the crime and mental status at that time. Standard psychological tests, including intelligence, projective, personality, and neuropsychological instruments, are variably used in forensic evaluations, depending on the forensic mental health issue in the case (Nicholson and Norwood 2000). However, traditional psychological testing measures do not specifically relate to forensic purposes such as competence to stand trial or criminal responsibility (Skeem and Golding 1998).

Evaluators may also choose to conduct structured interviews using forensic instruments. Indeed, there is a trend toward evaluators' growing use of forensic assessment instruments when conducting forensic evaluations (Nicholson and Norwood 2000). Many instruments, scales, and standardized psychiatric interview schedules have been published and may be useful to the evaluator, depending on the forensic or legal issues in the case (Grisso 2002; Rogers 2001). The following list is offered as illustrative, not comprehensive or exhaustive:

1. *Risk assessment of violence or sexual violence:* Rapid Risk Assessment for Sex Offense Recidivism (Hanson and Thornton 2000); the Violence Risk Appraisal Guide (Barbaree et al. 2001; Loza et al. 2002); STATIC-99 (hanson and Thornton 1999); Minnesota Sex Offender Screening Tool—Revised (Epperson et al. 1998)

2. *Evaluation of malingering:* Structured Interview of Reported Symptoms (Rogers 1992)
3. *Assessment of psychopathy:* Psychopathy Checklist—Revised (PCL-R; Hare 1980)
4. *Assessment of criminal responsibility:* Rogers Criminal Responsibility Assessment Scales (Rogers and Shuman 2000)
5. *Assessment of criminal competency:* Georgia Court Competency Test (Ustad et al. 1996); MacArthur Competence Assessment Tool—Criminal Adjudication (Otto et al. 1998); Fitness Interview Test (Roesch et al. 1998)
6. *Assessment of civil competency:* MacArthur Competence Assessment Tool for Treatment (Grisso and Appelbaum 1998)

Some instruments rely on self-report data from the evaluee, but others (e.g., PCL-R) require that the evaluator incorporate third-party data as part of the assessment.

The instruments can be helpful in conducting interviews, in obtaining relevant information, and in decision making regarding the forensic opinions in the case. Some instruments are useful as screening tests rather than as definitive measures of a forensic issue. The use of cutoff scores for the forensic instruments is discouraged, given that they may not correspond well with legal standards (Rogers et al. 2001). Forensic evaluators should be aware, however, that the reliability and validity of these instruments are often the subjects of debate in the scientific literature (see Chapter 21: "Understanding Risk Assessment Instruments," this volume). Moreover, these instruments, like psychological testing generally, may or may not satisfy legal criteria for admissible evidence under the law (Boccaccini and Brodsky 1999). Forensic evaluators should be familiar with the development, utility, administration, scoring, and limitations of the instruments before their use. In addition, familiarity with the extensive research literature on forensic instruments is essential to their proper use (Campbell et al. 2009; Walters et al. 2009).

Issues in Using Self-Report Data

Several concerns arise with regard to the accuracy of information obtained from evaluees. In clinical evaluations, self-report data are typically the basis for diagnostic and treatment decisions. Self-report tests are commonly used in screening for alcohol problems in primary care medicine (Allen et al. 1995). Traditional psychological tests, such as the Minnesota Multiphasic Personality Inventory (MMPI), are self-report testing instruments. Research,

however, has demonstrated that the accuracy of such self-report data in medical and mental health settings is questionable. For example, there is low agreement between patients and informants in the assessment of personality disorders (Riso et al. 1994) and adult attention-deficit/hyperactivity disorder (Zucker et al. 2002). In addiction psychiatry, patient self-report of illicit drug use can be highly inaccurate, depending on the patient population (i.e., arrestees vs. patients in treatment), the context in which the data are collected, the type of drug used, the method of survey, and the recency of use (Harrison and Hughes 1997; McNagny and Parker 1992; Weiss et al. 1998). In the assessment of major life stressors, there is a poor rate of agreement between subjects and informants regarding whether a particular life event has occurred (Schless and Mendels 1978). Even the self-report of one's stature has been shown not to be accurate, at least for men (Giles and Hutchinson 1991).

Evaluees in forensic evaluations typically have a reason or motivation to distort their history or presentation to the forensic evaluator, based on their interest in the outcome of the litigation. Accused sexual offenders commonly deny, minimize, or distort previous sexual offenses in a self-serving manner, consciously or unconsciously, and denial is a significant clinical issue in their assessment and management (Lanyon 2001). Head injury claimants in litigation retrospectively inflate their pre-injury scholastic functioning to a greater degree than nonlitigating control subjects (Greiffenstein et al. 2002). Beyond these distortions, memory for past events is generally reconstructive and often inaccurate; it is not complete and accurate like a videotape (Haber and Haber 2000; Hyman and Loftus 1998). An evaluee's memory for relevant events such as the presenting crime may be distorted as a result of intoxication, emotional arousal, psychosis, mood disturbance, or personality disorder (Porter et al. 2001; Stone 1992). The presence of clinical depression can affect neuropsychological functioning and reduce recollection memory (MacQueen et al. 2002) as well as cause overreporting of functional impairment (Morgado et al. 1991).

In addition, forensic evaluations often occur long after the legal incident in question, and memories change over time. Attorneys have been known to explicitly or indirectly coach their clients regarding how to behave in a forensic evaluation. Repeated forensic evaluations can inadvertently contaminate later forensic interviews when evaluees have learned how to respond to an evaluator's psychiatric questioning. Defendants who are incarcerated can be influenced by family members or other inmates regarding how to present in the forensic evaluation. For these reasons, it is standard practice for forensic evaluators to corroborate relevant information through multiple data sources and to explicitly assess the evaluee's response style as honest, deceptive, distorting, or otherwise (Heilbrun 2001).

Issues in Conducting Collateral Interviews

In treatment settings, collateral data sources are routinely obtained in the practice of geriatric and child psychiatry because of the cognitive limitations of elderly and young subjects. Problems regarding confidentiality, however, generally arise in collecting collateral data for other subjects. Thus, clinicians may not be accustomed to considering when and how to obtain collateral data. In contrast, forensic evaluators are obligated to consider how to obtain collateral data, either from third parties or from written documentation. Third-party information can be challenged in court as inadmissible hearsay, but this is unlikely to occur to any significant extent in practice (Heilbrun 2001; Melton et al. 2007).

The forensic evaluator's initial task is the selection or identification of appropriate collateral contacts. In striving for objectivity, ethics obligations dictate that the evaluator must seek information from all sides of the case and not just bolster a preformed expert opinion by contacting one set of collaterals. Even the appearance of unfairness in selecting collateral sources can form the nidus of cross-examination at trial or deposition. Established rules or procedures for selecting and conducting collateral interviews do not exist. The evaluator is obligated to adhere to the applicable professional ethics guidelines when contacting collateral sources, as well as during the direct evaluation of the evaluee.

Nominations of specific contacts can come from a variety of sources such as the retaining agency or attorney, the evaluee, family members, coworkers, or crime victims. It is advisable to consult with the retaining attorney or agency before contacting any collateral sources. It may be awkward for the evaluator to contact collateral sources on the opposing side of the case. A crime victim or the arresting police officer might refuse to consent to an interview with a defendant-retained evaluator, but contact with such sources can be enlightening. Some spouses of litigants may refuse to be interviewed by opposing-side evaluators, but court orders to interview them can be obtained if they are named plaintiffs in the litigation. Evaluators can bolster or demonstrate their independence and objectivity by pursuing those collateral sources who are reluctant to be interviewed or those who provide information contrary to the position of the retaining side of the litigation.

The initial contact with the collateral source can occur through several means. In some situations, the evaluee or evaluee's attorney can request that the collateral sources contact the evaluator. When the evaluator is retained by the opposing side of the legal case from the evaluee, the evaluator may need to solicit collateral sources through the attorney who has retained the

evaluator. In general, evaluators do not have significant, if any, direct contact with the opposing-side attorney because of the legal or ethical considerations it can create in areas such as confidentiality, contractual obligations, attorney-client privilege, or attorney work product.

The number of collateral interviews the evaluator conducts will depend on the particular facts, circumstances, and complexity of the case itself. A crime scene involving multiple victims and witnesses will require multiple interviews with those individuals. An employment law case involving a personality-disordered worker may require numerous interviews with coworkers and supervisors. More interviews, rather than fewer, are required when there is disputed information about the evaluee's mental state or behavior at the event in question or when the evaluator is attempting to reconcile conflicting accounts of what happened. Collateral sources can provide discrepant information from each other and from the evaluee about such matters as the existence of child physical abuse in the family (Kraemer et al. 2003). Mood disorders and intoxication can cause fluctuations over time; therefore, collateral interviews that expose the evaluee over time may be needed in such cases. Memories fade for collateral sources as well as evaluees, so more informants may be needed if the legal events in question occurred years earlier.

Collateral interviews can be conducted in person or, perhaps more frequently, by telephone, depending on time and availability of the collateral source (Heilbrun et al. 2003). Many evaluators prefer in-person interviews to telephone contacts, because of the usefulness provided by nonverbal input in the interview. Collateral interviews typically require the consent of the collateral source or the court, but not of the evaluee. The collateral source will typically not be under court or agency order to appear for the collateral interview, although such a circumstance could occur. Some evaluees will instruct the evaluator not to contact third parties or conduct collateral interviews, but these instructions can often be disregarded after consulting with the retaining attorney or agency. Audio- or videotaping of the collateral interview may require the collateral source's consent.

The evaluator should inform the collateral source about who retained the evaluator as well as about the nonconfidentiality of the interview. Some evaluators provide a written notice of nonconfidentiality; they may further request that the collateral source sign an acknowledgement of that notice. The evaluator should ordinarily not release written or verbal information about the evaluee to the collateral source, absent consent from the retaining party. Information obtained from the collateral interview should be shared with the retaining party or attorney but should not otherwise be disclosed.

Obtaining collateral interview data can sometimes create problems or conflict between the collateral source and the evaluee once the evaluee has discovered the content of the collateral interview. In a child custody case, for

example, a teacher or neighbor who provides information critical of one parent might thereafter have a strained relationship with the evaluee. Similarly, an evaluee in employment litigation could have more conflict with coworkers once he or she learns of their negative evaluation of him or her. One approach to this dilemma is for the evaluator to list the collateral sources of information in the report but to summarize the content of the collateral interviews without specifying their source (Bow and Quinnell 2002).

The evaluator must assess the collateral source's credibility and motivation with regard to the evaluee. The evaluator should not be surprised to discover that collateral sources can provide as much distorted information as the evaluee, given the presence and biasing effect of the litigation itself. Information obtained from neutral parties has more credibility and is therefore more valuable to the evaluator. Nonestranged spouses of criminal defendants and civil plaintiffs will often be supportive and biased in favor of the evaluee to a considerable degree. Similarly, crime victims may have difficulty being objective in their recall of the defendant's behavior. Arresting police officers, too, may conceal information that indicates a defendant was irrational, delusional, hallucinating, or severely intoxicated. Child custody cases are notably prone to biased information provided by the respective parties (Austin 2002).

The collateral source's objectivity can be compromised by influence or input from the evaluee's attorney or staff; attorneys have been known to coach family as well as evaluees before contact with the opposing-side evaluator.

On occasion, a collateral source will provide incriminating rather than mitigating or exculpatory information about a defendant to the evaluator, even if the evaluator was retained by the same side as the evaluee and collateral source. That information may necessitate additional interviewing of the evaluee.

Data Analysis

Forensic evaluations often require many complex determinations. Evaluators must initially be thoroughly informed about the relevant legal standard, which includes case law, statute, regulation, and policy. Data analysis is framed by the relevant legal issue in the case—for example, psychiatric diagnosis, violence risk, criminal or civil competence, voluntariness of action, criminal responsibility, and causation.

Forensic evaluators ideally approach each evaluation in a neutral manner, without preconceived expectations and biases that could distort data

collection or data analysis. Evaluee and collateral credibility must be assessed. As noted previously, dissimulation and malingering must be considered through careful record review, interviewing, testing, and cross-checking of data sources. Knowledge of the natural course of the mental disorder in question is essential to assessing secondary gain issues.

In criminal responsibility evaluations involving multiple crimes committed over a period of time, the evaluator must separately evaluate the defendant with regard to each alleged act. This is typically an issue in white-collar crimes such as embezzlement, but it also occurs in multiple or serial homicides or sexual assaults. In such cases, multiple forensic evaluations are essentially required.

Causation is an important issue in most forensic evaluations. Scientific reasoning (i.e., hypothesis generation and testing) must be used to assess the connection between a clinical condition and the relevant psycholegal functional ability (Heilbrun 2001). Causation determinations require that the evaluator distinguish the respective effects of premorbid emotional problems, comorbid mental and physical disorders, and psychosocial stressors (e.g., deaths, job termination, and victimization). For example, separating the effects of a manic episode, cocaine intoxication, and narcissistic personality disorder and determining the main cause or a contributing cause of the criminal offense may be problematic. In Case Vignette 1, the evaluator must separate the effects of three potentially traumatic life events (i.e., two sexual victimizations and one motor vehicle accident) in reaching forensic opinions appropriate to the litigation in question. Extensive interviewing and collateral data are likely to be essential in such situations. Accepted, rather than idiosyncratic, theories of causation must be used (Chadwick and Krous 1997).

Conducting personality disorder assessments can be challenging in many forensic evaluations, but these are often essential tasks in both civil and criminal forensic evaluations. Forensic evaluations are relatively limited in time spent with and direct exposure to the evaluee. Comorbid psychiatric disorders such as an evaluee's mood disorder can confound the assessment of personality functioning and lead to a false diagnosis of a personality disorder (Fava et al. 2002). Psychological testing can similarly fail to distinguish between personality disorders and comorbid mental or physical disorders. Ideally, personality assessments should be conducted in the absence of significant comorbid conditions and over an extended time interval to ensure personality trait stability. Previous mental health evaluations and treatment records are likely to be useful in compensating for the forensic evaluator's otherwise limited exposure to the evaluee. Collateral interviews can overcome some of the limitations of the psychiatric interviews with the evaluee, but they have their own deficiencies, including witness credibility issues.

Given that maintaining objectivity and credibility are such essential tasks of the forensic evaluation, evaluators often perform several integrity checks to ensure that their work is of the highest quality. An evaluator's opinions and conclusions should be similar if not identical, regardless of which side retains that evaluator, though, of course, different evaluators may reach different expert opinions in a given case. Evaluators should question themselves when formulating their expert opinions and conclusions to ensure that the presence of a retaining party has not significantly influenced their forensic work on the case. They should be alert to the phenomenon of "forensic identification," which occurs when the evaluator comes to identify or ally himself or herself with the retaining party as the case proceeds over time (Zusman and Simon 1983). Evaluators may permissibly choose to emphasize those aspects of the expert's conclusions that are favorable to the retaining side, but the expert's opinions should not fundamentally be different on the basis of the identity of the retaining party. Similarly, the outcome of the legal case should not concern the evaluator. The evaluator is not a party to the litigation, and he or she is not being compensated according to the case outcome. The evaluator who is particularly pleased or dissatisfied with the legal outcome of the case may have unwittingly become overinvested in the case and may have sacrificed objectivity.

Some evaluators routinely maintain a log of their previous cases and ultimate opinions to monitor any pattern or distortions that occur over time. Experts should have a significant percentage of cases for which their conclusions are unfavorable to the retaining party. They should be wary when they have been repeatedly retained by a given party and reach conclusions identical to those of the retaining party over an extended period of time (Murrie and Warren 2005). Finally, experts should be self-aware enough to monitor for the presence of significant countertransference in their forensic work—to a particular defendant, crime, accident, or legal cause of action. The literature has documented the significant presence of childood sexual abuse among mental health professionals (Little and Hamby 1996), and this history could potentially bias the evaluation process. Individual consultation with an experienced forensic colleague or a brief course of individual psychotherapy can be useful to forensic evaluators involved in emotionally stressful cases.

Peer review of the expert's evaluation and testimony is another vehicle that enhances the quality of one's forensic work (American Psychiatric Association 1992, 1997). Peer review is available on a voluntary and confidential basis for members of the American Academy of Psychiatry and the Law, but it can also be arranged independently and privately by the evaluator. Such a peer consultation process provides an invaluable means of checking on the soundness of the expert's work and can illuminate any actual or po-

tential problems in the evaluator's approach to the case at hand or similar cases (Chadwick and Krous 1997). State peer review statutes may or may not protect the peer review from legal discovery in subsequent proceedings. Peer review typically occurs after the evaluator has completed the evaluation rather than during it. If he or she has discussed the case with a colleague, the evaluator could be questioned when testifying at deposition or trial on what effect such consultation has had on him or her. In such situations, the evaluator must, of course, testify honestly about the consultation.

Forensic Report Writing

After completing the forensic evaluation, the evaluator is usually asked to prepare a detailed written report of the evaluation. Report writing is an essential task and competency in forensic psychiatry (Griffith and Baranoski 2007). The evaluator should not, however, prepare a written report unless specifically requested to do so. Some retaining attorneys or agencies initially request a verbal report and may not seek a written report from the evaluator if the evaluator's findings and opinions are unfavorable to the evaluee's legal case. The absence of an unfavorable written report from the evaluator could protect the retaining attorney or agency from having to disclose the negative evaluation results and prevent their being disclosed to the opposing side. However, some retaining parties will solicit a written report from the evaluator even if it is unfavorable and then use that report to persuade the litigant to change legal tactics or dismiss the case; other retaining attorneys will use an unfavorable report to protect themselves against anticipated charges of ineffective assistance of counsel.

Some retaining parties request a preliminary written report from the evaluator. Providing such a report before the completion of the evaluation is often problematic because proper analysis of the data requires that all relevant data be obtained before the expert reaches any forensic opinions on the case. An evaluator who provides a preliminary opinion may have difficulty reconciling that preliminary opinion with subsequently obtained data.

Even if the retaining party requests a written report from the evaluator, the evaluator and retaining party should discuss the length and substance of that report before it is prepared. Some retaining parties seek a brief report that simply states the examiner's forensic opinions without providing details of the evaluee's social, medical, or psychiatric history. Limitations in funds available to the retaining party could also limit the length and complexity of the expert's report because extensive reports typically take considerable time

and expense to prepare. Advance discussion of the evaluator's opinions also minimizes the likelihood that the retaining party will later seek to modify or edit the evaluator's report.

When the evaluator has been retained by a court rather than by a party to the litigation, the evaluation report might be more extensive and inclusive than if the evaluator has been retained by a party, though ideally there should be little difference in this regard.

The Report

In general, the written report of the forensic evaluation must be comprehensive, detailed, precise, clearly written, and well substantiated. The primary purpose of the report is to communicate the evaluator's conclusions and supporting data to the retaining party and, ultimately, to the trial court or jury. The evaluator should assume that every word of the report is meaningful and exposes the evaluator to testimony on direct or cross-examination. He or she is likely to regret report-writing characterized by casual, rushed, careless, unsubstantiated, or exaggerated statements or opinions. The evaluator will need to defend the report at deposition or in court and can use the report to assist in presenting testimony.

There is no single required report format for preparing all forensic mental health evaluations, and several are available and acceptable. In general, however, the evaluator's report should be well organized, with appropriate subject headings and subheadings for data sources, relevant history, collateral data, test results, mental status examination, diagnosis, and expert opinions (Berger 2008). The report should specify the data sources used, including the dates of available records reviewed and the dates and time spent conducting interviews with the evaluee and collateral sources. The report should also indicate that the evaluee was appropriately warned about the nature, purpose, and nonconfidentiality of the evaluation and that the evaluee understood these terms. The evaluator should refer to the evaluee as a litigant, plaintiff, defendant, or by name, but not as a "patient." In reports, evaluators should ordinarily not refer to the opposing experts by name or make personal attacks on their credibility or expertise.

The report should be precisely written with minimal use of technical jargon or explanations of such, when appropriate. Casual or informal language should be avoided, but it is often useful to provide direct quotations from the evaluee or others. The source of statements in the report (e.g., defendant, crime victim, witness, and police) should be clear to the reader. The report should be focused on the referral forensic issue, even though related or even extraneous information about the evaluee is often appropriately included in the report, and even though retaining attorneys may not initially compre-

hend the justification for including such material. The evaluator must use judgment in deciding what is essential and relevant to include in the report; evaluators can be questioned in court regarding why some information was or was not included in the report. Some agencies or retaining attorneys will request only brief and conclusory reports rather than lengthy and detailed ones. (Sample expert reports are included in Melton et al. 2007 and Greenfield and Gottschalk 2009.)

Individual evaluators bring their own particular life experiences, skills, and perspectives to the forensic evaluation and report-writing process. Evaluators, for instance, may see themselves as forensic scientists, clinicians, journalist-reporters, quasi-attorneys (i.e., prosecutors, defense counsel, judge, and jury), business people, health care administrators, or artist-writers. Forensic reports are aimed at persuading the non-clinically trained reader, not simply reporting the evaluator's observations and findings. Report writers commonly have different writing styles, which reflect the author's inner "voice" (Griffith and Baronoski 2007), making the reports individualized and unique rather than impersonal and objective—a blend of science and art. As in clinical psychiatric practice, evaluators need to be self-reflective in their forensic report writing. They should be aware that their own biases and perspectives are revealed through their report writing.

Potential problems or errors in forensic report writing are numerous (Table 7–3). In accordance with the evaluator's ethical responsibility to strive for objectivity, the evaluator must explore and consider all data sources rather than ignoring, or even neglecting to explore, the data that fail to support the expert's diagnoses and expert opinions. Retaining attorneys, however, sometimes object to the evaluator's inclusion of data and findings that support the opposing side. The evaluator must remain within his or her expertise, use accepted rather than idiosyncratic psychiatric theories, correctly interpret the professional literature, use the data extant in the case, and not fabricate information (Chadwick and Krous 1997). Limitations to the expert's opinion should be disclosed to the extent feasible. Evaluators should be open to changing their diagnosis and expert opinion upon the receipt of additional information. They should state that no conclusions can be reached with the presently available database, if that is indeed the situation.

The most significant deficiency in forensic mental health expert reports is the failure to adequately substantiate the evaluator's forensic opinions in the case (Skeem and Golding 1998). The legal system is the ultimate consumer or client for forensic consultation. Expert opinions without foundation are of limited value to the legal system. Evaluators should be able to fully explain their forensic opinions and to ground them in the available data. Experts who speculate, and those who "go beyond the data," are not properly serving the system. Such reports will be difficult for the evaluator

TABLE 7–3. Problems in forensic reports

Failing to clarify data sources
Providing preliminary reports
Failing to consider all data sources in reaching opinions
Mixing data and expert opinions
Exceeding or stretching the existing data in the case
Suppressing disconfirming data
Including speculation or demonstrating overconfidence
Relying on unsubstantiated diagnoses and expert opinions
Addressing the wrong forensic issue
Using idiosyncratic psychiatric theories
Using idiosyncratic psychiatric diagnoses and criteria
Failing to disclose the limitations of the expert's opinion
Aggregating multiple causes of a psychiatric disorder and legal damages
Failing to analyze mental status for each criminal charge
Offering personal opinions about the desired outcome of a case
Acting like an attorney, not a forensic clinician
Allowing attorney-requested changes in expert's opinion
Submitting inaccurate curriculum vitae

to defend in court. Expert opinions need to be reached with "reasonable medical certainty"—in its absence, the report or testimony will not be admissible in court (Rappeport 1985). There is sometimes a narrow window between overstating and understating one's expert opinion. When there are substantial clinical or legal data to support more than one forensic opinion, then an accepted approach is to defer the ultimate opinion issue to the judge or jury rather than forcing an opinion that ignores substantial data.

Retaining attorneys sometimes request to edit the report before disclosing it to the opposing side. The attorney may ask that the evaluator delete certain factual information, change emphasis, or even change the ultimate expert opinion. Any substantial changes made at the attorney's request should be avoided—altering the expert's opinion at the attorney's request is unethical. Typographical and factual errors, and failure to address the appropriate legal standard, can be rectified without problem in this regard. A supplemental report can be provided to remediate any deficiencies in the original report, if necessary (Simon and Wettstein 1997). Cross-examiners at deposition or trial sometimes inquire about earlier drafts of the expert's report, and a court may order the disclosure of earlier drafts, if available, even if they are only available in electronic form.

Evaluators should distribute their report only to the retaining party unless directed otherwise by the retaining party or the court. Requests for a copy of the report by the evaluee or the evaluee's treating physicians should be referred to the retaining party who is responsible for all information disclosure resulting from the evaluation.

Submitting only an electronic copy of the report via the Internet, rather than a hard copy, can expedite the evaluation but may lead to unintended problems. Security issues can be addressed by encryption of the email or the report with password protection. However, the party receiving the report as a final copy without a hard copy could easily alter the report without the evaluator's knowledge and consent. That risk can be obviated by sending a "read-only" version of the report that cannot be edited by the reader.

Evaluators are typically required to submit a recent copy of their curriculum vitae along with their report. Such resumes should show a date, be current, and accurately reflect professional activities. Memberships in professional association committees or on boards or other activities should not be overstated. Submission of an erroneous or misrepresented resume diminishes the expert's credibility and can subject the evaluator to charges of unprofessional conduct by a state board of medicine or of perjury by a court. Similarly, evaluators should not misrepresent their credentials if they advertise their forensic services, either in print media or on a Web site.

Documentation

Documentation for risk management is an important area of forensic practice and for clinical work. Forensic clinicians are at significant exposure to negligence or other legal liability, and they risk complaints of unethical conduct (Gold and Davidson 2007; Jensen 1993). Formal complaints against psychiatrists for alleged breach of ethical standards of practice in the conduct of forensic evaluations have been brought to the American Psychiatric Association. Dissatisfied litigants in either the criminal or civil arena readily bring lawsuits against the forensic evaluator, with or without counsel (Slovenko 2001). And state licensure board complaints from a parent about the opposing expert regularly occur following child custody litigation (Glassman 1998; Kirkland and Kirkland 2001). Forensic evaluators must maintain relevant records to later defend themselves against charges of unlawful or unethical conduct, the latter of which may have no statute of limitations. The evaluator's report also serves as risk management protection. Beyond risk management, handwritten notes and audio- or videotapes taken during the course of a forensic evaluation are discoverable in the litigation, and opposing attorneys may request to review them before or during court testimony.

Stress of Forensic Psychiatry

For many reasons, forensic mental health work is often stressful, although experience and competence likely to reduce its stressfulness (Strasburger et al. 2003). Sources of stress in forensic work include lack of control over one's schedule, evaluating the perpetrators of horrific acts, exposure to the emotional and physical trauma of evaluees, dealing with coercion from retaining attorneys, collecting fees from the retaining party, being physically or legally threatened by litigants and their associates, and being confronted in court with cross-examiners who make personal and professional attacks on the examiner's ability, performance, and character. Strong countertransference reactions to litigants and their alleged behavior commonly occur (Sattar et al. 2002). Professional isolation by forensic psychiatrists can contribute to the distress of a psychiatrist who does significant forensic work. Vicarious traumatization of practitioners can also take place, as it does for anyone working with a traumatized population (Hegaty 2002).

Conclusion

Forensic consultation, evaluation, and testimony are qualitatively distinct from evaluations for treatment purposes. Unlike clinical evaluations, forensic evaluations sometimes attract much media attention and visibility. Accountability for and scrutiny of forensic work are greater than in clinical work (Otto and Heilbrun 2002). Even though forensic experts are not the ultimate decision-makers in the litigation, they wield considerable power, and the litigants and associated family can be injured by evaluators who are dishonest, corrupted by financial remuneration, unqualified, or otherwise disreputable. Clinicians without significant forensic training, experience, and relevant skills tread on thin legal and ethical ice when they undertake forensic work. Forensic experts must maintain objectivity, honesty, integrity, and humility in their evaluations and court testimony. Forensic work often requires diligence, conscientiousness, and hard work in fact finding.

As is true of those practicing clinical work (Unutzer et al. 2001), forensic evaluators should strive for excellence and undertake quality improvement efforts to the extent possible (Dietz 1996). These efforts require honest self-examination of one's work, enhanced by peer review by one's colleagues, with reference to professional standards and guidelines for forensic practice (Wettstein 2005).

Key Points

- Forensic evaluations must be comprehensive and detailed.
- Forensic evaluations should be conducted without conflicts of interest.
- The forensic evaluator should:
  - Identify the forensic issue and clarify the expert role in the case.
  - Strive for objectivity and neutrality.
  - Use accepted psychiatric literature, theories, and definitions.
  - Not exceed his or her role or expertise or draw conclusions beyond those supported by the existing case data.
  - Clearly articulate forensic opinions in the written report and fully explain reasoning.

Practice Guidelines

1. Self-monitor case selection.
2. Remain within your area of expertise.
3. Obtain comprehensive data from original sources.
4. Perform multiple interviews with evaluee.
5. Obtain corroborative data.
6. Reconcile conflicting data.
7. Offer the same opinion regardless of retaining side.
8. Self-monitor the pattern of forensic opinions.
9. Attend to countertransference.
10. Fully substantiate the basis for forensic opinions.
11. Disclose limitations of forensic opinions.
12. Do not become competitive with opposing experts.
13. Undertake peer review and quality improvement efforts.

References

Allen JP, Maisto SA, Connors GJ: Self-report screening tests for alcohol problems in primary care. Arch Intern Med 155:1726–1730, 1995

American Academy of Child and Adolescent Psychiatry: Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. J Am Acad Child Adolesc Psychiatry 36:122S–139S, 1997a

American Academy of Child and Adolescent Psychiatry: Practice parameters for child custody evaluation. J Am Acad Child Adolesc Psychiatry 36:57S–68S, 1997b

American Academy of Child and Adolescent Psychiatry: Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. J Am Acad Child Adolesc Psychiatry 38:55S–76S, 1999

American Academy of Psychiatry and the Law: Videotaping of forensic psychiatric evaluations. Bull Am Acad Psychiatry Law 27:345–358, 1999

American Academy of Psychiatry and the Law: Practice guideline: forensic psychiatric evaluation of defendants raising the insanity defense. J Am Acad Psychiatry Law 30:S3–S40, 2002

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Bloomfield, CT, American Academy of Psychiatry and the Law, May 2005. Available at: http://www.aapl.org/pdf/ETHICSGDLNS.pdf. Accessed January 6, 2010.

American Academy of Psychiatry and the Law: Practice guideline: forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law 35:S3–S72, 2007

American Academy of Psychiatry and the Law: Practice guideline: forensic evaluation of psychiatric disability. J Am Acad Psychiatry Law 36:S3–S50, 2008

American Psychiatric Association, Council on Psychiatry and Law: Peer review of psychiatric expert testimony. Bull Am Acad Psychiatry Law 20:343–352, 1992

American Psychiatric Association, Task Force on Peer Review: American Psychiatric Association resource document on peer review of expert testimony. J Am Acad Psychiatry Law 25:359–373, 1997

American Psychological Association: Guidelines for child custody evaluations in family law proceedings. Washington, DC, American Psychological Association, 2009

Austin WG: Guidelines for utilizing collateral sources of information in child custody evaluations. Family Court Review 40:177–184, 2002

Barbaree HE, Seto MC, Langton CM, et al: Evaluating the predictive accuracy of six risk assessment instruments for adult sex offenders. Criminal Justice and Behavior 28:490–521, 2001

Berger SH: Template for quickly creating forensic psychiatry reports. J Am Acad Psychiatry Law 36:388–392, 2008

Boccaccini MT, Brodsky SL: Diagnostic test usage by forensic psychologists in emotional injury cases. Prof Psychol Res Pr 30:253–259, 1999

Bow JN, Quinnell FA: A critical review of child custody evaluation reports. Family Court Review 40:164–176, 2002

Bow JN, Quinnell FA, Zaroff M, et al: Assessment of sexual abuse allegations in child custody cases. Prof Psychol Res Pr 33:566–575, 2002

Campbell MA, French S, Gendreau P: The prediction of violence in adult offenders: a meta-analytic comparison of instruments and methods of assessment. Crim Justice Behav 36:567–590, 2009

Chadwick DL, Krous HF: Irresponsible testimony by medical experts in cases involving the physical abuse and neglect of children. Child Maltreat 2:313–321, 1997

Connell M: Notification of purpose in custody evaluation: informing the parties and their counsel. Prof Psychol Res Pr 37:446–451, 2006

Cramer RJ, Brodsky SL: Undue influence or ensuring rights? Attorney presence during forensic psychology evaluations. Ethics and Behavior 17:51–60, 2007

Dietz PE: The quest for excellence in forensic psychiatry. Bull Am Acad Psychiatry Law 24:153–163, 1996

Epperson DL, Kaul JD, Hout S, et al: Minnesota Sex Offender Screening Tool—Revised (MnSOST-R) Technical Paper: Development, Validation, and Recommended Risk Level Cut Scores. St Paul, MN, Department of Corrections, 1998

Farkas GM, DeLeon PH, Newman R: Sanity examiner certification: an evolving national agenda. Prof Psychol Res Pr 28:73–76, 1997

Fava M, Farabaugh AH, Sickinger AH, et al: Personality disorders and depression. Psychol Med 32:1049–1057, 2002

Foote WE, Shuman DW: Consent, disclosure, and waiver for the forensic psychological evaluation: rethinking the roles of psychologist and lawyer. Prof Psychol Res Pr 37:437–445, 2006

Giles E, Hutchinson DL: Stature- and age-related bias in self-reported stature. J For Sci 36:765–780, 1991

Glassman JB: Preventing and managing board complaints: the downside risk of custody evaluation. Prof Psychol Res Pr 29:121–124, 1998

Gold LH, Davidson JE: Do you understand your risk? Liability and third-party evaluations in civil litigation. J Am Acad Psychiatry Law 35:200–210, 2007

Greenfield DP, Gottschalk JA: Writing forensic reports: a guide for mental health professionals. New York, Springer, 2009

Greiffenstein MF, Baker WJ, Johnson-Greene D: Actual versus self-reported scholastic achievement of litigating postconcussion and severe closed head injury claimants. Psychol Assess 14:202–208, 2002

Griffith EEH, Baronoski MV: Commentary: the place of performative writing in forensic psychiatry. J Am Acad Psychiatry Law 35:27–31, 2007

Grisso T: Evaluating Competencies: Forensic Assessments and Instruments, 2nd Edition. New York, Plenum, 2002

Grisso T, Appelbaum PS: MacArthur Competence Assessment Tool for Treatment. Sarasota, FL, Professional Resource Press, 1998

Gutheil T, Simon RI: Attorneys' pressures on the expert witness: early warning signs of endangered honesty, objectivity, and fair compensation. J Am Acad Psychiatry Law 27:546–553, 1999

Gutheil T, Simon RI: Avoiding bias in expert testimony. Psychiatric Annals 34:260–270, 2004

Haber RN, Haber L: Experiencing, remembering and reporting events. Psychol Public Policy Law 6:1057–1097, 2000

Hanson RK, Thornton D: Improving Actuarial Risk Assessment for Sex Offenders (User Report 1999–02). Ottawa, Ontario, Department of the Solicitor General of Canada, 1999

Hanson RK, Thornton D: Improving risk assessments for sex offenders: a comparison of three actuarial scales. Law Hum Behav 24:119–136, 2000

Hare RD: A research scale for the assessment of psychopathy in criminal populations. Pers Individ Dif 1:111–119, 1980

Harrison L, Hughes A: The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates (NIDA Research Monograph 167). Rockville, MD, National Institute on Drug Abuse, 1997

Hegaty A: Vicarious traumatization, in Principles and Practice of Child and Adolescent Forensic Psychiatry. Edited by Schetky DH, Benedek EP. Washington, DC, American Psychiatric Publishing, 2002, pp 59–66

Heilbrun K: Principles of Forensic Mental Health Assessment. New York, Kluwer/Plenum, 2001

Heilbrun K, Rosenfeld B, Warren J, et al: The use of third-party information in forensic assessments: a two-state comparison. Bull Am Acad Psychiatry Law 22:399–406, 1994

Heilbrun K, Warren J, Picarello K: Third-party information in forensic assessment, in Handbook of Psychology, Vol 11: Forensic Psychology. Edited by Goldstein AM. Hoboken, NJ, Wiley, 2003, pp 69–86

Hyman IE, Loftus EF: Errors in autobiographical memory. Clin Psychol Rev 18:933–947, 1998

Jensen EG: When "hired guns" backfire: the witness immunity doctrine and the negligent expert witness. University of Missouri-Kansas City Law Review 62:185–207, 1993

Kirkland K, Kirkland KL: Frequency of child custody evaluation complaints and related disciplinary action: a survey of the Association of State and Provincial Psychology Boards. Prof Psychol Res Pr 32:171–174, 2001

Kraemer HC, Measelle JR, Ablow JC, et al: A new approach to integrating data from multiple informants in psychiatric assessment and research: mixing and matching contexts and perspectives. Am J Psychiatry 160:1566–1577, 2003

Lanyon RI: Psychological assessment procedures in sex offending. Prof Psychol Res Pr 32:253–260, 2001

Little L, Hamby SL: The impact of a clinician's sexual abuse history, gender and theoretical orientation on treatment issues of childhood sexual abuse. Prof Psychol Res Pr 27:1–9, 1996

Loza W, Villeneuve DB, Loza-Fanous A: Predictive validity of the Violence Risk Appraisal Guide: a tool for assessing violent offender's recidivism. Int J Law Psychiatry 25:85–92, 2002

MacQueen GM, Galway TM, Hay J, et al: Recollection memory deficits in patients with major depressive disorder predicted by past depressions but not current mood state or treatment status. Psychol Med 32:251–258, 2002

McNagny SE, Parker RM: High prevalence of recent cocaine use and the unreliability of patient self-report in an inner-city walk-in clinic. JAMA 267:1106–1108, 1992

McSweeny AJ, Becker BC, Naugle RI, et al: Ethical issues related to the presence of third party observers in clinical neuropsychological evaluations. Clin Neuropsychol 12:552–559, 1998

Melton G, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts, 3rd Edition. New York, Guilford, 2007

Morgado A, Smith M, Lecrubier Y, et al: Depressed subjects unwittingly overreport poor social adjustment which they reappraise when recovered. J Nerv Ment Dis 179:614–619, 1991

Murrie DC, Warren JI: Clinician variation in rates of legal sanity opinions: implications for self-monitoring. Prof Psychol Res Pr 36:519–524, 2005

Nicholson RA, Norwood S: The quality of forensic psychological assessments, reports, and testimony: acknowledging the gap between promise and practice. Law Hum Behav 24:9–44, 2000

Otto RK, Heilbrun K: The practice of forensic psychology. Am Psychol 57:5–18, 2002

Otto RK, Poythress NG, Nicholson RA, et al: Psychometric properties of the MacArthur Competence Assessment Tool—Criminal Adjudication. Psychol Assess 10:435–443, 1998

Porter S, Birt AR, Yuille JC, et al: Memory for murder. Int J Law Psychiatry 24:23–42, 2001

Rappeport JR: Reasonable medical certainty. Bull Am Acad Psychiatry Law 13:5–15, 1985

Recupero PR: Clinical practice guidelines as learned treatises: understanding their use as evidence in the courtroom. J Am Acad Psychiatry Law 36:290–301, 2008

Riso LP, Klein DN, Anderson RL, et al: Concordance between patients and informants on the Personality Disorder Examination. Am J Psychiatry 151:568–573, 1994

Roesch R, Zapf PA, Eaves D, et al: The Fitness Interview Test, Revised Edition. Burnaby, BC, Mental Health, Law and Policy Institute, 1998

Rogers R: Structured Interview of Reported Symptoms. Tampa, FL, Psychological Assessment Resources, 1992

Rogers R: Handbook of Diagnostic and Structured Interviewing. New York, Guilford, 2001

Rogers R, Shuman DW: Conducting Insanity Evaluations, 2nd Edition. New York, Guilford, 2000

Rogers R, Grandjean N, Tillbrook CE, et al: Recent interview-based measures of competency to stand trial: a critical review augmented with research data. Behav Sci Law 19:503–518, 2001

Sattar SP, Pinals DA, Gutheil T: Countering countertransference: a forensic trainee's dilemma. J Am Acad Psychiatry Law 30:65–69, 2002

Scheiber SC: The psychiatric interview, psychiatric history, and mental status examination, in The American Psychiatric Publishing Textbook of Clinical Psychiatry, 4th Edition. Edited by Hales RE, Yudofsky SC. Washington, DC, American Psychiatric Publishing, 2003, pp 155–187

Schless AP, Mendels J: The value of interviewing family and friends in assessing life stressors. Arch Gen Psychiatry 35:565–567, 1978

Simon R: "Three's a crowd": the presence of third parties during the forensic psychiatric examination. J Psychiatry Law 24:3–25, 1996

Simon R, Wettstein RM: Toward the development of guidelines for the conduct of forensic psychiatric examinations. J Am Acad Psychiatry Law 25:17–30, 1997

Skeem JL, Golding SL: Community examiners' evaluations of competence to stand trial: common problems and suggestions for improvement. Prof Psychol Res Pr 29:357–367, 1998

Slovenko R: Holding the expert accountable. J Psychiatry Law 29:543–574, 2001

Stone JH: Memory disorder in offenders and victims. Crim Behav Ment Health 2:342–356, 1992

Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–456, 1997

Strasburger LH, Miller PM, Commons ML, et al: Stress and the forensic psychiatrist: a pilot study. J Am Acad Psychiatry Law 31:18–26, 2003

Strier F: Whither trial consulting? Issues and projections. Law Hum Behav 23:93–115, 1999

Unutzer J, Rubenstein L, Katon W, et al: Two-year effects of quality improvement programs on medication management for depression. Arch Gen Psychiatry 58:935–942, 2001

Ustad KL, Rogers R, Sewell KW, et al: Restoration of competency to stand trial: assessment with the Georgia Court Competency Test and the Competency Screening Test. Law Hum Behav 20:131–146, 1996

Walters GD, Knight RA, Thornton D: The latent structure of sexual violence risk: a taxometric analysis of widely used sex offender actuarial risk measures. Crim Justice Behav 36:290–306, 2009

Weiss RD, Najavits LM, Greenfield SF, et al: Validity of substance use self-reports in dually diagnosed outpatients. Am J Psychiatry 155:127–128, 1998

Wettstein RM: Quality and quality improvement in forensic mental health evaluations. J Am Acad Psychiatry Law 33:158–175, 2005

Williams CW, Lees-Haley PR, Djanogly SE: Clinical scrutiny of litigants' self-reports. Prof Psychol Res Pr 30:361–367, 1999

Zucker M, Morris MK, Ingram SM, et al: Concordance of self and informant ratings of adults' current and childhood attention-deficit\hyperactivity disorder symptoms. Psychol Assess 14:379–389, 2002

Zusman J, Simon J: Differences in repeated psychiatric examinations of litigants to a lawsuit. Am J Psychiatry 140:1300–1304, 1983

Suggested Readings

Ackerman MJ: Essentials of Forensic Psychological Assessment. New York, Wiley, 1999

Benedek EP, Ash P, Scott CL (eds): Principles and Practice of Child and Adolescent Forensic Mental Health. Washington, DC, American Psychiatric Publishing, 2010

Goldstein AM: Handbook of Psychology, Vol 11: Forensic Psychology. Hoboken, NJ, Wiley, 2003

Greenfield DP, Gottschalk JA: Writing Forensic Reports. New York, Springer, 2009

Grisso T: Forensic Evaluation of Juveniles. Sarasota, FL, Professional Resource Press, 1998

Heilbrun K: Principles of Forensic Mental Health Assessment. New York, Kluwer/Plenum, 2001

Melton G, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts, 3rd Edition. New York, Guilford, 2007

Rogers R, Shuman DW: Fundamentals of Forensic Practice. New York, Springer, 2005

Rosner R (ed): Principles and Practice of Forensic Psychiatry, 2nd Edition. New York, Chapman & Hall, 2003

Simon RI (ed): Posttraumatic Stress Disorder in Litigation, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2003

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PART

II

Civil Litigation

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Chapter 8

Professional Liability in Psychiatric Practice and Requisite Standard of Care

Donald J. Meyer, M.D.

Robert I. Simon, M.D.

Daniel W. Shuman, J.D.

All physicians are subject to multiple levels of legal, administrative, and professional standards and regulation from the courts, state licensing board regulations, codes of professional organizations (state and national medical societies), codes of conduct of health care organizations (e.g., hospitals), and contracts between practitioners and public and private insurers of health care. Physicians may be exposed to civil liability for their negligent or intentional acts that fail to meet accepted standards of medical practice and conduct and proximately result in harm. On rare occasions, physicians may additionally face charges of criminal conduct.

Medical malpractice usually refers to medical negligence but may also include battery. The injured individual making the allegation is the *plaintiff,* and the accused doctor is the *defendant*. For an allegation of malpractice to prevail, the plaintiff must prove that, more likely than not, the plaintiff's injuries were proximately caused by the defendant's conduct and that the conduct fell below what an ordinary, prudent practitioner would do in similar circumstances.

Other practitioner exposures derive from state licensing board (Board of Medicine) regulations, the codes of professional organizations (state and national medical societies), codes of conduct of health care organizations (e.g., hospitals), and contractual requirements between practitioners and public and private insurers of health care.

A Negligent Act: A Departure From the Standard of Care

Central to a malpractice claim is the *standard of care*. The standard of care is a legal term of art that defines the standard against which allegations of negligence are measured. *Negligence* is conduct that falls below the level of care that an average, prudent individual would provide in similar circumstances. It applies to all members of society. The concept applies to a homeowner with a dilapidated front entrance that injures a delivery person and to a psychiatrist's treatment of a delusionally depressed patient who commits suicide. Homeowner and psychiatrist both have a duty to provide the level of care of an average, prudent individual in similar circumstances. The circumstances ultimately shape the nature and the extent of the duty of both homeowner and physician. For example, a physician with a duty of care to a patient will be held to a professional standard of care.

Psychiatrists practice in different settings and with different colleagues. A direct administrative supervisor of many clinicians, a solo practitioner, a medicating psychiatrist collaborating with a nonphysician therapist, and a specialist in electroconvulsive therapy all have some duties in common, but their respective standards of care will be nuanced by the differing circumstances in which they practice and by the expertise that they have proffered to the patient.

Not all conduct that is below the standard of care harms anyone. A person who drinks large quantities of alcohol and then drives a car has committed a crime, but if he or she arrives home without injuring another, there is

no tort. Similarly, a psychiatrist who incorrectly prescribed a potentially toxic dose of medication that the patient did not take for other reasons is not liable in a tort. A complaint could be filed with the state medical licensing board, with professional societies, or with health care institutions, all of which have regulatory authority over health care providers and are not bound by tort law.

Prudent medical care does not ensure successful treatment of disease or immunity from harmful side effects or other iatrogenic harm. All harm is not compensable in our tort system—only negligently or intentionally caused harm. When harm occurs and the physician's conduct was not negligent, the law does not recognize any tort liability.

Sources of the Applicable Standard of Care: Expert Testimony, Common Law, State Statute, and Administrative Regulation

In a jury trial, the jury is the *trier of fact* and determines the standard of care. In a bench trial, the judge is the trier of fact and makes that determination. The right to a jury trial may be granted under a relevant state or federal court rule, statute, or constitutional provision. Whether or not to exercise that right may be a complex tactical decision on which an informed consulting psychiatrist's opinion may be sought. Ascertaining whether it is a jury trial—in which the jury as the trier of fact determines the standard of care, or a bench trial, in which the judge is the trier of fact—is not an abstract consideration. Who are the parties and the witnesses?; what is the evidence?; who is the judge?; and what is the nature of typical juries in this locale?

In a trial of alleged psychiatric malpractice, the standards of a reasonable, prudent psychiatrist are usually outside the training and experience of either the judge or the jury and will require expert testimony. Rule 701 of the Federal Rules of Evidence provides for the admissibility of expert witnesses' testimony at trial:

> …scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise.

Comparison of *Nathansen v. Kline* (1960) and *Canterbury v. Spence* (1972), both cases that are concerned with the standard of care of physician disclosure during informed consent, provides an interesting clarification about the necessity for expert testimony. In *Nathansen v. Kline,* the court found that state law required the physician to disclose what a reasonable physician would disclose under like circumstances. The "reasonable physician" standard required physician expert testimony, given that what ordinary doctors do is outside the knowledge of the trier of fact.

Over time, many states were persuaded to reject the "reasonable physician" standard and replace it with the "reasonable patient" standard articulated in *Canterbury v. Spence*. According to this later decision, what a reasonable patient would want to know about the medical event shapes the body of information that the doctor must convey in the informed consent process. A trier of fact requires no medical expert to opine what a reasonable patient would want to know.

Fact witnesses are limited to testimony about events that they have perceived directly with their own five senses. Expert witnesses may offer opinions about facts and testimony at trial. They may also offer opinions about hypothetical situations.

Although all court rules grant judges the authority to use court-appointed experts, their use is the exception. Most experts are retained by one party in the adversarial adjudicatory process. Unlike the retaining attorney, who is bound ethically to be a zealous advocate for the client's interests, experts are bound ethically to strive for objectivity (American Academy of Psychiatry and the Law 2005; American Medical Association 2004).

The expert witness should be an advocate for his or her expert opinion and not for a client per se. In the view of the court, even within the context of an adversarial process, the justification for the presence of the medical expert at trial is to educate the trier of fact about issues such as the standard of care, what is reasonably foreseeable, and causation.

The actual wording of the standard of care may vary from one state to another. Adjectives such as *ordinary, reasonable,* and *prudent* may raise or lower the level of expected conduct in a given jurisdiction. Many jurisdictions favor a national standard of care, relying on the notion that medical information is shared across state borders. Psychiatrists' risk assessments in New York and Nebraska can all rely on the same scientific information and so—in the view of many jurisdictions—should conform to the same medical standards. The wording "in similar circumstances," common to all jurisdictional definitions of the standard of care, serves to introduce a degree of locality even where a national standard is observed.

Other states may have a local rather than a national standard. The standard of care is what is customary in that jurisdiction and not the nation at large. Ex-

pert witnesses who do not practice locally will need to educate themselves through the use of local consultants about that specific region's medical practices. Over time, many jurisdictions have moved away from what is customary in a region to what is prudent across the nation (Lewis et al. 2007).

Expert opinions about customary medical practices are not the only source to clarify the standard of care. The standard of care may also be set by judicial decision, by state statute, and by administrative authorities. For example, in *Tarasoff v. Regents of the University of California* (1976), the California Supreme Court articulated a new element of the standard of care: psychiatrists and psychologists had a duty to protect foreseeably endangered persons from their violent patients. Many other states' appellate courts have also adopted *Tarasoff*-like case law. These cases are examples of instances in which the standard of care of medical practice was defined by common (court judgment–based) law.

An element of the standard of care may also be defined by statute. Unlike those states whose *Tarasoff* duty derives from court decisions, other states have enacted laws that specifically define that clinical duty (e.g., Massachusetts General Law c123 § 36B). State laws mandating health care professionals to report child or elder abuse are additional examples of an element of the medical standard of care that is defined by statute and not by expert testimony about professional customs.

State medical boards, through their administrative authority, promulgate regulations that may also define an element of the standard of care. For example, the Board of Registration in Medicine in Massachusetts has published policies on maintenance of appropriate boundaries between physicians and patients (Commonwealth of Massachusetts 1994) and on disruptive physician conduct (Commonwealth of Massachusetts 2001). These policies are binding elements of the standard of care of physicians in that jurisdiction.

Professional codes of ethics are often relied on for guidance by trial courts when physician conduct is at issue, even though they do not have the same jurisdictional legal authority as common-law decisions, state statutes, and administrative regulations. Professional codes of ethics can thereby be a significant factor in the trier-of-facts determination of the standard of care.

Damages and Their Legal Causation: Proximate Cause and Foreseeability

Not only must the defendant's conduct be substandard, it must also be sufficiently linked to the harm claimed by the plaintiff. That sufficient linkage be-

tween substandard conduct and the plaintiff's harm is defined by the legal term *proximate cause*. Like the standard of care, proximate cause is a legal concept that is pivotal to understanding the harm for which an individual is or is not legally responsible and whether or not that harm is legally compensable.

Scientific or medical causation and legal causation serve different masters. Scientific causation casts the widest possible net in the pursuit of all relevant factors. In contrast, legal causation seeks to define legal responsibility, as implied by the maxim "Medical causes are discovered. Legal causes are decided" (Baranoski 2009). Proximate cause and legal cause are professional terms of art that serve to separate causal factors that confer legal responsibility from more remote factors that do not (Melton 1997).

We are liable for the harm we have in fact caused, as measured by the "but for" test: *but for* the defendant's conduct, would this have occurred? Actual causation is a necessary but not a sufficient condition for imposing liability for negligence. Tort law imposes a second, conjunctive requirement for proximate causation. Even when the defendant is the cause in fact of harm, the conduct must also have been the proximate cause. In most courts that means whether that harm was also foreseeable. Could one reasonably foresee that the former event would lead to the latter? The law does not require an individual to "foresee events which are merely possible but only those that are reasonably foreseeable" (*Hairston v. Alexander Tank and Equipment Co.* 1984). In other courts, this second element of proximate cause has been used to draw a pragmatic line to limit disproportional monetary awards, shape public policy, or clarify moral responsibility.

Legally, *foreseeability* is defined as the reasonable anticipation that harm or injury is likely to result from certain acts or omissions (Black 1999). A person who trips his friend as a joke is expected to foresee that harm could occur. A psychiatrist may assess a patient with depressive delusions to be foreseeably at high risk for self-harm and take reasonable actions within the standard of care of the profession to mitigate the risk.

Foreseeing the risk of harm is different from predicting harm itself. Whereas there are psychiatric standards of care for assessing risk and mitigating risk, there are no such standards or methods for the prediction of rare events, such as suicide and violence. These are statistically low-base-rate events that have no before-the-fact identifying markers to distinguish them from commonplace findings. "Although foreseeability is a prospective test to be applied from the perspective of the defendant at the time of the injury-producing conduct, its application at trial is affected by hindsight bias" (Shuman 1995).

In the North Carolina case of *Williamson v. Liptzin* (2000), the defendant psychiatrist appealed a plaintiff's $500,000 jury verdict against a university health service psychiatrist on the absence of proximate cause. The harm (a shooting rampage) had occurred 8 months after the psychiatrist's allegedly neg-

ligent risk assessment. The appellate court agreed and reversed, reasoning that there were too many intervening events the psychiatrist could not have foreseen.

Expert psychiatric witnesses need to be mindful that their opinions about foreseeability should be based on what an individual knew or could have reasonably known at the time and should not biased by the truism that someone could always have done something more.

Case Vignette

A psychiatrist is treating a young post-combat veteran for psychotic depression. The psychiatrist is prescribing an antidepressant and an antipsychotic. In addition to neurovegetative signs and symptoms of depression, the patient has a delusion that helicopters are conducting surveillance on him to chronicle his misdeeds. He denies suicidal ideation or intent. He lives with his wife. He has refused hospitalization.

Unbeknownst to the psychiatrist, the patient becomes nonadherent with his antipsychotic medication. His delusions worsen. His wife calls the psychiatrist. The psychiatrist tells her that the patient has refused hospitalization and does not meet commitment criteria. He does not reexamine his patient. The patient argues with his wife and leaves his home. He stays with a friend, who is also from the military. In the middle of the night, the patient uses his friend's handgun to shoot and kill himself.

In a malpractice suit, the plaintiff's expert would likely opine that the psychiatrist's failure to reassess and hospitalize his patient was the proximate cause of the decedent's suicide, given that suicide is a foreseeable risk of worsening depressive delusions and that no prudent psychiatrist would have forgone a reassessment under such clinical circumstances.

The defense expert would likely opine that the patient's nonadherence to antipsychotic medication and the friend's having a loaded handgun were the proximate cause of the suicide, and that in the absence of knowledge of his patient's nonadherence, the suicide was not foreseeable, nor was the psychiatrist's conduct below the standard of care.

Admissibility of Testimony and Requisite Expert Qualifications

Expert witnesses should be familiar with the law governing the admissibility of expert testimony. The trial judge serves as the gatekeeper who determines which experts and which expert opinions may be presented to the trier of fact, be that the judge or the jury.

From 1923 to 1993, the prevailing legal standard of expert admissibility applied by judges in the United States was the *Frye* rule (*Frye v. United States* 1923). According to *Frye,* expert evidence should be "established to have gained general acceptance on the particular field to which it belongs." The *Frye* rule also was known as the "general acceptance rule." There are still some states that continue to use *Frye* as their legal standard for admissibility of scientific and expert testimony. The *Frye* rule has been criticized as sometimes being unduly hostile to new scientific findings and overly hospitable to unscientifically scrutinized convention.

In 1993 in *Daubert v. Merrell Dow Pharmaceuticals, Inc.,* the U.S. Supreme Court rejected the *Frye* standard and articulated new standards for admissibility of expert testimony in federal court. Under *Daubert,* a trial judge's decision on the admissibility of testimony should be determined by the relevance of the testimony to the case at trial and the reliability (trustworthiness) of the scientific field's underlying principles and methodology. In assessing reliability, judges could determine whether the principles and methods 1) have been or can be tested, 2) have been peer-reviewed, 3) have a known error rate, and 4) have gained general acceptance (as in *Frye*).

In addition to *Daubert* and the Federal Rules of Evidence, there are two other U.S. Supreme Court decisions that clarified issues initially unarticulated in *Daubert: General Electric Co. v. Robert K. Joiner* (1997) and *Kumho Tire Co., Ltd. v. Patrick Carmichael* (1999). Experts typically frame their opinions based on their training and experience. However, an expert's training and experience are not by themselves sufficient foundation. In *Daubert*, the U.S. Supreme Court stated that the opinion must be relevant and reliable.

In 1997, in *General Electric v. Robert K. Joiner,* the Supreme Court set limits on how far experts may inferentially reach from scientific studies to the particular facts at trial: "Experts commonly extrapolate from existing data. But nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence which is connected to existing data only by the ipse dixit [he, himself, said it] of the expert." Experts must construct a scientific foundation for their opinions, remaining mindful of the standards of relevance and reliability originally outlined in *Daubert*.

An example of courts' expectations of expert opinions is illustrated in *Blanchard v. Eli Lilly* (2002). On appeal, the defendant psychiatrist was granted summary judgment based on the *Daubert* review of testimony of the plaintiff's expert. The plaintiffs, through their psychiatric expert, had alleged that a selective serotonin reuptake inhibitor (SSRI), Prozac, was the proximate cause of the decedent's filicide and suicide. The expert had relied on an article that noted the association between drug-induced akathisia and suicide. The court found there was no evidence that the decedent had akathisia

and, quoting *General Electric v. Robert K. Joiner,* found that "there is simply 'too great an analytical gap between the data and the opinion proffered.'" The court also noted the expert "had no direct clinical experience with patients who have experienced newly emergent suicidal thoughts, attempted or committed suicide or become violent while taking Prozac or any SSRIs." The expert's belief "remains just that, a belief, an insightful even an inspired hunch that lacks scientific rigor" (*Blanchard v. Eli Lilly* 2002).

In *Kumho Tire Co., Ltd. v. Patrick Carmichael* (1999), the Supreme Court clarified an unresolved question of how the standards of *Daubert,* which were easily applicable to hard bench science, would apply in arenas such as psychiatric practice, where some clinical methods and concepts have not been tested and have no known error rate and where the treatment of an individual patient is always, to some degree, unique unto itself. The Court made the following statement:

> A federal trial judge's gatekeeping obligation under the Federal Rules of Evidence—to insure that an expert witness' testimony rests on a reliable foundation and is relevant to the task at hand—applies not only to testimony based on scientific knowledge, but rather to all expert testimony that is based on technical and other specialized knowledge. The FRE grant to all experts—not just to "scientific" ones—testimonial latitude unavailable to other witnesses on the assumption that an expert's opinion will have a reliable (trustworthy) basis in knowledge and experience of the expert's discipline. (*Kumho Tire Company, Ltd. v. Patrick Carmichael* 1999 at 642)

The U.S. Supreme Court continued referencing *Daubert:*

> A federal judge may properly consider one or more of some specific factors—whether the theory or the technique 1) can be and has been tested, 2) has been subjected to peer review or publication, 3) has (a) a high known or potential rate of error, and (b) standards controlling the technique's operation and 4) enjoys general acceptance within a relevant scientific community—where such factors are reasonable measures of the testimony's reliability. The trial judge may ask questions of this sort not only where an expert relies on the application of scientific principles, but also where an expert relies on skill- or experience-based observation. (*Kumho Tire Company, Ltd. v. Patrick Carmichael* 1999 at 642)

In 2000, the revised Federal Rules of Evidence incorporated the *Daubert* criteria for admissibility and the central role of the trial judge's discretion. Many state jurisdictions have followed suit using the revised Federal Rules of Evidence.

Experts seeking a foundation that can withstand the scrutiny of *Daubert* can avail themselves of the applicable research literature, texts upon which the field typically relies, and unbiased clinical practice guidelines and evi-

dence-based *learned treatises* (Recupero 2008; Zonana 2008). None of these sources is, by itself, the standard of care. As the American Psychiatric Association asserted in its Statement of Intent for practice guidelines, a guideline "is not intended to be construed or to serve as a standard of care.... The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available" (American Psychiatric Association 2006, p. vii).

Experts must have more than academic expertise. Their opinions should be based on actual experience. The appeals court in *Blanchard v. Eli Lilly* clearly was troubled that plaintiff's expert had no direct clinical experience with the clinical facts at trial on which to rely in forming his opinion. The case of *Commonwealth of Massachusetts v. Barresi* (1999) illustrated a court's exclusion of an expert whose testimony was based on academic rather than clinical experience.

Some states' legislatures (e.g., *Seisinger v. Siebel* 2008) have taken additional steps to ensure that purported experts are still actively involved in the practice of medicine and that forensic testimony has not become a retirement venue for doctors who no longer practice.

In addition to unqualified experts' risk of being discredited by vigorous cross-examination, being excluded by judicial review, and not passing some state statutory requirements, they may also face complaints of unethical conduct to their professional societies (*Austin v. American Association of Neurological Surgeons* 2001). The Council on Ethical and Judicial Affairs of the American Medical Association has defined *medical testimony* as the practice of medicine and made the following statement:

> When physicians choose to provide expert testimony, they should have recent and substantive experience or knowledge in the area in which they testify and be committed to evaluating cases objectively, and deriving an independent opinion. Their testimony should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field. If a medical witness knowingly provides testimony based on a theory not widely accepted in the profession, the witness should characterize the theory as such. Also, testimony pertinent to a standard of care must consider standards that prevailed at the time the event under review occurred. (American Medical Association 2004)

Experts' personal vigilance to admit and adhere to the limits of their knowledge and experience is essential to resisting financial and narcissistic inducements of the expert role—inducements that can undermine the important contribution experts can make in educating the trier of fact.

The Standard of Care With More Than One Clinician: Split Treatment, Supervision, and Vicarious Liability

The most straightforward cases of psychiatric malpractice involve one patient and one doctor. However, the provision of mental health care may involve multiple mental health care providers. Those providers may or may not be independently licensed. The care they provide may be within or outside the auspices of a health care institution. All of these factors will have an effect on shaping the requisite standard of care of each health care provider to each individual patient.

Split Treatment

Split or collaborative treatment involves mental health care provided concurrently by more than one mental health clinician. For many years, prototypical split treatment was synonymous with a nonphysician therapist providing psychotherapy and a psychiatrist providing pharmacotherapy. Currently, there are increasing numbers of specialized psychotherapies that may be used concurrently with other medicinal and nonmedicinal treatments: a patient with a treatment-resistant depression might concurrently be receiving psychotropic medication, interpersonal psychotherapy, cognitive-behavioral therapy, and group therapy, all with different mental health professionals. Psychiatrists are particularly vulnerable to the mistaken notion that their responsibilities for the patient and the requisite standard of care are delimited by the medication they are prescribing. All pharmacotherapy of a mentally ill patient involves a psychological understanding of the patient. All split treatment of psychiatric patients involves both a degree of psychotherapy and an appreciation of the respective roles of the other mental health clinicians.

Split treatment often involves sicker psychiatric patients who need multimodal treatments. Although some facets of the patient's treatment will fall squarely into one clinician's duties, clinical risk assessment, risk mitigation, prospective clinical monitoring, and clinical emergencies will be shared, not parsed, and require prospective teamwork (Meyer 2002; Meyer and Simon 2006).

Supervision

Supervision in mental health care is an ambiguous term that can refer to several distinct health care relationships that depend on what the nature of the clinician's license is, whether the interaction is required or voluntary, and whether the supervision is within or independent of an institution.

Independently licensed clinicians may voluntarily seek clinical onetime or ongoing consultation from an independently licensed colleague. Typically, the effort documents the treating clinician's good-faith interest in learning and does not establish a doctor-patient relationship between the supervising clinician and the patient. The doctor-patient relationship is a legally required element of an allegation of malpractice (*Schrader v. Kohout* 1999). Although the supervisor has a supervisory standard of care to observe, the supervisor's actual liability is very limited, because the duty is owed to the fellow clinician, not the patient.

Sometimes the treating clinician's supervision is not voluntary, because of either statutory requirements of the treating clinician's licensure (Massachusetts General Law Chapter 112, § 80E) or the requirements of the institution, as in *Andrews v. United States* (1984). In cases for which the supervision of the treating clinician is not voluntary, the supervisor has a standard of care of supervision that typically will involve a duty to the patient's care.

In the example of licensed clinical psychiatric nurse specialists in Massachusetts, the terms of their licensure require psychiatric supervision. Legally, that psychiatrist-supervisor may have liability exposure in the event of a malpractice suit against the supervisee. The supervisor in his or her defense would demonstrate that the supervisory standard of care had been observed.

In *Andrews,* the therapist, a physician's assistant, had had a sexual relationship with his patient, and the therapist's supervisor had not thoroughly investigated a report of such from a friend of the patient. The patient could not have recovered for damages by her therapist's misconduct because the conduct was outside the terms of the therapist's employment. However, she did recover for the supervisor's negligent supervision—supervision that had been required by the therapist's licensure and by the terms of the employer, the U.S. Navy.

Therapists in training also require supervision. Trainee supervisors sometimes have supervisory responsibilities that derive directly from their having administrative authority for a clinical service of which the trainee is a member. Some trainee supervisors only provide clinical supervision. This latter group often wrongly assumes they have no liability for their supervisory work. In most jurisdictions, the law expects that trainees will meet the standard of care of a trained clinician, and the supervisors are the public's guarantors of that level of care (*St. Germain v. Pfeifer* 1994). *Cohen v. State of New York* (1976) illustrates an appellate opinion about inappropriate delegation

of clinical authority by the trainee's supervisors and the resulting liability. Supervisors have the authority, whether or not they use it, to exercise substantial influence over their trainees. Courts that investigate questions of negligent supervision will inquire not only about what the supervisor did know but also about what a prudent supervisor could have known and should have known in his or her assessment of what constituted appropriate standard of care.

Vicarious Liability for Another's Negligence: *Respondeat Superior*

An individual whose departure from the standard of care caused the injury of another is usually the legally liable individual. Vicarious or indirect liability derives from a legal doctrine, *respondeat superior* ("Let the master answer"), by which the owner of a business and the employer of a negligent employee may be legally responsible, even in the absence of having done anything negligent to the injured party.

The social policy rationale for this common-law doctrine is that many employees are less able to provide financial compensation for negligent acts than are their employers. Furthermore, it is thought that exposure to vicarious liability is an incentive for employers to observe the proper oversight and supervision of their employees. Owners or directors of health care entities and the directors of clinical services can be exposed to suits of vicarious liability for negligent acts of their employees.

The plaintiff must show that 1) the vicarious defendant had the authority—whether or not it was used—to control and direct the conduct of the employee; 2) the employee's conduct departed from the standard of care and was the proximate cause of the plaintiff's damages; and 3) the employee's conduct was within, not outside, the employee's terms of employment.

In *Andrews v. United States,* the employer (the United Sates) was not liable by a doctrine of vicarious liability for the therapist's misconduct (therapist-patient sex), given that the professional misconduct was outside the terms of the therapist's employment. The employer was vicariously liable for the supervisor's negligent supervision.

In the case vignette described earlier about the veteran with a psychotic depression, the following factors would be relevant to exposures to vicarious liability:

- Were the treating psychiatrist a psychiatric resident, the clinical supervisor's employer would be vicariously liable for a successful suit of negligent supervision as the proximate cause of the decedent's suicide.

- If the resident were treating the patient in the hospital outpatient clinic, the medical director's employer could be vicariously liable for allegations of negligence made about the medical director's conduct.
- Were the patient being treated by a psychiatrist and a psychotherapist in split treatment, it is likely each clinician's employer would be exposed to suit by vicarious liability.

Professional Oversight From Administrative Agencies and Peer Review

Medical malpractice is the most common but by no means the only possible professional sanction that physicians may face. In 1986, the U.S. Congress passed and President Reagan signed the Health Care Quality Improvement Act and, in so doing, forever changed every physician's risk of professional liability. As stated in the act, "The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State" (42 U.S.C. § 11101 1998). The act established the National Practitioner Data Bank to prevent negligent physicians' escape of their past record by crossing state lines to practice elsewhere:

> This nationwide problem can be remedied through effective professional peer review. The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review. There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

What is not commonly known is that the act mandated all health care entities to report not only findings of malpractice but also a range of professional discipline that had adversely affected the respondent physician's membership in that health care entity. So long as peer review was done 1) in the reasonable belief that it was in the service of health care, 2) after a reasonable effort to obtain the facts, and 3) with the observance of due process, the participants in peer review were immune to suit for financial damages alleged by the respondent (defendant) physician.

The health care entities to which this federal statute referred included not only state boards of registration but also organizations that physicians

may voluntarily choose to join: hospitals, clinics, practice associations, professional societies, training programs, medical schools, health maintenance organizations, and other third-party payors. From a legal perspective, when a physician joins one of these health care entities, whether to be on clinical staff or to be a member of a society, the physician has made a voluntary choice to join and be bound by the peer review process and other bylaws of that organization. All of these organizations are required to have mechanisms to investigate complaints of professional misconduct.

Although the peer review process is intended to be an instrument for quality improvement in medical care, the liability risks to a respondent physician can be considerable. Unlike malpractice, in which a physician's poor practice must have caused actual injury, administrative and peer review adjudication of complaints of substandard professional care is about professional conduct itself and does not require that anyone have been injured (Meyer and Price 2006).

Also distinct from malpractice, in which only the plaintiff has standing to make an allegation, in administrative and peer review adjudication, colleagues, coworkers, patients, patients' friends, and patients' relatives may all generate complaints. Due process in court provides considerably more protection for the defendant, as compared with the circumscribed due process afforded a respondent in administrative and peer review hearings (Meyer 2006).

A court's adjudication of malpractice is retrospective and legally limited in scope. Adjudication in an administrative peer review investigation is both retrospective and prospective, and the scope of inquiry can be widened if it is in the service of improving health care. Malpractice insurance for legal defense and for damages is relatively substantial, whereas insurance for peer review hearings is, in general, deficient. Finally, a disciplinary finding often sets in motion obligatory notice of other health care organizations, which in turn may initiate their own investigation and further sanctions.

Although it is not often acknowledged by professionals as a substantial professional liability risk to the individual professional, disciplinary findings from an administrative or peer review investigation and hearing can be professionally more far-reaching and longer lasting than a guilty verdict in a malpractice trial.

Conclusion

Psychiatrists wishing to mitigate their risks for professional liability benefit from an understanding of the core legal concepts and the legal process of med-

ical malpractice, as well as of the investigative and adjudicatory process of administrative and peer review organizations that oversee health care providers.

The two systems serve different goals. Malpractice litigation provides monetary compensation for an individual when that individual has been damaged by the doctor's substandard care. Monetary compensation is provided in response and in proportion to an injury. Concepts that are key to understanding which claims are compensable include the requisite standard of care, proximate cause, and foreseeability, each of which is a professional term of art having specific meaning under the law.

In administrative and peer review investigations into alleged professional misconduct, conduct is central to the investigation, even when no individual has been injured. The goal is not restitution to an injured individual but rather protection of the public by quality assurance through peer review. Unlike malpractice litigation, administrative and peer review investigation and adjudication can have an enlarging professional scope of inquiry and are concerned prospectively, not just retrospectively, with the physician's professional conduct.

Key Points

- All harm is not compensable in our tort system, only negligently or intentionally caused harm. When harm occurs and the physician's conduct was not negligent, the law does not recognize any tort liability.
- Negligence is conduct that falls below the standard of care, a legal term of art defined as what an ordinary, prudent person would do in similar circumstances.
- The medical standard of care may derive from multiple sources, including expert witness testimony, common or court judgment-based law, state statute, or administrative regulation.
- The expert who opines about the standard of care typically relies on practice guidelines, the psychiatric literature, hospital policies and procedures, and other authoritative sources in addition to the expert's individual training and experience.
- In many jurisdictions, proximate cause or legal cause combines the "but for" test with the legal concept of foreseeability.
- Admissibility of expert opinions in federal and many state jurisdictions is determined by the standards set out in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993), *General Electric Co. v.*

Robert K. Joiner (1999), and *Kumho Tire Co., Ltd. v. Patrick Carmichael* (1999), as applied by the trial judge.

- Physicians are also subject to regulation and review by state licensing board regulations, codes of professional organizations (state and national medical societies), codes of conduct of health care organizations (e.g., hospitals), and contracts between practitioners and public and private insurers of health care.
- These administrative regulations and inquiries are focused on conduct and protection of the public and do not require proof of harm to anyone.
- In contrast to the tort system, the scope of administrative and peer review investigation and adjudication is both retrospective and prospective.
- The due process protections for a respondent physician in administrative and peer review investigations and hearings are substantially less than those offered to a defendant in the tort system.
- Malpractice insurance is usually substantially less adequate for administrative and peer review inquiries, as compared with allegations of malpractice in the tort system.

Practice Guidelines

1. Advocate for your independent, objective opinion and not for a side. Although expert witnesses are most commonly retained by a side in an adversarial proceeding, the expert's duty is to educate the trier of fact about matters at trial that are beyond the trier's knowledge and experience.
2. Ensure that an expert witness in the tort system understands the relevant legal terms of art such as standard of care, proximate cause, and foreseeability.
3. Clarify the sources of the requisite standard of care in the jurisdiction in which the expert is testifying.
4. Do not rely solely on your training and experience as the foundation for admissibility of their opinions.
5. Rely on the American Medical Association Council of Judicial Affairs report on medical testimony and the American Academy of Psychiatry and Law Ethical Guidelines for ethical guidance of the requisite training, experience, and objectivity for an expert.

6. Be aware that professional societies of which the expert is a member have the authority to ethically review and sanction confirmed complaints of unethical testimony.
7. In contrast to the tort system, expect to be asked to offer opinions about the respondent physician's prospective capacity to adhere to standards of conduct when participating in administrative and peer review investigations and adjudications.

References

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Bloomfield, CT, American Academy of Psychiatry and the Law, May 2005. Available at: http://www.aapl.org/pdf/ETHICSGDLNS.pdf. Accessed January 6, 2010.

American Medical Association, Council on Ethical and Judicial Affairs: Report of the Council on Ethical and Judicial Affairs. CEJA Report 12-A-04: Subject: Medical Testimony. Chicago, IL, American Medical Association, 2004

American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. Washington, DC, American Psychiatric Association, 2006

Andrews v United States, 732 F.2d 366 (1984)

Austin v American Association of Neurological Surgeons, 253 F.3d 967 (7th Cir 2001)

Baranoski M: Psychiatry Grand Rounds at Beth Israel Deaconess Hospital, Boston, MA, March 5, 2009

Black HC: Black's Law Dictionary, 7th Edition. St Paul, MN, West Publishing, 1999

Blanchard v Eli Lilly, 207 F.Supp.2d 308; LEXIS 16470 (U.S. Dist. 2002)

Canterbury v Spence, 464 F.2d 772, 789 (D.C. Cir. 1972)

Cohen v State of New York, 382 N.Y.S.2d 128 (1976)

Commonwealth of Massachusetts, Board of Registration in Medicine: Policy 94-001: General guidelines related to the maintenance of boundaries in the practice of psychotherapy by physicians (adult patients). January 12, 1994. Available at: http://massmedboard.org/regs. Accessed February 25, 2010.

Commonwealth of Massachusetts, Board of Registration in Medicine: Policy 01-01: Disruptive physician behavior. June 13, 2001. Available at: http://massmedboard.org/regs. Accessed February 25, 2010

Commonwealth of Massachusetts v Barresi, 46 Mass. App. Ct. 907, 705 N.E.2nd 639 (1999)

Daubert v Merrell Dow Pharmaceuticals, Inc, 509 U.S. 579, 113 S.Ct. 2786 (1993)

Frye v United States, 54 App.D.C. 46, 47, 293 F. 1013, 1014 (1923)

General Electric Co v Robert K Joiner, 522 U.S. 136 (1997) at 519

Hairston v Alexander Tank and Equipment Co, 310 N.C. 227, 233, 311 S.E.2d 559, 565 (1984)

Kumho Tire Company, Ltd v Patrick Carmichael, 526 U.S. 137 (1999)

Lewis MH, Gohagan J, Merenstein DJ: The locality rule and the physician's dilemma: local medical practices vs the National Standard of Care. JAMA 297:2633–2637, 2007

Melton GB: Psychological Evaluation for the Courts, 2nd Edition. New York, Guilford, 1997, p 371

Meyer DJ: Split treatment and coordinated care with multiple mental health clinicians: clinical and risk management issues. Primary Psychiatry 9:56–60, 2002

Meyer DJ: Psychiatric malpractice and administrative inquiries of alleged physician misconduct. Psychiatr Clin North Am 29:615–628, 2006

Meyer DJ, Price M: Forensic psychiatric assessments of behaviorally disruptive physicians. J Am Acad Psychiatry Law 34:72–81, 2006

Meyer DJ, Simon RI: Split treatment, in The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Edited by Simon RI, Hales RE. Washington, DC, American Psychiatric Publishing, 2006, pp 235–251

Nathanson v Kline, 350 P.2d 1093, 1106 (Kan. 1960)

Recupero PR: Clinical practice guidelines as learned treatises: understanding their use as evidence in the courtroom. J Am Acad Psychiatry Law 36:290–301, 2008

Schrader v Kohout, 522 S.E.2d 19 Ga. (App. 1999)

Seisinger v Siebel, 219 Ariz. 163, 195 P.3d 200 (App. 2008)

Shuman DW: Persistent reexperiences in psychiatry and law: current and future trends in posttraumatic stress disorder litigation, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment. Edited by Simon RI. Washington, DC, American Psychiatric Press, 1995, pp 1–11

St Germain v Pfeifer, 418 Mass 511–522 (1994)

Tarasoff v Regents of the University of California, 13 Cal.3d 177, 118 Cal. Rptr. 129, 529 P.2d 553 (1974), reargued, 17 Cal.3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976)

Williamson v Liptzin, 539 S.E.2d 313 (N.C. App. 2000)

Zonana H: When is a practice guideline only a guideline? J Am Acad Psychiatry Law 36:302–305, 2008

Suggested Readings

Binder RL: Liability for the psychiatric expert witness. Am J Psychiatry 159:1819–1825, 2002

Knoll J, Gerbasi J: Psychiatric malpractice case analysis: striving for objectivity. J Am Acad Psychiatry Law 34:215–223, 2006

Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals, 3rd Edition. New York, Guilford, 2007

Scott CL, Resnick PJ: Patient suicide and litigation, in The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Edited by Simon RI, Hales RE. Washington, DC, American Psychiatric Publishing, 2006, pp 235–251

Simon RI, Shuman DW: Clinical Manual of Psychiatry and Law. Washington, DC, American Psychiatric Publishing, 2007

Chapter 9

Competencies in Civil Law

Alan A. Abrams, M.D., J.D.

Mental competency for a specific activity is perhaps the most common reason for a consultation and expert opinion in forensic psychiatry. The requirements for specific competencies are not monolithic or equivalent, but many share the concept that to fully participate in socially sanctioned decision making, an individual must have some understanding and appreciation of the nature and consequences of the task at hand, and be able to use that information in a process akin to reasoning. All societies face the questions of when and upon whom full, legally enforceable rights and responsibilities of membership should be bestowed. Conversely, there is the question of when full rights and responsibilities should be removed or restricted. In our society, there has been a steady movement away from the mere status of a person determining his or her rights, and toward according or withdrawing rights based on the construct of mental capacity. In the past, status factors used in determining rights or competencies included age, race, religion, gender, marital status, property ownership, legitimacy of birth, and country of birth. Some status-based restrictions remain, particularly for minors. Even a sophisticated 17-year-old cannot write a valid will in many jurisdictions. Status limitations on rights can be modified by mental characteristics for certain competencies, such as whether a person is a "mature minor."

The construct of mental capacity is an amalgam of multiple dimensions based on often competing value systems, particularly respect for individual

autonomy and protection of those not fully capable of reasoned decision making. Similarly, the construct of mental capacity reflects a spectrum of cognitive abilities such as accurate perception of sensory impressions, memory, comprehension, use of language and various executive functions, contact with reality, and affect regulation. Short of severe dementia, retardation, or catatonic stupor, most people referred for competency evaluations have some abilities to understand and appreciate the world around them, to reach decisions, express preferences, and communicate with others. Determining threshold levels of abilities and the extent to which they must be demonstrated in adjudicating competency allow experts to reach differing opinions.

In the civil law, an individual must have the minimum required level of capacity in order to marry, divorce, be a parent, consent to sex, consent to medical treatment, refuse medical treatment, create a binding contract, make a will, make a gift, vote, testify in court, or serve on a jury, among other acts. The requirement for a mental capacity threshold for enforceable rights is founded on concern about protecting the integrity of important social processes from impaired participants, as well as concern about protecting the impaired from neglect or exploitation. Much of the Anglo-American historical legal tradition for protecting the disabled or incompetent is based on the doctrine of *parens patriae,* which viewed the king as the "parent of the country." In England, the Court of Chancery had jurisdiction for "all infants, idiots, and lunatics" (Blackstone 1979). The historical connection with Courts of Equity or Chancery is important because the equitable fairness of the outcome appears to still play a role in many individual case decisions involving competency issues, although it is rarely articulated as such. In the United States, the doctrine of *parens patriae* was accepted early on, and the Supreme Court gave it voice in a case in 1890: "This prerogative of *parens patriae* is inherent in the supreme power of every State.…It is a most beneficent function, and often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves" (*The Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States* 1890; see Custer 1978). In contrast to *parens patriae,* interventions focused on the welfare and best interest of the individual are the police powers of the state, which are based on the state's responsibility to protect the general populace from the harmful conduct of the individual.

The fact that there are so many subspecies of competencies implies that context is also a significant variable in determining task-specific competencies. Cases, law reviews, statutes, and even "objective" tests regarding competency reflect differing values placed on autonomy, privacy, beneficence, paternalism, economic efficiency, tolerance of differences, and protection from harm. Legal opinions often reflect compromises among valuing personal autonomy, valuing life, promoting social welfare, respecting family processes

and decisions, maintaining the integrity of the medical profession, and limiting or expanding the role of the state's *parens patriae* obligations to care for the incompetent and the state's police powers. Many cases involving competency determinations have factors supporting both sides and require a thoughtful balancing of factors, along with an assessment of the risks and benefits for both the individual and the family members.

This balancing-of-factors approach is articulated in the American Bar Association's Model Rules of Professional Conduct. The official Comment 6 to Rule 1.14 advises attorneys, "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" (American Bar Association 2009).

Despite contextual differences, there is much that is similar between a criminal justice competency-to-stand-trial evaluation and a civil competency evaluation. The examiner searches for objective data on present (or relevant time period) functioning to support or reject the presumption that the subject understands specific facts and can use that understanding to make decisions. Unlike criminal justice–related competencies, determinations of civil competency may involve retrospective assessments on a subject that is deceased, particularly when testamentary competency, competency to marry, undue influence, or insane delusion are at issue. The scope of civil competency issues is large and continues to expand. Although intimately related to other civil competencies, both philosophically and historically, the topics of civil commitment and involuntary psychiatric treatment will not be addressed in any detail here (Dawson and Szmukler 2006). In this chapter, I will also not address the very important fields of competency to practice a particular profession, fitness to operate a motor vehicle or airplane, or fitness-for-duty examinations (Anfang et al. 2005). Some clinicians prefer to use the term *capacity* to refer to a clinical finding and *competency* to a legal finding. However, the terms *capacity* and *competency* are used interchangeably in the law, and that practice is followed in this chapter.

Also in contrast with criminal justice competencies, there are fewer constitutional requirements in the area of civil competencies. States have traditionally been allowed to create statutory and common law in probate law, contract law, and family law, without significant federal regulation or constitutional minimums. This custom is changing to some degree with the promulgation of federal legislation such as the Adoption and Safe Families Act of 1997 (Public Law 105-89) and the Adoption Assistance and Child Wel-

fare Act of 1980 (Public Law 96-272). Among civil competency issues, those related to end-of-life issues and mental health care have been more often discussed in federal appellate and Supreme Court decisions. The lack of standards as widespread as the *Dusky* (*Dusky v. United States* 1960) criteria for criminal competencies makes it essential that the expert know the specific statutes and common law in the jurisdiction governing the consultation. Many state and federal appellate decisions have focused on technical legal questions rather than fundamental rights or concepts. Civil competencies can involve constitutional due process concerns. Landmark cases related to civil competencies have, for example, considered the burden of proof for a finding of incompetency that leads to the abridgment of a fundamental right, such as in the cases of *Santosky* or *Addington* (*Santosky v. Kramer* 1982; *Addington v. Texas* 1979); the burden of proof that a state may impose on a surrogate decision-maker, as in *Cruzan* (*Cruzan v. Director, Missouri Department of Health* 1990); or the circumstances under which a Section 1983 civil rights action can be dismissed, as in *Zinermon* (*Zinermon v. Burch* 1990). At present, there is an increasing movement toward adopting more uniform state laws.

The Civil Competency Evaluation

The consultant or examiner is typically asked to assess the subject's cognitive, emotional, and psychiatric state in order to delineate in detail what factors exist that might impose limitations on the subject's ability to participate in the process at issue, how those factors functionally affect the individual's participation in the process, and whether the limitations are so severe that the integrity of the process is compromised. As an overall approach to a request for a consultation or expert opinion regarding competency, the forensic psychiatrist will want to clarify exactly what the subject's current situation is, what behaviors are of concern, and what exactly the requesting physician, family member, or attorney wants assessed. The expert must clarify the relationship of the requesting party to the subject and whether the requesting party has the right to obtain medical or financial records if those are needed. The ability to obtain informed consent or proxy consent to allow the consultant to perform an evaluation also needs to be clarified.

The focus of the assessment may be contemporary or retrospective (Simon 2002). When it is retrospective, the relevant time periods may be multiple if, for example, there are various wills and codicils, some of which may not be valid. Discussion with the referring source may indicate that the ca-

pacity assessment is not the only or the preferred approach. This is particularly the case in a contemporary evaluation, when there is family conflict that is driving the request for the evaluation. If a competency evaluation is indicated and possible, the evaluator will want full details about the immediate situation, such as whether there is already ongoing litigation, who the affected stakeholders are, and what other background history from the requesting party is available. The forensic evaluator will then need to clarify what the statutory legal standards are for the questions posed in that particular jurisdiction. Often the legal definitions are quite general, but they provide the starting point for analysis. Case law may provide some additional details.

Once the purpose of the examination or consultation is clarified and the legal criteria understood, the expert will need to develop a plan for the collection of relevant data. The most relevant data provide details of the subject's actual functioning in various contexts. Important information is often provided in interviews with people who have had contact with the subject. Other more circumstantial data, such as imaging studies, hospital records, physician notes, nursing notes, or financial records, will require the expert to make inferences about functioning and functional capacities. At a minimum for a retrospective assessment, collection of data must include all medical records from all providers spanning the time period at issue, along with interviews with family and friends who had the opportunity to observe and interact with the subject, records from social service agencies, financial records of bills paid or neglected, and letters or other writings created by the subject. Medical records that account for a longer time span may be helpful if central nervous system injury or chronic disease predated the relevant time period. Data from after the period in question may allow some inferences to be made that are based on assumptions about disease progression. For a contemporary evaluation, the clinical examination of the subject and psychological or neuropsychological testing allow more complete data collection. Examinations and testing may provide better information if done on multiple visits, given that mental states can be dynamically influenced by time of day, emotional state, medication administration, and a host of other factors. If the subject lives independently or in assisted living, a home visit can be revealing.

The examination of the subject should address the person's understanding of the purpose of the examination and whether he or she could give informed consent. The evaluator should also compile a biographical report that contains accounts of the important relationships in the subject's life, his or her history of any mental illness, general cognitive abilities—including clinical cognitive testing results—and awareness of his or her limitations, current mental health status, and specific abilities and compensatory strategies in the areas touching on the question to be addressed. If present, an assessment of the degree of denial or agnosia regarding limitations is essential.

The subject's understanding of his or her finances, assets and debts, medical conditions, life plans, values, treatment, and communications from physicians may all need to be detailed, depending on the purpose of the evaluation. Specific recent history of functioning that includes the activities of daily living and instrumental living such as personal hygiene, preparation of meals, feeding, shopping, personal safety, management of money, problem solving, treatment adherence, and following medical instructions must be obtained from both the subject and collaterals. Discrepancies in the accounts should be explored.

Many forensic psychiatrists are very strict about not mixing a therapeutic approach with an assessment approach. However, in a contemporary competency evaluation, it is reasonable for the expert, faced with a subject who may not have considered the issue in full detail or who is reacting emotionally, to ask about the emotional reason that (for example) the person is disinheriting a family member and leaving the estate to a pet, or is stopping medical treatment, and to suggest discussing that with a counselor. As regularly stated in the legal cases, competency for a particular task does not require that the outcome be wise, thoughtful, or rational. Nonetheless, it is not unethical for the expert, if he or she is comfortable doing so, to explore in detail with the subject the emotional factors affecting the subject's decision. If a will is later challenged, the expert evaluator will have a basis for distinguishing a decision driven by emotion from one based on delusion or cognitive impairment. It will often be very relevant to discuss with the subject his or her fears or denial of dying, concerns with abandonment, and the subject's spirituality and attempts to make sense of life. Other relevant topics can include the subject's disappointments with his or her life, the lives of his or her spouses and children, his or her finances, and the circumstances of other family members in similar situations (e.g., what effect the subject's mother's and father's deaths had on him or her).

Once the medical records are collected, a full medical review is necessary, listing all the diagnosed conditions, the basis for those diagnoses, and how those conditions might affect cognitive functioning. Prognosis for improvement or deterioration, if known, should be considered. The medical review should also include the medications prescribed at the time at issue, with consideration of their side effects. The role of medication or substance-induced cognitive impairment should be investigated. A psychiatric review might reveal areas of delusions, false beliefs, and overvalued emotional concerns. Laboratory tests should be reviewed, along with brain imaging results, to assess whether the impairments are transient or correctable. Additional clarifying laboratory tests, neuropsychological tests (particularly tests of executive functioning), standardized mental status examinations, and electroencephalogram or imaging approaches can be discussed with the requesting

source. A number of specific tests have been devised for many areas of competency evaluation, and these can be very useful in helping the expert structure an approach to the subject (Grisso 2003). The evaluator should consider if the subject has a temporary condition that will improve with treatment, if there is a relatively stable or static impairment, or if the disabilities are progressively worsening. Mental illnesses and cognitive impairments are dynamic, and the evaluator should attempt to articulate factors that may have led to improved or impaired dynamic performance.

The legal standards in civil competency cases are often both terse and vague (e.g., "able to know the natural consequences of sexual intercourse"), and the expert will have to give some operational meaning to the standard (e.g., are the natural consequences of sexual intercourse only pregnancy or the possibility of sexually transmitted disease, or do they include the emotional consequences of sexual intimacy?). Similarly, the expert must offer personal understanding of whether the competency requirement is set to screen out few (minimal threshold, low bar, weak standard) or many (high bar, strict standard), how many type I or type II errors will be created by that standard setting, and what the social cost of false positives or false negatives is (*Mathews v. Eldridge* 1976). The expert should attempt to explain in the note or report what functional factors and objective factors were considered in his or her opinion.

The California Probate Code (Cal Probate Code § 811 2009; emphasis added) gives a thoughtful summary of the sort of evidence the court expects in an evidentiary hearing for determinations of capacity and the common core standard for competency:

> (a) A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to contract, to make a conveyance, to marry, to make medical decisions, to execute wills, or to execute trusts, shall be supported by **evidence of a deficit** in at least one of the following mental functions, subject to subdivision (b), and **evidence of a correlation between the deficit or deficits and the decision or acts in question**....
>
> (b) A deficit in the mental functions listed above may be considered only if the deficit, by itself or in combination with one or more other mental function deficits, significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question.
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> (d) The mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act.

Specific areas of civil competency will be discussed briefly in the following sections. As illustrated in the probate code section excerpt, the various laws regarding civil competency center on the general question of the person's "ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question."

Case Vignette

Ms. S is a 95-year-old widow living alone at home; she is able to shop and cook. Ms. S has regular telephone contact with her children in different cities. She is in reasonably good health, taking only medications for hypertension. Mr. A is a 30-year-old handyman soliciting business door to door. Mr. A is hired by Ms. S to make repairs on her home. Ms. S enjoys having someone around the house to talk to, finds more and more projects for Mr. A, and eventually offers him a room in which to live in exchange for repairs. After Mr. A moves in, Ms. S has fewer contacts with her children, who detect a change in their mother's attitude. Her son visits from out of town, and Ms. S is distant and appears "not herself." Ms. S tells her son that she has married Mr. A, has executed a durable power of attorney for health care naming Mr. A as her decision-maker, and has changed her will, leaving nearly all to Mr. A. Her son believes that Mr. A is taking advantage of his mother, that his mother is not able to think clearly, and that something isn't right. The son hires an attorney to see what can be done, and the attorney contacts you to perform an evaluation.

Competency to Bring Litigation

There are very few restrictions or competency issues related to the ability to file a lawsuit. Minors, persons with mental illness, or persons on guardianship are able to bring nearly all forms of civil legal actions. Courts may allow a next friend or guardian to initiate the suit, or they may appoint a guardian *ad litem* to assist in the litigation, but the ability or competency to bring a lawsuit is rarely restricted based on mental state. The one exception is that a number of jurisdictions require that a married person must be mentally competent to file an action for dissolution of marriage. This exception is based on the societal interest in promoting and preserving marriage. An Ohio case presents the reasoning behind this restriction: "a valid petition for divorce cannot be filed for an insane or incompetent plaintiff by a next friend or guardianship, for in such instance the will and decision exercised would be that of the next friend or guardian and not that of the real party in interest" (*Shenk v. Shenk* 1954). Some jurisdictions are eliminating this restriction (*Broach v. Broach* 2008).

Competency can be an issue in tolling the statute of limitations; this is referred to as "equitable tolling." The mentally or physically ill may not be subject to the statute of limitations during the periods when they are hospitalized, incompetent, or otherwise unable to pursue their legal action despite due diligence (*Commonwealth v. Stacey* 2005; *Nara v. Frank* 2001). In most jurisdictions, minors may only be subject to the statute of limitations for bringing a tort action after they achieve majority.

A concept closely analogous to mental competence to file a lawsuit is the statutory bar in some jurisdictions against "vexatious litigants." Texas, California, Canada, England, and Australia have such statutory limits on repeated filing of lawsuits without merit. Many of those labeled as querulous litigants are driven by economic motives or are pursuing a social agenda, but some are clearly mentally ill. The diagnoses associated with vexatious litigants are varied (Mullen and Lester 2006).

Competency to Stand Civil Trial

As with competency to bring a civil lawsuit (i.e., to be a civil plaintiff), there are few mental capacity requirements for civil defendants. In recent years, given the issues of preventive civil commitment for sexual offenders in many states, there have been questions raised about whether such civil respondents should have a right to be competent at their hearing (Abrams et al. 2007). In the areas of capital punishment habeas appeals (a collateral civil proceeding), a right to be competent has been found by the Ninth Circuit Court of Appeals (Rohan 2003).

Civil commitment respondents in a typical involuntary psychiatric hospitalization case involving dangerousness or grave disability do not have a right to be competent at their commitment hearing, and many will not be. Committing severely ill and incompetent psychiatric patients can be justified by the relatively brief nature of the commitment, and it reflects in part a beneficial *parens patriae* function to assist the detained individual in regaining his or her mental health. Sexually violent predator proceedings are meaningfully different, because they primarily involve the state's police power and persons who are generally not psychotic. Most state courts that have addressed the question of whether there is a due process requirement for competency to stand trial for sexually violent predator proceedings primarily have considered the simple civil versus criminal dichotomy (*In re Detention of Cubbage* 2003; *In re Fisher* 2005; *State ex rel. Nixon v. Kinder* 2003). In finding a right to be competent for a sexually violent predator commitment proceeding, one state court ruled that this right only exists if hear-

say evidence is introduced by the state (*Branch v. State* 2004). In a recent appellate case in California, applying a civil due process analysis, the court ruled that a sexually violent predator respondent did have the right to be mentally competent before his or her case could be adjudicated (*Moore [Ardell] v. Sup. Ct.* 2009). The court implied that the standard for competency would be the same as in a criminal case. Case law does not support the right to be competent at a deportation hearing (*Jaadan v. Gonzales* 2006; *Nee Hao Wong v. I.N.S.* 1977). There is, however, in most jurisdictions a right to be competent for an extradition hearing (*State ex rel. Jones v. Warmuth* 1980). Future cases may consider whether a respondent has a right to be competent in other civil matters such as insanity commitment extensions or dangerous criminal commitments.

In a Ninth Circuit case, the court, in the context of a capital habeas appeal, made an extensive analysis of state, federal, and U.S. Supreme Court cases supporting the argument that a statutory right to counsel implies a right to be competent. The court held that a district court must stay habeas proceedings when a petitioner cannot assist counsel because he or she is incapable of rational communication. The case did not specify what the criteria for habeas competence should be but indicated it could be less than the *Dusky* standard (*Rohan, ex rel. Oscar Gates v. Woodford* 2003).

Competency to Testify

Children, atheists, convicted criminals, codefendants, and the insane were historically excluded in the common law from testifying at trials. During the eighteenth and nineteenth centuries, the status of the proposed witness was dropped as the central determination, and the ability of the witness to enhance the reliability of the outcome took the place of mere status. In 1895, the U.S. Supreme Court wrote, in a case involving a 5-year-old boy who witnessed the murder of his father: "That the boy was not by reason of his youth, as a matter of law, absolutely disqualified as a witness, is clear. While no one would think of calling as a witness an infant only two or three years old, there is no precise age which determines the question of competency" (*Wheeler v. United States* 1895). The Court articulated that the standard for competency to testify would be determined by "the capacity and intelligence of the child, his appreciation of the difference between truth and falsehood, as well as of his duty to tell the former." This standard was expanded into the current standard:

> The disposition of courts and of legislative bodies to remove disabilities from witnesses has continued, as that decision shows it had been going forward

> before, under dominance of the conviction of our time that the truth is more likely to be arrived at by hearing the testimony of all persons of competent understanding who may seem to have knowledge of the facts involved in a case, leaving the credit and weight of such testimony to be determined by the jury or by the court, rather than by rejecting witnesses as incompetent. (*Rosen v. United States* 1918)

In 1975, Congress enacted the Federal Rules of Evidence, in which it is declared: "every person is competent to be a witness" (Fed. R. Evid. 601). The advisory committee noted, "No mental or moral qualifications for testifying as a witness are specified. Standards of mental capacity have proved elusive in actual application." Rule 602 requires a witness to have personal knowledge of the matter he or she testifies about, and Rule 603 requires that the witness take an oath or affirmation to tell the truth. Many states have adopted the Federal Rules directly, whereas others have modified the language somewhat. In California, the rule of evidence regarding witness competency is as follows: "except as otherwise provided by statute, every person, irrespective of age, is qualified to be a witness and no person is disqualified to testify to any matter" (Cal. Evid. Code § 700, 2009). However, a person in California "is disqualified to be a witness if he or she is 1) incapable of expressing himself or herself concerning the matters so as to be understood, either directly or through interpretation by one who can understand him; or 2) incapable of understanding the duty of a witness to tell the truth" (Cal. Evid. Code § 701, 2009) (Morris 2002).

The majority of modern competency-to-testify litigation has been centered on the ability of children to testify in cases in which they have been sexually abused. Some states have specifically waived the ability to disqualify child witnesses when they are the victims (Ga. Code Ann. 24–9–5 2008). The modern approach is to allow testimony and have the jury decide the weight and credibility to place on the witness's statements (*State v. Ward* 1995).

As the barriers against children testifying have fallen, children have come into the courtroom in ever greater numbers. A sizable body of research has evolved in the past 30 years, in which factors have been studied relating to the accuracy, reliability, and credibility of witnesses, and child witnesses in particular (Ceci et al. 2007). The very low standard for witness competency—that is, being able to distinguish the truth from a lie—allows for testimony that may be distorted. Forensic mental health experts can be involved in providing testimony about the factors affecting the accuracy of eyewitness testimony for both children and adults (Ceci and Friedman 2000; Loftus and Pickrell 1995).

There is still no reliable method of distinguishing distorted or suggested memories from accurate recall by content analysis. The forensic expert is on more secure footing educating the trier of fact about where possible bias

might have occurred as a result of both intentional and unintentional distortions, or, alternately, that bias was not likely.

Psychiatrists may be asked to examine a witness regarding his or her mental availability. If a declarant is psychologically "unavailable," his or her out-of-court statements may be admissible under a hearsay exception. Federal Rule of Evidence 804 provides that a declarant is unavailable if he or she is "unable to be present or to testify at the hearing because of death or then existing physical or mental illness or infirmity." Unavailability due to psychiatric illness is not the same as incompetence to testify. Reasons for unavailability might include a witness who was a victim of crime and would be further psychologically damaged by having to testify (*People v. Winslow* 2004).

Competency to Marry, Have Sexual Relations, and Divorce

Marriage is viewed as a fundamental right, and laws restricting the right to marry are subject to strict scrutiny by appellate courts. "[T]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men" (*Loving v. Virginia* 1967; *Turner v. Safely* 1987).

The Supreme Court, however, has also stated that reasonable limitations may be imposed by jurisdictions (*Zablocki v. Redhail* 1978). All jurisdictions have restrictions based on age and competency. A person is presumed to have capacity to marry. Because it is viewed as a fundamental right, it is believed that the mental capacity to consent to marriage is very low (*Edmunds v. Edwards* 1980). A person thus may have sufficient mental capacity to consent to a valid marriage but may not have sufficient mental capacity to create a will, to enter into a business contract, or to consent to sexual relations. Questions of competency to marry most often arise when there is a deathbed marriage between an institutionalized patient and a caretaker, a marriage between the mentally retarded, or when the difference in age between the marital parties is substantial. The focus of the competency inquiry is at the moment of the celebration of the marriage. A lucid moment at that time will negate an argument of incompetency. Tests for lack of competency to marry in most jurisdictions contain phrases such as "unable to appreciate the solemnity of the marriage vows," "lacking the capacity to understand the nature of the marital contract," "lacking the capacity to understand the obligations and responsibilities of marriage," or "suffering from a mental defect that pre-

vented the party from comprehending the nature of the marriage contract and from giving intelligent consent to it." Such cases are typically brought after the marriage ceremony and often after one party is deceased. Although the relevant period of capacity inquiry is on the day of the marriage, a history of "mental unsoundness" before and after is relevant. As in other capacity questions, the "unsoundness" must directly bear on the ability to understand the nature of the marriage proceeding and to provide valid consent. In most states, suits for annulment of a marriage on the grounds of incompetency must be brought during the lifetime of the spouses. There is also an issue of "temporary incompetency" to marry, which occurs when one or both of the parties are intoxicated (*Dobson v. Dobson* 1948).

Sexual activity involving minors, the elderly, and the developmentally and intellectually disabled is frequently viewed with concern, distortion, and denial in our culture (*Buck v. Bell* 1927). Because these groups are subject to abuse, including sexual mistreatment, laws exist to protect impaired persons from sexual exploitation. Sexual activity with a member of these groups can be criminal, even when it is accompanied by actual consent, if a person lacks either legal or mental capacity to consent (i.e., lacks the right or the ability to give legal consent). The meaning of the concept of *capable* of giving consent for sexual relations is still sharply debated in ethics, law, psychology, and psychiatry. States vary from extremely low criteria, which allow most adults to be found competent (e.g., mere knowledge of the sexual act), to very high criteria, which exclude many (e.g., making a choice based on the person's best interest). One California case defined a high standard as follows: "Legal capacity [for intercourse] is the ability to exercise reasonable judgment, i.e., to understand and weigh not only the physical nature of the act, but also its moral character and probable consequences" (*People v. Giardino* 2000). Clinicians will often need to address the concerns and values of the family, who may view sexual activity from a more paternalistic vantage point.

Insanity can be grounds for a divorce in fault-based states, but most jurisdictions also have a competency requirement for filing a divorce proceeding.

Competency to Parent

Parents have wide latitude in their approach to child rearing, short of actual abuse. However, the modern trend is to recognize the rights of children in addition to those of the parents. When a parent's neglect, abandonment, or mistreatment comes to light, most jurisdictions have detailed statutory procedures for protecting the child and correcting the parental mistreatment.

Initially, the goal of the proceeding is to promote family unification, but with the passage of time, the goal becomes to promote the best interest of the child, usually by severing parental rights to allow for the child's adoption (Adoption and Safe Families Act of 1997). When the initial interventions fail, an interested party or the jurisdiction can petition the court for a finding that the parents or parent is incompetent to parent the child. The party can then ask the court for a finding of unfitness and a severing of the parent-child relationship. Termination is viewed as an extreme measure when no less drastic measures are available. The constitutionally required standard of proof in proceeding for the termination of parental rights is clear and convincing evidence (*Santosky v. Kramer* 1982). Although many reasons for termination of parental rights, such as abandonment, neglect, abuse, or failure to support, are not directly related to mental capacity, parental rights can be terminated due to unfitness because of substance abuse or mental disability. A parent who is developmentally disabled or mentally ill and is not capable of supporting or controlling a child in a proper manner can have his or her parental rights terminated (Cal. Fam. Code. § 7826, 2009; *In re Anthony P.* 2000). Most jurisdictions require that the parent's incapability to care for the minor must be causally related to his or her mental illness. The combination of future detriment, present circumstances, past acts, and the best interests of the child is considered by the court in deciding parental unfitness. Clinicians involved with parental fitness evaluations will, if possible, want to observe the subject's interactions with the children along with the review of interventions and removals.

Parental "fitness" and mental health are often at issue in child custody proceedings in divorce cases with contested custody arrangements, but this is distinct from incapacity to parent. In custody disputes, the issue is which arrangement of caretaking is best for the child or children and is rarely whether one parent is lacking capacity to parent.

Generally, parents are also the decision-makers for the medical treatment of a minor child, who is presumed incompetent to make medical decisions, unless the child is emancipated or otherwise in the role of an adult. A "mature minor" can act without parental consent in certain circumstances (*Bellotti v. Baird* 1979). States vary widely in their specific statutes on when minors are able to consent to mental health treatment, substance abuse treatment, medical treatment, or reproductive medical treatment without parental consent or notification. Clinicians in nonemergency situations should obtain legal advice before treating a minor without parental notification and consent, unless they are very familiar with their jurisdiction's statutes (Holder 1985). Parents can also decide to withhold consent, even for lifesaving treatment. The decision should reflect the child's best interests. Such a decision can be challenged in court if it is alleged to constitute child neglect. Federal law was

passed following the 1982 "Baby Doe" case, in which the parents withheld consent to treat their severely disabled newborn. Medical care for newborns can now only be withheld in narrow circumstances, despite the contrary wishes of the parents.

Competency to Make a Gift or Create a Bequest

Property can be transferred from one owner to another through gift, sale, trust, or bequest. Competency to sell property is covered under competency to enter a contract. When disputes over gifts, trusts, or wills arise, courts are primarily concerned with effecting the intent of the original owner, donor, settlor, or testator. The U.S. Supreme Court has left regulation of gifts and bequests, aside from federal taxation, entirely up to the states (*Irving Trust v. Day* 1942).

When potential heirs or beneficiaries feel that the bequest was not what they believe the settlor or testator intended, they have two principal legal means to set aside or alter the terms of the bequest in a probate proceeding. They can mount a challenge based on fraud, duress, and/or undue influence or a challenge based on the testator lacking the required mental state for the will to be probated. Testamentary capacity is specific to the creation of the will. Challenges based on lack of mental capacity can also be brought when a will has been revoked. Related to a challenge based on testamentary incapacity is a challenge that the decedent's marriage was voided because the decedent lacked the capacity to consent to marriage (but only in those states that allow a challenge to the validity of a marriage after the death of one of the spouses).

As in most forensic psychiatry matters, the legal tests for testamentary capacity often require an inference of a subjective state, though the tests are phrased in objective terms. All jurisdictions require that the testator be "of sound mind" for a valid will. There is a presumption that all testators are of sound mind. Generally, statutes go on to define "sound mind" as the testator's ability to know the nature and extent of his or her property, the natural objects of his or her bounty, the nature of the testamentary act, and that he or she can coordinate that information into the testamentary plan. Most testamentary competency statutes consider the testator's ability to know the extent of the estate, not whether every item can be recalled. A long line of courts have attempted to distinguish eccentricity from incompetence. A California case that reviewed the general principles developed in common law offered the following statement:

> It has been held over and over in this state that old age, feebleness, forgetfulness, filthy personal habits, personal eccentricities, failure to recognize old friends or relatives, physical disability, absent-mindedness and mental confusion do not furnish grounds for holding that a testator lacked testamentary capacity. Nor does the mere fact that the testator is under a guardianship support a finding of lack of testamentary capacity without evidence that the incompetence continues at the time of the will's execution. It must be remembered, in this connection, that "[when] one has a mental disorder in which there are lucid periods, it is presumed that his will has been made during a time of lucidity." (*In re Estate of Mann* 1986)

Related to cases that focus on lack of sound mind are those in which the testator was cognitively intact and thus had testamentary capacity but suffered from a mental illness that so distorted the process of creating a will that the court in equity will rewrite the will to approximate what it believes the testator would have intended, absent the "insane delusion." Courts tend to require an absence of any rational basis for the belief before they will conclude the will was based on a delusion. As one court explained, "The meaning of insane delusion, in its legal sense, is a belief in things impossible, or a belief in things possible but so improbable under the surrounding circumstances that no man of sound mind would give them credence. It is a belief which has no basis in fact or reason" (*In re Estate of Raney* 1990). Most jurisdictions require a causal "but for" link between the delusional belief and the terms of the will (*In re Estate of Scott* 1900). The burden of proof of rebutting the presumption of sound mind is on the contestants to the will. Most jurisdictions set that burden as a preponderance of the evidence.

The doctrine of "lucid interval" applies when the testator's mental state is in flux, through substance abuse, mental illness, or the early and middle stages of dementia. The burden is on the contestant to demonstrate that the will was not created at a time when symptoms were minimal. Demonstrating lack of capacity at other times, when symptoms are most severe, is not sufficient to create the presumption that the symptoms were so severe when the will was created.

Even if a testator has capacity, he or she may be vulnerable to the "undue influence" of a beneficiary. Forensic psychiatrists may be asked to assess the degree of the testator's psychological vulnerability to undue influence. Undue influence can be defined as pressure that was brought to bear directly on the testamentary act and used directly to procure the will. The pressure must amount to physical or mental coercion destroying or overcoming the free will of the testator and substituting the intent of the influencer. The following factors are considered by courts to increase the risk of undue influence:

1. The testator was particularly vulnerable because of dependencies or mental or physical disabilities.
2. The influencer increased the testator's level of perceived helplessness.

3. The influencer kept others away from the testator.
4. The influencer brought the testator to an attorney of the influencer's choosing and was present during the drawing up of the will.
5. The influencer isolated the testator from news of friends and family.
6. The influencer actively misled the testator about other potential beneficiaries.
7. The undue influence caused an unnatural disposition of the property.

There is a rebuttable presumption of undue influence when a confidential relationship exists between the decedent and the beneficiary and the beneficiary both actively participated in procuring the execution of the will and unduly profited by it. This presumption places on the beneficiary the burden to show that the will was freely made. Determining if a confidential relationship exists can be variable, but generally, attorney-client or doctor-patient relationships are considered confidential. Challenges in probate related to undue influence are fraud and duress.

Forensic psychiatrists retained to assess the mental state of the testator or settlor on the day of the signing of the will or trust have a task more akin to that of the clinician performing a "psychological autopsy" than performing a competency-to-stand-trial evaluation. Broadly, the expert is trying to determine what the testator's intent was and whether there were psychiatric or medical conditions that distorted the expression of the intent. These are very fact-intensive cases. The expert will need to clarify with the retaining attorney all of the terms of the bequest being probated, the beneficiaries and the objectors, their relationships with the testator and each other, the bases of the objection to probating the will, the names of the witnesses and the attorney who drafted the will, the terms of prior wills and codicils, and all other information that the attorney might have. The forensic psychiatrist will need to have the retaining attorney obtain all medical records. The executor can sign a release for the testator, or the probate judge can issue a subpoena for the decedent's confidential medical and psychiatric records. The focus of the competency and/or duress assessment is the day on which the instrument was signed. Observations of good cognitive and emotional functioning after the date of creation are more relevant than later observations of impairment, but the expert must relate the evidence to the time of the will's creation.

A thorough evaluation often requires interviewing the physicians who cared for the testator regarding their observations beyond what is in the chart notes; nursing staff, if the decedent was in a care facility at the time of the creation; friends; business associates; family members; witnesses to the will; and all others with relevant information. Information about the testator's ability to perform both the basic activities of daily living, such as feeding, cleaning, and maintaining personal hygiene, and the more complex activities, such as managing money,

taking medication as directed, or driving, is essential. Collaterals may also be able to comment on the testator's ability to make a variety of decisions at the time the will was created. If a marriage was performed just prior to the signing of the will, wedding guests can be interviewed, if possible. If "insane delusion" is alleged, the expert needs to show either that the testator's beliefs about beneficiaries were not based on any rational facts or that the testator's bias against a potential beneficiary had some basis in fact. If duress or undue influence is alleged, the expert must investigate if conditions surrounding the testator significantly isolated the testator or limited his or her ability to communicate with others, or if there were threats of some sort to undermine the testator's intentions.

The expert will want to determine if there was a psychiatric, neurological, or medical diagnosis on the day of the creation and, more importantly, to establish if there were mental impairments or vulnerabilities at that time. It is relatively easy to establish from the medical records, for example, that the decedent had a stroke with expressive aphasia, but connecting the medical or psychiatric condition to the testator's abilities and limitations on the day of the creation of the instrument is more complex. The expert will need to relate the diagnoses and objective abilities with the jurisdiction's statutes and common law on testamentary capacity, insane delusion, fraud, and undue influence. Conclusory statements, such as that the testator suffered dementia and therefore lacked capacity, are rarely useful. Although lack of capacity invalidates the entire will, the expert should also consider whether the testator's limitations affected all the terms of the will or only certain terms. Most will contests settle prior to trial, and the expert's report is often central to the terms of the settlement. Issues of competency can also exist when a beneficiary refuses a bequest because of delusion or cognitive impairment.

Attorneys increasingly may retain a forensic psychiatrist to perform a capacity examination while the testator is still alive. The exam should not only touch on the questions of knowledge of the estate, knowledge of the expectable beneficiaries, the intent of the testator, the terms of the will, and the testator's general cognitive ability but should also explore the possibility of undue influence and possible misperceptions due to mental illness. The examiner should consider inquiring why there is concern about a possible challenge to the testator's competency or the terms of the will. The exam should be video recorded, if the examinee consents.

Competency to Enter Into a Contract

As a central element for the creation of a contract, contract law holds that there must be an agreement or a "meeting of the minds" among the parties to the

contract, along with consideration for the contract. Most states have statutory definitions of when a minor achieves the status to enter into a binding contract. All states have mental capacity requirements for a binding and enforceable contract. In a case involving a land transfer early in San Francisco's history, the U.S. Supreme Court articulated the common law tradition as follows:

> Looking at the subject in the light of reason, it is difficult to perceive how one incapable of understanding and of acting in the ordinary affairs of life can make an instrument the efficacy of which consists in the fact that it expresses his intention, or, more properly, his mental conclusions. The fundamental idea of a contract is that it requires the assent of two minds. But a lunatic or a person non compos mentis has nothing which the law recognizes as a mind, and it would seem therefore, upon principle, that he cannot make a contract which may have any efficacy as such." (*Dexter v. Hall* 1872)

The general test of contractual capacity is to determine whether the subject has the ability at the time of signing the contract to understand the nature of the transaction, its scope and effect, and its nature and consequences. In some jurisdictions, if a person is under guardianship as a result of the inability to care for himself or herself, he or she may be forbidden from entering into contracts, and any that are signed are void. In other jurisdictions and other circumstances, when a person was not already adjudicated by the court but was equally incompetent to enter into the binding contract, the contract may be voidable. Contracts entered into by minors and intoxicated persons are also voidable. Persons with bipolar disorder are often extravagant in contracting to do things consistent with their grandiose delusions. When they recover, actions to void the contracts may result. These can be difficult cases because the person's manic actions are based on grandiose optimism and, later, desperation rather than a misunderstanding of the transaction. Some courts consider as a factor in their decision whether the other party knew that the person had a mental disorder.

The issue of competency to marry is related to the issue of whether prenuptial agreements were executed by an incompetent spouse. These are viewed as forms of contracts, and contractual incapacity will allow them to be voided.

Competency to Care for Oneself and Guardianship Proceedings

When an individual can no longer make basic decisions for himself or herself, legal proceedings are available in all jurisdictions to protect the individ-

ual (the ward) and designate a person or agency (the guardian) to make decisions for him or her generally or only in specified domains. Guardians are typically appointed because the ward is a minor, or because the ward has some form of somatic illness or mental disability affecting the proposed ward's cognitive functioning. Specific standards for the threshold of the ward's level of incapacitation vary with jurisdictions, and in some cases the ward can volunteer for the appointment of a guardian. Determination of the process that is due to the proposed ward varies from state to state. The Uniform Guardianship and Protective Proceedings Act of 1997 (section 102[5]) defines an incapacitated person as one who is "unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety or self-care even with appropriate technological assistance." As with other tests of competency or capacity, the test measures functional ability, not whether the person is acting responsibly or even reasonably.

Guardianship must be established through the courts. An "emergency guardian" is appointed by the court without a formal hearing when an emergency exists and a guardian is necessary to prevent injury to the person or estate of the ward. Guardianship proceedings can be voluntary if the proposed ward has capacity to consent and wishes assistance in his or her life or can be involuntary and disputed in the court hearing. Voluntary forms of guardianship do not require proving the proposed ward's incompetence and are not proof of incompetence in other proceedings. The issue at a contested hearing is whether the proposed ward is capable of caring for himself or herself safely, providing for the necessities of life, or managing his or her finances. Appointed guardians can make many routine decisions without obtaining court approval, but a guardian would require court approval for major decisions, including placement in a more restrictive environment. Guardians typically cannot consent to marriage or divorce for the ward. Many states have separate forms of protection and substitute decision making when the mental disability is a result of psychiatric illness that does not affect cognitive functioning.

Terminology for the appointment of a person to oversee the welfare of an incapacitated person varies from jurisdiction to jurisdiction; a *guardian* in one state is the equivalent of a *conservator* or *curator* in another. Some jurisdictions have limited or general conservatorships or guardianships, but most have guardians for the person and guardians for the estate. In some states, the protector of the person is called the *guardian,* and the protector of the estate is the *conservator*. In some states, the term *plenary guardian* refers to a guardian who can make decisions in all areas of the ward's life. Generally, the guardianship-of-the-person process is used for those who are unable to provide properly for their personal needs for physical health, food, clothing, or shelter. Guardian-

ship of the estate is used for persons who are substantially unable to manage their own financial resources or resist fraud or undue influence. A guardian of the estate is typically responsible for directing the management of the ward's assets and finances. A guardian of the person is typically responsible for making decisions on behalf of the ward regarding his or her well-being, such as directing medical care or placement in care facilities. Guardians may not have the power to make life-terminating decisions (*Wendland v. Wendland* 2001). In California, the term *guardian* is used for a minor and *conservator* for an adult ward. Most jurisdictions have provisions for emergency or temporary guardians. Guardianships can last until they are terminated by the court, usually when a ward recovers the ability to function. The standard of proof in contested guardianship proceedings is clear and convincing evidence.

Guardianship was traditionally distinct from involuntary psychiatric commitment or involuntary medication proceedings, but the modern practice is to use guardianship proceedings for patients with dementia, which includes allowing the guardian to authorize the use of psychotropic medications. Some states allow a guardian to consent to administration of psychotropic medications in other situations. An individual with an appointed guardian may retain specific rights; in some jurisdictions, these are granted under limited guardianships. A guardian *ad litem* is appointed by the court during a specific lawsuit to protect the interests of the minor or incapacitated person and report to the court.

For an incapacitated adult, there are alternatives to the guardianship proceeding. There has been a public health campaign for the past two decades, supported by the Patient Self-Determination Act (1990), to make people aware of the need to face debilitation and incapacity in serious illness and at the end of life. Instruments available to plan for future incompetence include *living wills, heath care proxies,* and *durable powers of attorney for healthcare*. While they are competent, adults can execute a general durable power of attorney, a durable power of attorney for property, or a durable power of attorney for health care that "springs" into effect when a certain event occurs, such as failing health or incapacity. A durable power of attorney for health care decisions or medical power of attorney allows the individual to appoint someone to consult with the doctor and make the treatment decision if there is future incapacity. Another device that is used to avoid the need for a guardian of the estate is the *revocable trust* or a *living trust*. A physician's certification of incapacity is generally required; it can be written to take effect at the time it is executed. A *living will* and an *advance directive* differ from the durable power of attorney for health care in that they provide content and instruction regarding future care rather than leaving the future decisions to the substitute decision-maker. The purpose of a living will is to communicate to the attending physician if the person wants life-sustaining

procedures withheld or stopped specific procedures administered or if there is a terminal or irreversible condition caused by illness, disease, or injury. Unlike advance directives, living wills only become effective when death is imminent. Whether physicians can be liable for not following the terms of a living will or advance directive will be very fact- and law-specific (*Wright v. Johns Hopkins Health Care System* 1999).

Competencies Related to Health Care Decisions and Research Participation

Normally, every competent adult individual has the legal right to make his or her own decisions about health care. For many, however, there may come a time when they are too ill to understand or make health care decisions. *Capacity* in the health arena reflects an individual's ability to understand that he or she has an illness; to assess the significant benefits, risks, and alternatives to proposed health care; and to rationally make and communicate a health care decision. This is often referred to as "decisional capacity," to indicate that it is medical decision making that is at issue. Persons lacking these abilities to understand and appreciate the nature of their medical condition or the consequences of their decisions regarding treatment may be found to lack capacity for medical decisions. As in many areas of competency, the precise boundary between competency and incapacity is ambiguous. Numerous studies have demonstrated that subpopulations such as older patients, patients with psychosis, or those placed on involuntary commitments contain many members with significant disabilities in their understanding of proposed treatments (Cairns et al. 2005; Okai et al. 2007; Owen et al. 2008). Additionally, many cognitively impaired patients or those with serious mental illness may have agnosia of their symptoms and thus might not appreciate or agree that treatment is even needed. Whether they are considered incompetent to make medical decisions depends on subjective assessments regarding how the threshold for competency is set. However it is set, there will be a large middle group of patients with some impairment of understanding and appreciation of their illness and proposed treatment. Nearly all of the landmark legal cases involving the question of competency to make medical decisions have involved obviously incompetent persons, whose surrogate decision-makers have petitioned the court for approval to

end life-sustaining treatments when there is no hope of further recovery (In re Quinlan 1976; Cruzan v. Director 1990).

Dr. Grisso and his MacArthur Foundation coworkers have articulated four fundamental abilities that underlie the capacity to make treatment decisions (Appelbaum and Grisso 1988; Grisso 2003; Grisso and Appelbaum 1995a, 1995b, 1995c):

1. Ability to express a choice about treatment
2. Ability to understand information relevant to the treatment decision
3. Ability to appreciate the significance of that treatment information for one's own situation
4. Ability to reason with relevant information in a logical process of weighing treatment options

The MacArthur Competence Assessment Tool for Treatment (MacCAT-T) provides a means of rating a semi-structured interview with the patient about his or her understanding of the proposed treatment (Grisso and Appelbaum 1998; Grisso et al. 1997). It is not "normed" or meant to provide cutoff scores. Other instruments for assessing treatment decisional competency include the Hopkins Competency Assessment Test (HCAT) (Janofsky et al. 1992) and the Capacity to Consent to Treatment Instrument (CCTI) (Bean et al. 1996; Marson et al. 1995). Capacity assessment instruments have a variety of limitations (Dunn et al. 2006).

Some jurisdictions have tried to specify, to the degree possible, what abilities are required for decisional capacity. The California Probate Code (§ 813 2009) provides the following guidelines for the determination of a patient's capacity to give informed consent:

> For purposes of a judicial determination, a person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:
>
> 1. Respond knowingly and intelligently to queries about that medical treatment.
> 2. Participate in that treatment decision by means of a rational thought process.
> 3. Understand all of the following items of minimum basic medical treatment information with respect to that treatment:
> The nature and seriousness of the illness, disorder, or defect that the person has.
> A. The nature of the medical treatment that is being recommended by the person's health care providers.
> B. The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.
> C. The nature, risks, and benefits of any reasonable alternatives.

A fair reading of the California statute implies that the threshold for decisional capacity is high—requiring all of the enumerated abilities, including an understanding of the illness, the course of the illness with and without the proposed treatment, and the ability to apply rational thought to the data presented.

Consent to medical treatment must be given voluntarily by an appropriately informed patient with the capacity to decide. The right of a competent patient to refuse medical care, even if the refusal will lead to death, is well established in modern law (*Bouvia v. Superior Court* 1986). There are rare exceptions to this right when third parties, usually minor children, will be affected (*Application of President and Directors of Georgetown College, Inc.* 1964). The same right to refuse treatment survives despite the person's incapacity—if it is exercised while the person is competent in a legally valid form. A psychiatric patient who is involuntarily committed to a hospital does not automatically become incompetent to make medical decisions, and generally retains the right to refuse treatment except in emergency situations (*Mills v. Rogers* 1982; *Rennie v. Klein* 1978; *Riese v. St. Mary's Hospital and Medical Center* 1989). In some states, however, the involuntary hospitalization process involves a judicial determination of incompetence to make medical decisions (*Jurasek v. Utah State Hospital* 1998). In other jurisdictions, if the involuntary commitment process involves a judicial determination of mental illness and dangerousness, the person's right to refuse medication is abridged without creating a finding of incompetency (*In re Qawi* 2004).

When a patient appears to lack capacity to make health care decisions, and thus may not be able to make a valid decision regarding health care, the problem then arises as to who should decide that the patient, in fact, lacks capacity and then who should make the treatment decision for him or her (Karlawish 2008; Kitamura et al. 1998). It is usually the treating physician who makes the initial judgment regarding whether a particular patient is competent. The treating physician may ask for a consultation about a case if competency is uncertain, treatment refusal by a patient raises anxiety about future legal actions, or a desire is expressed for a second opinion regarding the patient's competency. Competent treatment refusal does not have to be rational in an economic sense. Patient decisions can validly express the patient's religious beliefs, emotional experiences, or aesthetic concerns but must be based on some reasoning process that is applied to information and understanding of the illness and treatment possibilities. Going to court in every case of a possibly incompetent decision-maker, either to appoint a guardian or to decide a treatment question, is impracticable. Comment 7 to Rule 1.14 in the American Bar Association's Model Rules of Professional Conduct notes, "In many circumstances, however, appointment of a legal representative may be more expensive or traumatic for the client than circumstances in fact require" (American Bar Association 2009). Some states have statutes defining priorities

in surrogate decision making for health care in the absence of an advance directive to avoid formal court proceedings. The hierarchy is usually cited in the following order: spouse, adult child, parent, and sibling. Most state statutes require a consensus or a majority vote of equally ranked surrogates if there is disagreement (Uniform Health-Care Decisions Act of 1994, section 2[e]). The reader is referred to the summary table prepared by the American Bar Association Commission on Law and Aging (http://new.abanet.org/aging/Pages/StateLawCharts. aspx) for state-by-state statutes. Many states provide for a committee at a hospital or nursing facility to make surrogate decisions for incompetent residents of the facility. In the absence of an advance directive or a statutory scheme for surrogate decision making, many physicians will consult with the family. These informal processes do not have legal recognition, so technically the physician is acting without the consent of the patient. This is often satisfactory when all are in agreement and the treatment is benign. However, when there is family conflict, the physician and hospital need to seek appointment of a formal guardian. When there are no advance directives and no family members, a public guardian may be appointed by the court.

Cases vary on the process by which the proxy decision-maker should reach decisions. Generally, consistency with the subject's prior statements, beliefs, or directives and decisions that center on the patient's best interests are mixed in some combination, depending on the jurisdiction. Many of the significant legal decisions in this area have been raised with regard to the situation of a person in a persistent vegetative state, when a family member and/or guardian wishes to terminate life-sustaining treatment. In *Quinlan,* the court adopted a "substituted judgment" approach—that is, the judgment of the guardian or family would take the place of a now-incompetent decision-maker (*In re Quinlan* 1976). In another case, the Supreme Judicial Court of Massachusetts adopted a substituted judgment standard whereby courts were to determine what the decision of an incompetent individual— who had never been competent—might have been under the circumstances (*Superintendent of Belchertown State School v. Saikewicz* 1977). In effect, the court adopted a best-interest approach but labeled it "substituted judgment." In *Cruzan,* the Supreme Court held that the Missouri living-will law requiring clear and convincing evidence of the patient's wishes did not violate the due process clause of the Constitution (*Cruzan v. Director* 1990).

Competency to agree to nonstandard treatment that might provide a benefit but that would definitely involve increased risk should require more scrutiny to ensure that the patient or the surrogate is able to give full and express informed consent. Many commentators talk about a sliding scale with a low bar for competency when the risk is low and the benefit is strong; they note that competency must be more clearly established when the risk is higher or

the benefit is weaker (Cahana and Hurst 2008). Competency to make the decision to participate in a research study is different from the competency necessary to make a medical decision, because research rarely confers a direct benefit to the patient (Saks and Jeste 2006). A higher standard of competency and a higher level of scrutiny are needed, particularly, for example, in an early-stage investigation into the safety of a medication. The MacArthur Competency Assessment Tool for Clinical Research (MacCAT-CR) can be useful to establish competency to participate in research (Appelbaum and Grisso 2001).

Nonobjecting Assent by the Impaired Patient

Typically, patients have their competency assessed and litigated only when they decline treatment (Farnsworth 1990). The implication is that when patients are agreeable to receiving proposed treatment, physician concern about their actual decisional competency is diminished. This current concern may reflect the evolution of the *doctrine of informed consent* from a mere duty to disclose to a duty to disclose to a competent patient.

The doctrine of informed consent in the law covers the physician's legal obligation to disclose information and make the patient aware of the risks associated with the proposed treatment. The origin of the doctrine of informed consent is usually traced back to Justice Cardozo's opinion in *Schloendorff v. Society of New York Hospital* (1914), in which he stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." This opinion was more fully articulated in later cases such as *Salgo v. Leland Stanford Junior University Board of Trustees* (1957), *Nathanson v. Kline* (1960), and *Canterbury v. Spence* (1972). Informed consent as a legal theory for malpractice negligence did not require the physician to assess the patient's comprehension of the information provided. Liability for failure to provide informed consent in medical litigation occurred when the physician obtained consent for treatment but did not disclose significant risks, when the nondisclosure was of material and significant information, when the nondisclosure was a breach of the duty owed to the patient, and when, by reason of the nondisclosure, the patient was injured (*Cobbs v. Grant* 1972). All of these cases only discussed the duty to disclose information to the patient. None of them stated that the physician had any obligation to ensure that the disclosed information

was properly understood without distortion. Current state statutes generally provide a requirement that the patient must understand the information. The statute in California for informed consent to electroconvulsive therapy requires "a person knowingly and intelligently, without duress or coercion, clearly and explicitly manifests consent." There is also a requirement that consent must be written on a specified form. The person will be "deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligently act upon, the information [provided]" (Cal. Wel. and Inst. Code § 5326.5 2009).

Informed consent as an ethical doctrine rooted in patient autonomy *does* require that the patient not only receive the information but also have the capacity to understand the information. Some legal decisions *in dicta* have included patient understanding as a part of the legal test for informed consent. The law, however, presumes that all adult persons are competent, and this presumption transfers to the doctor-patient interaction. If there is strong evidence to the contrary, the presumption is no longer reasonable or is rebutted.

Very few states require that any patients must have an independent clinical assessment of competency or a judicial or administrative determination of competency before they can make a medical decision. This general presumption of decisional competency created the situation addressed in *Zinermon v. Burch* (1990) of the nonobjecting but questionably competent-to-consent patient signing a voluntary admission to a state hospital. The case centered and was decided on a very narrow technical question in federal jurisprudence regarding the dismissal of a Section 1983 civil rights lawsuit. The justices did not address the larger question of whether competency to agree to treatment must be determined prior to providing treatment to effectuate informed consent.

The facts of the case were that Darrell Burch was found wandering in a psychotic state on a Florida highway. He was first brought to a private hospital and then transferred to the state hospital. At both the private and the state hospitals, Mr. Burch voluntarily signed forms authorizing treatment. Mr. Burch was hospitalized for 5 months at the state hospital, and when released, he filed a Section 1983 suit that stated he was deprived of his liberty without due process of law. The Florida mental health statute for hospitalization required that the patient give voluntary "express and informed consent" or else undergo involuntary commitment proceedings. The Florida statute provided that involuntary commitment proceedings were then to be followed by a competency-to-make-treatment-decisions hearing. The statute defined "express and informed consent" as "consent voluntarily given in writing after sufficient explanation and disclosure…to enable the person…to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion" (*Zinermon v. Burch* 1990). Mr. Burch claimed that the

hospital and the doctors should have known that he could not give express and informed consent and that involuntary proceedings should have been instituted. The court found that the deprivation of liberty was predictable and that, therefore, a Section 1983 suit was appropriate. The case was not decided on its merits, that is, on whether Mr. Burch was competent to sign the voluntary admission papers. The case did not hold that it is a violation of constitutional rights to treat a consenting adult who might have impairments in understanding or who might lack decisional capacity, nor did it decide whether all voluntary patients admitted to a psychiatric hospital must receive a competency assessment (Appelbaum 1990).

Under California law related to mental health, there is no requirement for a capacity hearing for nonobjecting involuntary patients taking antipsychotic medication after they have been informed of the right to refuse medication and the required disclosure of risks and benefits. However, objecting patients must be given a capacity hearing before medication can be administered over their objection (Cal. Wel. and Inst. Code § 5332 2009).

In the absence of a state statutory requirement, the duties and responsibilities of a physician to assess capacity in a patient agreeing to treatment in the patient's best interest are very murky (Appelbaum et al. 1998; Irwin et al. 1985). There are no appellate cases to give guidance when lack of capacity has not been adjudicated and is still presumed. Thus, unless a state statute like the California statute for electroconvulsive therapy consent or the Florida statute for state hospitalization requires expressly that the patient must be competent, there is little incentive for a physician to want to discover impairment or incapacity. It is time-consuming to assess decisional competency properly, and a finding of incapacity complicates a treatment program that is otherwise agreeable to both the physician and the patient. Physicians are rarely as committed to the doctrine of patient autonomy as medical ethicists. Certainly, if the patient is determined by the physician to lack decision-making capacity, consent should be obtained from a surrogate decision-maker or a guardian. If there are advance directives, it is necessary for the physician to consider them and to consult with family members, regardless of whether a formal petition for a finding of guardianship based on incompetence is filed.

Conclusion

The forensic psychiatrist can expect to be consulted on issues related to mental competency in a range of areas in civil law. All civil competency evaluations stem from the long-standing principle that certain individuals or

groups, due to immaturity or incapacity, cannot make choices that society should endorse or allow. Because of the competing social values underlying the limitations on individual decision making, the exact mixture of abilities and limitations in the various domains of functioning leads to vague general statements about what constitutes capacity in differing areas of the law. Objective or standardized instruments that attempt to measure fundamental components of competency can be useful in the overall clinical evaluation. The clinician, similarly, will want to infer from the legal standard what functional behaviors and abilities would reflect on the capacity to meet the legal principle involved. Most civil competency evaluations will reveal a balance of factors arguing for and against competency, and the expert will need to address how those factors combined at the relevant time.

Key Points

- Mental competency for a specific task is judged according to the requirements of the task and for the immediate time period that the task is performed.
- Jurisdictions vary in their definitions and procedures regarding civil competencies.
- Adult individuals are presumed to be decisionally competent in all areas of the law. The presumption of competency must be overcome by the objecting party, often with clear and convincing evidence, if a fundamental liberty is at stake.
- Medical treatment of a patient with a somatic illness requires the informed consent of the competent patient. Treatment can be involuntarily given if the patient is incompetent and the surrogate decision-maker provides consent or if it is an emergency.
- In most jurisdictions, involuntary psychiatric hospitalization does not allow involuntary medical treatment, without a separate proceeding.

Practice Guidelines

1. Identify the specific requirements for the competency being assessed in the jurisdiction at issue.

2. Clarify at the outset of a proposed evaluation who the patient is, what the limits of confidentiality are, and who can give consent for an examination and release of records.
3. Correlate observational data, diagnoses, and test data with task-specific functional ability.
4. Consider structured clinical assessment to assess levels of functioning and limitations in different domains. Abilities and capacities differ in the various skill areas being assessed. Structured clinical assessment using both assessment instruments and clinical observations can assist the clinician in detailing levels of functioning and limitations in different domains, particularly in equivocal cases.
5. Do not assume that status or disability in one domain will lead to lack of capacity in a separate domain.

References

Abrams AA, Patel M, Muth A, et al: The case for competency in sexually violent predator civil commitment proceedings. Am J Forensic Psychiatry 28:7–25, 2007

Addington v Texas, 441 U.S. 418 (1979)

American Bar Association, Center for Professional Responsibility: Model Rules of Professional Conduct. Washington, DC, American Bar Association, 2009. Available at: http://www.abanet.org/cpr/mrpc/mrpc_toc.html. Accessed January 7, 2010.

Anfang SA, Faulkner LR, Fromson JA, et al: American Psychiatric Association's Resource Document on Guidelines for Psychiatric Fitness-for-Duty Evaluations of Physicians. J Am Acad Psychiatry Law 33:85–88, 2005

Appelbaum BC, Appelbaum PS, Grisso T, et al: Competence to consent to voluntary psychiatric hospitalization: a test of a standard proposed by APA. Psychiatr Serv 49:1193–1196, 1998

Appelbaum PS: Voluntary hospitalization and due process: the dilemma of Zinermon v. Burch. Hosp Community Psychiatry 41:1059–1060, 1990

Appelbaum PS, Grisso T: Assessing patients' capacities to consent to treatment. N Engl J Med 319:1635–1639, 1988

Appelbaum PS, Grisso T: The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR). Sarasota, FL, Professional Resources Press, 2001

Application of President and Directors of Georgetown College, Inc, 331 F.2d 1000 (D.C., 1964)

Bean G, Nishisato S, Rector NA, et al: The assessment of competence to make a treatment decision: an empirical approach. Can J Psychiatry 41:85–92, 1996

Billick SB, Naylor PW, Majeske MF, et al: A clinical study of competency in psychiatric inpatients. Bull Am Acad Psychiatry Law 24:505–511, 1996

Blackstone, Commentaries. Chicago, IL, University of Chicago, 1979, Book 3, Chapter 4, p 47

Bouvia v Superior Court, 179 Cal. App. 3d 1127 (1986)
Branch v State, 890 So.2d 322 (Fla. 2004)
Broach v Broach, 177 Ohio App. 3d 664 (2008)
Buck v Bell, 274 U.S. 200 (1927)
Cahana A, Hurst SA: Voluntary informed consent in research and clinical care: an update. Pain Practice 8:446–451, 2008
Cairns R, Maddock C, Buchanan A, et al: Prevalence and predictors of mental incapacity in psychiatric in-patients. Br J Psychiatry 187:379–385, 2005
Canterbury v Spence, 464 F.2d 772 (D.C. 1972)
Ceci SJ, Friedman RD: The suggestibility of children: scientific research and legal implications. Cornell Law Rev 86:34–108, 2000
Ceci SJ, Kulkofsky S, Klemfuss JZ, et al: Unwarranted assumptions about children's testimonial accuracy. Annu Rev Clin Psychol 3:311–328, 2007
Cobbs v Grant 8 Cal.3d 229, 104 Cal. Rptr. 505, 502 P.2d 1 (1972)
Commonwealth v Stacey, 177 S.W.3d 813 (Ky. 2005)
Cruzan v Director, Missouri Department of Health, 497 U.S. 261 (1990)
Custer LB: The origins of the doctrine of parens patriae. Emory Law J 27:195–244, 1978
Dawson J, Szmukler G: Fusion of mental health and incapacity legislation. Br J Psychiatry 188:504–509, 2006
Dexter v Hall, 82 U.S. 9 (1872)
Dobson v Dobson, 193 P.2d 794 (Cal. App. 1948)
Dunn LB, Nowrangi MA, Palmer BW, et al: Assessing decisional capacity for clinical research or treatment: a review of instruments. Am J Psychiatry 163:1323–1334, 2006
Dusky v United States, 362 U.S. 402 (1960)
Edmunds v Edwards, 287 N.W.2d 420 (Neb. 1980)
Farnsworth MG: Competency evaluations in a general hospital. Psychosomatics 31:60–66, 1990
Grisso T: Evaluating Competencies: Forensic Assessments and Instruments, 2nd Edition. New York, Kluwer Academic, 2003
Grisso T, Appelbaum PS: Comparison of standards for assessing patients' capacities to make treatment decisions. Am J Psychiatry 152:1033–1037, 1995a
Grisso T, Appelbaum PS: MacArthur Treatment Competence Study, I: mental illness and competence to consent to treatment. Law Hum Behav 19:105–126, 1995b
Grisso T, Appelbaum PS: The MacArthur Treatment Competence Study, III: abilities of patients to consent to psychiatric and medical treatments. Law Hum Behav 19:149–174, 1995c
Grisso T, Appelbaum PS: The MacArthur Competence Assessment Tool for Treatment (MacCAT-T). Sarasota, FL, Professional Resources Press, 1998
Grisso T, Appelbaum PS, Hill-Fatouhi C: The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. Psychiatr Serv 48:1415–1419, 1997
Holder AR: Legal Issues in Pediatrics and Adolescent Medicine. New Haven, CT, Yale University Press, 1985
In re Anthony P, 84 Cal. App. 4th 1112 (2000)

In re Estate of Mann, 184 Cal. App. 3d 593 (1986)
In re Estate of Raney, 799 P.2d 986 (Kan. 1990)
In re Estate of Scott, 128 Cal. 57 (1900)
In re Fisher, 164 S.W.3d 637 (Tex. 2005)
In re Detention of Cubbage, 671 N.W.2d 442, 446 (Iowa 2003)
In re Qawi, 32 Cal.4th 1 (2004)
In re Quinlan, 355 A.2d 647 (N.J. 1976)
Irving Trust v Day, 314 U.S. 556 (1942)
Irwin M, Lovitz A, Marder SR, et al: Psychotic patients' understanding of informed consent. Am J Psychiatry 142:1351–1354, 1985
Jaadan v Gonzales, 211 Fed.Appx. 422 (6th Cir. 2006)
Janofsky JS, McCarthy R, Folstein MF: The Hopkins Competency Assessment Test: a brief method for evaluating patients' capacity to give informed consent. Hosp Community Psychiatry 43:132–136, 1992
Jurasek v Utah State Hospital, 158 F.3d 506 (10th Cir. 1998)
Karlawish J: Measuring decision-making capacity in cognitively impaired individuals. Neurosignals 16:91–98, 2008
Kitamura F, Tomoda A, Tsukada K, et al: Method for assessment of competency to consent in the mentally ill: rationale, development, and comparison with the medically ill. Int J Law Psychiatry 21:223 –244, 1998
The Late Corporation of the Church of Jesus Christ of Latter-Day Saints v United States, 136 U.S. 1, 57 (1890)
Loftus EF, Pickrell JE: The formation of false memories. Psychiatr Ann 25:720–725, 1995
Loving v Virginia, 388 U.S. 1, 12 (1967)
Marson DC, Ingram KK, Cody HA, et al: Assessing the competency of patients with Alzheimer's Disease under different legal standards: a prototype instrument. Arch Neurol 52:949–954, 1995
Mathews v Eldridge, 424 U.S. 319 (1976)
Mills v Rogers, 457 U.S. 291 (1982)
Moore (Ardell) v Sup. Ct. Los Angeles, Case B198550, 2nd Appellate District (2009)
Mullen PE, Lester G: Vexatious litigants and unusually persistent complainants and petitioners: from querulous paranoia to querulous behaviour. Behav Sci Law 24:333–349, 2006
Nara v Frank, 264 F.3d 310 (3d Cir. 2001)
Nathanson v Kline, 300 P.2d 1093 (1960)
Nee Hao Wong v I.N.S., 550 F.2d 521 (9th Cir. 1977)
Okai D, Owen G, McGuire H, et al: Mental capacity in psychiatric patients: systematic review. Br J Psychiatry 191:291–297, 2007
Owen S, Richardson G, David AS, et al: Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. BMJ 337:40–42, 2008
Patient Self-Determination Act (1990), 42 U.S.C. 1395 cc (a)
People v Giardino, 82 Cal. App. 4th 454 (2000)

People v Winslow, 123 Cal. App. 4th 464 (Cal. App. 2d Dist. 2004) (PTSD made witness unavailable)
Rennie v Klein, 462 F.Supp. 1131 (D.N.J. 1978)
Riese v St. Mary's Hospital and Medical Center, 774 P.2d 698 (Cal. 1989)
Rohan, ex rel. Oscar Gates v Woodford, 334 F.3d 803 (9th Cir. 2003)
Rosen v United States, 245 U.S. 467, 471 (1918)
Saks ER, Jeste DV: Capacity to consent to or refuse treatment and/or research: theoretical considerations. Behav Sci Law 24:411–429, 2006
Salgo v Leland Stanford Junior University Board of Trustees, 154 Cal. App. 2d 560 (1957)
Santosky v Kramer, 455 U.S. 745 (1982)
Schloendorff v Society of New York Hospital, 105 N.E. 92 (N.Y. 1914)
Shenk v Shenk, 100 Ohio App. 32 (1954)
Simon RI: A clinical review, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Arlington, VA, American Psychiatric Publishing, 2002, pp 30–31
State ex rel. Jones v Warmuth, 272 S.E.2d 446 (W.V. 1980)
State ex rel. Nixon v Kinder, 129 S.W.3d 5 (Mo. Ct. App. 2003)
State v Ward, 455 S.E. 2d 666 (N.C. Ct. App. 1995)
Superintendent of Belchertown State School v Saikewicz, 370 N.E.2d 417 (Mass. 1977)
Turner v Safely, 482 U.S. 78 (1987)
Wendland v Wendland, 26 Cal. 4th 519 (2001)
Wheeler v United States, 159 U.S. 523, 524 (1895)
Wright v Johns Hopkins Health Care System, 728 A.2d 166 (Md. 1999)
Zablocki v Redhail, 434 U.S. 374 (1978)
Zinermon v Burch, 494 U.S. 113 (1990)

Suggested Readings

Gutheil TS, Appelbaum PS: Clinical Handbook of Psychiatry and the Law, 3rd Edition. Baltimore, MD, Lippincott Williams & Wilkins, 2000
Slovenko RJ: Civil competency, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Arlington, VA, American Psychiatric Publishing, 2004, pp 205–224
Grisso T: Evaluating Competencies: Forensic Assessments and Instruments, 2nd Edition. New York, Kluwer Academic, 2003
Qualls SH, Smyer MA: Changes in Decision-Making Capacity in Older Adults. Hoboken, NJ, Wiley, 2007

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Chapter 10

Personal Injury Litigation and Forensic Psychiatric Assessment

J. Richard Ciccone, M.D.

Joshua C. W. Jones, M.D.

Civil forensic psychiatry includes the assessment of plaintiffs who claim psychiatric damages as a result of injury, wrongful action, or negligence by a defendant. The imagination is taxed when trying to come up with a comprehensive list of the types of injuries that can generate claims of psychiatric damage: automobile injuries, workplace harassment, toxic contamination, medication side effects, threats of bodily harm, discrimination in hiring or firing, and losses resulting from a criminal act are but a few.

When an individual has been injured by another, there are both criminal and civil mechanisms for dealing with the wrong. The criminal justice sys-

tem provides punishment for the guilty, deterrence against future crime, and retribution for the wronged party. The civil justice system under tort law provides the vehicle for the injured party to seek monetary damages, which is our modern society's attempt to make the injured party whole again.

The concept of compensation for psychiatric damages, mental damages, or psychic trauma, as it is called in various settings, has evolved over time. "Railway spines and brains" (Weisaeth 2002) led physicians to explore the interplay of physical injury and nervous symptoms (Harrington 2003). The connection between physical injury and psychological symptoms reemerged in the World War I phenomenon of "shell shock," and it evolved throughout the twentieth century history of warfare through the internecine "neurasthenia," World War II's "psychoneuroses," and finally to the post-Vietnam era "posttraumatic stress disorder." With the publication of DSM-IV, the concept of physical injury, or even the threat of physical injury causing psychic damage was expanded from the battlefield and broadened to include a wide range of potentially traumatic experiences.

In addition to the evolution of the terminology used to describe psychological injury related to a physical event or threat, there has been an evolution of the legal principles that underlie damages awarded for psychic injury. Common law had held that a plaintiff had to demonstrate that there was a physical injury in order to obtain recovery of damages. By the mid-twentieth century, case law had extended damages to those individuals within the "zone of danger" of a potentially traumatic event—that is, those people directly within harm's way could claim damages for emotional distress inflicted by the event (*Palsgraf v. Long Island Railroad* 1928). Some states have adopted the even more lenient "relative bystander test," in which compensation can be awarded for "reasonably foreseeable" psychic injuries, such as an event or accident that occurs to a close relative in close proximity to, and has a direct emotional impact on, the plaintiff (*Dillon v. Legg* 1968).

Evolving parallel to tort law, the workers' compensation system was adopted in the United States, from Germany via England, in the early twentieth century. The workers' compensation system abbreviates the process of injury litigation and provides a more certain outcome for the injured party in exchange for limiting the employer's liability. What distinguishes workers' compensation from tort injury litigation is that no single event must be shown to be the cause of the mental injury and resulting disability in order for compensation to be awarded (*Carter v GM* 1960). It is within these legal and policy frameworks that the psychiatrist may be requested to conduct an independent psychiatric examination to assist the court in determining damages.

Role of the Forensic Psychiatric Examiner

Striving for Objectivity

The examination by the expert witness, whether on behalf of the plaintiff or defendant, is guided by the ethical obligation to strive for objectivity (American Academy of Psychiatry and the Law 2005) (see also Chapter 5, "Ethics in Forensic Psychiatry," this volume). Therefore, the guidelines for conducting the examination on behalf of either party are the same and are described in detail later in this chapter. Many forces can compete to influence the expert's opinion one way or another. Hazards confronting the expert's efforts to strive for objectivity may include attempts by the attorney to influence the work of the psychiatrist by importuning, befriending, or withholding information from the expert. Diligent attorneys will advocate for their clients, as they should, and may be expected to present their clients in the best light, even to the expert psychiatrist. The subconscious impulse to please the side that hires the psychiatrist may be subtle but should always be recognized.

It is common practice for a plaintiff's attorney to request that the plaintiff's treating psychiatrist testify about the diagnosis and causation of the plaintiff's mental disorder. Stepping into the forensic role and opining about causation create an issue of *dual agency* (Strasburger et al. 1997), which can be a significant barrier in the quest for objectivity. Dual agency involves the psychiatrist acting on behalf of two different parties; that is, as a treating physician on behalf of the patient and as a forensic examiner on behalf of the court. The treating physician who decides to function as an expert witness puts the doctor-patient relationship in jeopardy by agreeing to comply with the court's need to have all the relevant facts and opinions about the case laid bare, whether or not they are helpful to the patient-plaintiff. The dual-agent psychiatrist also imperils his or her ability to strive for objectivity as an expert witness by confounding the expert role with the natural and important obligations of the treating physician. The treating physician is expected to be the champion of the patient, to look out for the patient's welfare, and to seek to maximize the benefits and minimize the risks of treating the patient; the expert witness does not have that obligation. The expert's obligation is to provide the court with information relevant to making an informed decision in the case at hand.

We advise the treating psychiatrist to avoid dual agency. Extraordinary circumstances, such as the reality of the lack of a second psychiatrist being available to function as an expert, may require the psychiatrist to act as a dual agent. One way to deal with unavoidable dual agency is to openly express the conflict to the court, to the attorney, to the patient-plaintiff, and to one's self.

Understanding the Attorney's Request

Clarification of the consultation question, preferably done early in the interaction with the attorney, sets the stage for the rest of the evaluation. The psychiatrist may find it helpful to assist the attorney in restructuring the consultation inquiry in an effort to arrive at a more appropriate or readily answerable question. Striving for objectivity in the opinion does not prohibit the psychiatrist from clarifying the consultation question, agreeing on the time frame in which the work is to be completed, or establishing the payment for the time allotted to a private case (Ciccone and Jones, in press).

Existence of a Mental Disorder

The attorney will want to know if the plaintiff has or has had a mental disorder. If there are no data to support a diagnosis of a mental disorder, either in the past or at the time of the examination, answering questions about causation and damage becomes moot in most instances. Psychiatrists should use the prevailing diagnostic schema in forensic psychiatric work, currently DSM-IV-TR (American Psychiatric Association 2000). The psychiatrist who chooses to disregard the psychiatric lingua franca and use an idiosyncratic diagnosis is obligated to justify that choice.

At times, the data will be robust, and the psychiatrist will be able to arrive at a diagnosis within a reasonable degree of medical certainty. At other times, even with a competent examination, the data are confusing, incomplete, inconsistent, or otherwise do not permit the psychiatrist to arrive at a diagnosis. In these circumstances, it behooves the psychiatrist to state forthrightly that the data are insufficient.

Causation

The critical question that the attorney will pose, once a DSM-IV-TR psychiatric disorder is diagnosed, is whether or not the accident or event caused or exacerbated the diagnosed mental disorder. According to the American Medical Association Guidelines, a cause is defined as follows:

> In medicine, cause refers to an identifiable factor (e.g., genetic abnormality, toxic or infectious exposure, trauma) that results in injury or illness. The cause or causes must be scientifically probable following causation analysis. (American Medical Association 2008a)

Correlation does not equal causation—that is, the mental disorder that followed the event may have been caused by the event or may have simply occurred in proximity to the event and been caused or exacerbated by other stressors. Determining if there was a preexisting psychiatric diagnosis allows the examiner to opine whether the current psychiatric disorder is a manifestation of the prior diagnosis or is a different disorder.

A subtle yet key distinction is made by determining whether the plaintiff's current psychiatric disorder is the result of the individual's susceptibility or predisposition to a psychiatric illness. A predisposition differs from a preexisting condition in that a person predisposed to developing a psychiatric disorder would not have developed it were it not for the event or accident at issue. The "eggshell skull" concept dictates that tort law "takes the plaintiff as the defendant found him"—that is, the defendant may not claim as a defense that an average person would not have been so affected by the event as was the plaintiff. On the other hand, the plaintiff with a vulnerability, who would have developed a mental disorder even if the accident or event had not occurred, is only entitled to damages to the extent that the incident hastened the onset or made the ultimate condition worse.

Prognosis

Prognosis depends on the nature of the mental disorder, the current impairment, and the potential mitigation of that impairment. Prognosis is relevant to the potential damages awarded. The American Medical Association Guidelines provide a useful discussion of the physician's role in assessing the plaintiff's level of impairment (American Medical Association 2008d, pp. 27–28; American Medical Association 2008b, pp 355–360). The cost of the plaintiff's treatment (e.g., clinic visits, therapy, medication) for a mental disorder can be calculated and included in a damage award. Prognosis is not necessarily determined by the maximum potential harm that could come to the plaintiff if the mental illness is untreated; the injured party has an obligation to mitigate the psychic injury by participating in effective treatment. The action or event may have diminished a person's ability to function (e.g., a high-functioning individual may not be able to do the highly skilled or intellectually challenging work that he or she was able to perform prior to the impairment but nonetheless is still able to do other, less demanding work).

Often, "motivation is a significant link between an impairment and resulting disability" (American Medical Association 2008b, p. 353). If the injured

party chooses not to participate in treatment or, while seeing a clinician, chooses not to follow the treatment recommendations, the plaintiff has not taken the necessary steps to mitigate the damages. Another circumstance to assess is one in which a plaintiff seeks treatment but is inadequately treated, for whatever reason, and does not have improvement of symptoms—not because he or she is not treatable, but because he or she was not treated effectively. These scenarios can be taken into account when the psychiatrist opines on the prognosis of the injury. If the expert opines that treatment may be necessary, the nature and extent of the treatment should be described.

Nature of the Examination

The examination has three parts: review of records, relevant testing, and the psychiatric examination. The specific nature and complexity of the evaluation will be dictated by the questions being assessed.

Record Review

Review of past records (Table 10–1) is an important part of the evaluation and, in some cases, may be the most important part. Previous medical records provide history relevant to the analysis of whether or not a condition was preexisting. They may also enhance the credibility of the plaintiff or diminish it if significant inconsistencies are found within the medical record or between the record and the plaintiff's presentation on examination. For the individual who has been, in fact, damaged and has developed a mental disorder as a result of the action or event, this analysis of the records helps to establish the legitimacy of the claim. Records should be requested, often in writing, from the retaining attorney. Some requested records might not be available.

Testing

The most common form of testing employed by the psychiatric expert witness is psychological testing (see Chapter 23, "Psychological Testing in Forensic Psychiatry," this volume). Unless one is specifically trained in the interpretation of psychological tests, the psychiatric examiner should have the psychological testing interpreted by a trained psychologist. Frequently used and well-standardized personality tests include the Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2; Butcher et al. 1989),

TABLE 10–1. Relevant records to review

Police records
Witness statements
Ambulance or first-responder reports
Emergency department records, including emergency department visits prior to the event in question
Workplace accident reports
School records
Medical records, especially psychiatric records
Hospitalization records
Chemical dependency treatment records
Laboratory and medical imaging reports
Psychological test results and reports
Employment records
Financial records
Legal records
Pharmacy records
Military records

the Millon Clinical Multiaxial Inventory–3 (MCMI-3; Millon et al. 2006), and the Personality Assessment Inventory (PAI; Morey 1991). There are many other tests available of varying levels of reliability and validity. Specific tests should be selected based on the needs of the psychiatric examination and the questions to be answered.

For cases involving traumatic brain injury or other neuropsychiatric injury, neuropsychological testing is invaluable. Although some may use a flexible battery of tests, many forensic neuropsychologists and neuropsychiatrists employ a standardized battery. A standardized battery of tests allows the specialist to analyze the tests results against base rates of neuropsychological findings in the general population.

The complexity of the case may require examination by other medical specialists. For example, neurological symptoms may make a neurological examination relevant. The neurological exam and any imaging, physiometric, or other relevant tests would be in the purview of the neurologist. The neurologist's report, including test results, is then used in arriving at the opinion and assisting the reasoning of the psychiatric examiner.

Test data may be consistent with a forthcoming and reliable plaintiff, or the data may support a finding of malingering, amplification, or exaggera-

tion of symptoms. As with the review of psychiatric records, the presence or absence of indicators of manufactured symptoms is relevant to consider when answering the questions put forth by the attorney.

The Psychiatric Examination

Psychiatrists are trained to interview individuals and be skilled listeners and observers. Under most circumstances the psychiatrist is examining a patient to whom the psychiatrist may be providing evaluation and treatment. That treatment purpose is absent during the forensic evaluation.

At the outset of the forensic psychiatric examination in a personal injury case, the psychiatrist should obtain informed consent from the examinee. This informed consent should include the following statements: 1) that the examiner is a psychiatrist, 2) the party for whom the psychiatrist is conducting the examination, 3) that a report may be generated, and 4) that the psychiatrist may be called upon to testify as to the result of the evaluation and the content of the examination. It is also important to review the fact that although the examiner is a physician, the examination is not for the purpose of providing treatment. The usual rules of doctor-patient confidentiality do not apply. If the examination is recorded, the elements of the consent may be stated on the recording. The examiner may find it helpful to have a written consent to examination containing the elements described, which can be reviewed and signed by the examinee.

There is a certain amount of anxiety that is inherent in any psychiatric examination. A psychiatric examination in the context of injury litigation is bound to increase that inherent anxiety. It behooves the independent psychiatric examiner to attempt to put the examinee at ease, regardless of whether the examination is done for the plaintiff's attorney or the defense's attorney.

Examiners should conduct a thoughtful psychiatric interview, using the principles of the clinical interview as a guide (Table 10–2) (MacKinnon et al. 2006). Open-ended questions, active listening, and minimal interruptions are basic tools in a psychiatrist's repertoire and should not be discarded in forensic settings. For numerous reasons, some examinees may be withholding, guarded, or mute. Perhaps a more difficult plaintiff to examine is the one who speaks volumes without content. These difficult-to-examine plaintiffs can be interviewed similarly to patients who exhibit the same behaviors. The examiner must be flexible, patient, and sometimes inventive in trying to complete the task at hand (see Chapter 7, "The Forensic Psychiatric Examination and Report," this volume, for a comprehensive discussion of the psychiatric interview).

Structured interviews can assist the examiner in arriving at a diagnosis; for example, the Structured Clinical Interview for DSM-IV Axis I Disorders

TABLE 10–2. Examination techniques

Be respectful and nonjudgmental.
Clearly review the parameters of the interview with the examinee.
Let the examinee know there are regularly scheduled breaks and that more can be requested.
Make the examinee aware of the restroom location.
Create a comfortable interviewing atmosphere with appropriate furniture, temperature, and lighting.
If the plaintiff's attorney has a right to be present, use a one-way screen when possible.
Have recording device(s) be as unobtrusive as possible.

(SCID; First et al. 1997), Schedule for Affective Disorders and Schizophrenia (SADS; Endicott and Spitzer 1978), and Diagnostic Interview Schedule (DIS; Robins 1981) are available. The goal of these instruments is to provide reliable methods for making psychiatric diagnoses and may be primarily designed for research purposes. Most have not been validated for use in forensic evaluations. The instruments should not be considered a substitute for experienced clinical judgment and may interfere with the flow of the psychiatric interview. Structured interviews and self-report symptom checklists can be easily obfuscated by an examinee who desires a particular result.

The Psychiatric Report

The psychiatric report requires the psychiatrist to put psychiatric information and conclusions in a legal context. In forensic psychiatric report writing—like psychiatric consultation in medical settings—making a diagnosis is not enough. The psychiatrist uses the report to explain to the legal system how the event or accident may have caused, contributed to, or exacerbated the plaintiff's psychic injury.

The forensic psychiatric report does not follow the same format as a medical report (see Chapter 7, "The Forensic Psychiatric Examination and Report," this volume). The forensic psychiatric report's format fits its purpose: to provide data and conclusions to be used by the legal system to decide a legal issue. The audience of the report should be assumed to not be medically trained; therefore, jargon and overly technical language should be avoided.

The psychiatric examiner should not write a psychiatric report until requested to do so by the retaining attorney. The knowledgeable attorney will want to know the strengths and weaknesses of the case in order to decide whether to settle the case before trial and, if so, at what monetary value to accept damages. The forensic psychiatric expert who minimizes weaknesses of the case, whether for the plaintiff or the defense attorney, does that attorney a disservice; if the attorney does not have all the facts, he or she is not able to make a fully informed decision about how to proceed.

If a report is written, it will be given to the retaining attorney. As such, the report may become available to all relevant parties, some of whom may not be known to the psychiatric examiner. Including gratuitous information or inflammatory characterizations not vital to the opinion and reasoning has the potential to be unnecessarily damaging to the examinee or others. Examiners should use discretion and tactful judgment in crafting the report.

The report format (Table 10–3) should reinforce, not detract from, the purpose of the report: providing the reader with the nature of the examination, the findings, the expert's opinions, and the reasoning used to arrive at the opinions. One format that we and numerous others have used is described in Table 10–3. Personal style should not be overlooked in organizing a report, and many forensic psychiatrists believe their personal modifications of the standard report format make their reports more powerful. Also, do not ignore that a personal report style may change over time as the needs of the referral source change, continuing professional education informs the psychiatrist on alternative styles, and the professional experience of the psychiatrist accumulates.

In some cases, the format of the examination will be dictated by the referral source. Whatever the ultimate length and style of the report, it should contain the referral question, the nature of the examination, and the conclusions and reasoning of the psychiatric examiner.

Expert Witness Testimony

The role of the expert witness in court is to provide relevant information to the fact-finder. Adequate preparation with the attorney is essential to expert witness testimony. The expert witness may be called on to testify at a trial or deposition. A comprehensive discussion of expert witness testimony is beyond the scope of this chapter; however, in personal injury litigation, depositions are frequent enough to warrant comment here (Gutheil 2009; Sales and Shuman 2005). The expert witness may be required to testify at a depo-

TABLE 10–3. Suggested report format

Identification of information
Statement of consent to examination
Description of the nature of the examination
Sources of information, including records requested but not received
Personal history
Psychological testing
Mental status examination
Opinion
Reasoning

sition for many reasons: 1) the deposition may be used for discovery purposes; 2) the expert witness may not be available to testify at trial; 3) the deposition is memorialized and may be used to impeach the expert witness with inconsistencies at trial. During a deposition, the opposing counsel will require the expert to state and clarify his or her opinions and to describe the basis for those opinions. Depositions may allow opposing counsels to determine the settlement value of the case. Inconsistencies between deposition and trial testimony will often result in the expert being confronted with and then impeached by the inconsistencies.

Diagnoses Often Encountered in Civil Litigation

Depressive Disorders

DSM-IV-TR outlines numerous affective disorders and provides reliable diagnostic criteria. A depressive disorder can be the final common pathway for a variety of insults, including the loss of function following a physical injury, the loss of sleep due to pain, the narcissistic injury of being fired, and the fear following harassment. For some individuals, the resultant symptoms may be consistent with an adjustment reaction with depressive features. For others, the accident or event may result in a major depressive disorder. When confronted with a depressed plaintiff, the psychiatrist should take care to make an accurate diagnosis and pay special attention to causation (see discussion

in earlier section, "Causation"), given that there are innumerable life stressors—including litigation itself—that can cause, precipitate, or exacerbate a depressive disorder.

Case Vignette 1

Ms. D is a 52-year-old separated woman who at age 49 years caught her hand in a machine and lost the distal portions of her third, fourth, and fifth fingers. This event resulted in a depression, impairment in her ability to practice her craft, a change in her appearance, and recurring pain.

Ms. D was the youngest of her parents' three children. She stated that her mother was emotionally abusive and had had electroconvulsive therapy for treatment of depression. Her paternal grandfather had a history of depression.

Record reviews revealed that while in college Ms. D took an overdose of pills, resulting in a psychiatric hospitalization. She returned to college 6 months later and completed her studies cum laude. She married at age 26 years and had two children. Her husband committed suicide, and his parents blamed her. In the aftermath of the suicide, she reentered psychiatric treatment. Within a year, she was no longer taking antidepressant medication. She remarried and had a volatile relationship with her husband. She sought both couples and individual therapy. She was diagnosed with depressive disorder not otherwise specified, with narcissistic traits.

Following her injury, Ms. D required surgery and rehabilitation. She was diagnosed with a major depressive disorder and responded to an antidepressant. At the time of the independent psychiatric examination, she remained on antidepressant therapy and was back to her pre-injury affective baseline.

On psychological testing, Ms. D's MMPI-2 (Minnesota Multiphasic Personality Inventory, 2nd Edition) profile was valid and consistent with an individual whose adult life was marked by feelings of inadequacy, depression, and pessimism. Her MCMI-3 (Millon Clinical Multiaxial Inventory–3) profile was valid; depressive and avoidant traits were notable.

The independent psychiatric expert opined that Ms. D had a significant history of depression that was exacerbated by the injury. The depressive disorder was well controlled by psychiatric treatment and there was psychiatrically caused impairment. However, Ms. D's coexisting personality disorder represented a lifelong adult pattern that was not caused or exacerbated by the injury.

Anxiety Disorders

A particular event or accident may not affect some individuals much at all, whereas it may cause others to become quite anxious. The individual who responds with anxiety can develop an anxiety disorder, the signs and symptoms of which are elucidated in DSM-IV-TR. The history of a plaintiff's responses to prior stress with anxiety can be helpful in determining whether a

current anxiety disorder exists or is impairing. A plaintiff who has no history or no significant history of responding to stress with anxiety is less likely but not precluded from developing an anxiety disorder in response to an accident or event. Therefore, the existence of an anxiety disorder in a plaintiff does not demonstrate that the event or accident in question caused or exacerbated the anxiety. Other stressors may be significant contributors to the person's presentation (see discussion in earlier section, "Causation").

Posttraumatic Stress Disorder

When an individual experiences a troubling event, he or she is all too often given a diagnosis of posttraumatic stress disorder (PTSD), even though the event may not meet both elements of the definition of traumatic exposure criteria as described in DSM-IV-TR. One of the challenges of diagnosing PTSD is that the symptoms may be easily learned from numerous sources—from worthy attempts by the military to educate service members on the warning signs of posttraumatic stress to the blatant magazine advertisements and how-to Web sites that cater to those who would deceive the system—and recounted by the examinee. The psychiatrist, examining on behalf of either the plaintiff's attorney or the defense's attorney, would want to establish the presence of PTSD through careful exploration of symptoms, beyond simply self-report, and would consider the possibility of malingering, amplification, or exaggeration of symptoms. Record review and psychological testing aid in correlating reported symptoms from the clinical examination.

Originally, the notion of PTSD came from combat circumstances and was translated to some horrific events that occur in civilian life. However, the term has now expanded to and is often loosely used for unpleasant circumstances that any individual may encounter. Consider the following vignette.

Case Vignette 2

After an honorable discharge from the Army, during which he had three deployments in the Middle East conflicts, Mr. X applies to the Department of Veterans Affairs for disability because of, in his words, "my PTSD." Mr. X reports that over the last few years—including 2 years while he was still in the Army—he experienced near-nightly nightmares and near-daily flashbacks to "that night in the summer of my first tour when my TC [truck commander] got hit by an IED [improvised explosive device] right next to me." He feels anxious most of the day, avoids large crowds and open spaces, and feels as if "I've got to always be alert in case someone's watching me." He feels sad most days and snaps at his wife and children frequently. He reports that he has tried to get a job since leaving the military but says, "I don't trust anybody enough to apply." He produces several e-mail exchanges between him and

his wife from his second tour after the attack and from his third tour, in which he writes about feeling "miserable," "alone," "afraid," and "not getting any sleep." He is also able to produce a military performance evaluation in which his superior officer confirmed he was in the attack that Mr. X described. Mr. X's military medical records indicate that his commander took him to a Combat Stress Clinic psychiatrist several times in the 2 weeks after the attack and that his "sleep problems, low mood, and anxiety that have invaded his dreams have been present for at least several months."

On first glance, this case seems compelling for a diagnosis of PTSD. Indeed, natural sympathies for people willing to defend their country may make the psychiatrist gloss over data that argue against the "obvious" diagnosis. In this veteran's case, he does meet the PTSD traumatic exposure criterion, in that he did witness and participate in a life-threatening attack that killed a fellow soldier. In Mr. X's case, the other hallmarks of PTSD are more difficult to pinpoint. The military psychiatrist records report that he had been experiencing depressive and anxious symptoms for several months prior to the event. There is no evidence that these symptoms worsened after the attack, only that Mr. X was seen by a psychiatrist after that event. Mr. X's symptoms seem to have predated the clearly horrendous attack he experienced and seem more consistent with a depressive disorder—perhaps due to his military service or perhaps not—than with PTSD.

PTSD is relatively unusual in DSM-IV-TR nosology because a cause must be identified in order for a person to qualify for the diagnosis. This element of PTSD diagnosis criteria can play into the all-too-human fallacy of correlation as causation, and it can confound the PTSD diagnosis in military and civilian injury litigation evaluations. The psychiatric examiner, whether examining for the plaintiff or defense, is advised to explore other possible reasons for PTSD-like symptoms—symptoms that overlap into many other anxious and depressive diagnoses—in order to add credibility to the psychiatric opinion.

Personality Disorders

The presence or absence of a personality disorder is relevant to a discussion of an individual's mental condition. Personality disorders may, in certain instances, be the source of the signs and symptoms that the person is suffering from, or the personality disorder may lead to behaviors that create life circumstances that are difficult and lead to distress for the plaintiff. Personality disorders are not caused by and virtually never exacerbated by the event or accident at issue.

The examiner should explore the possibility that although a personality disorder is present, an Axis I disorder was nonetheless created as a result of

the action or event in question. The examiner can help distinguish the Axis I diagnosis from the Axis II diagnosis that the plaintiff is suffering from so that he or she may be appropriately compensated.

Traumatic Brain Injury

An increasing number of cases involving traumatic brain injury are being litigated (Larrabee 2005). Determining whether or not someone has suffered a traumatic brain injury may require the participation of both a neurologist and a neuropsychologist. The standardized battery of neuropsychological tests not only provides data on the person's cognitive and psychological impairments as compared with the base rate of impairments for the general population but also offers a measure of the plaintiff's effort in performing the tests. Measures of effort are important. Poor results because of poor effort do not indicate traumatic brain injury but willful or unconscious intent to amplify or feign impairment.

Pain

Pain, as a discreet symptom or as part of a medical condition, is difficult to assess, and assessment of chronic pain is even more problematic (American Medical Association 2008c). Pain and concomitant physical limitations or injury may lead to a debilitating depressive disorder featuring hopelessness and helplessness, or they may not have significant impact on a person's capacity to function. If a psychiatrist chooses to perform independent medical examinations of patients for whom pain is a significant consideration, ensuring that there is one or more anatomical site of pain is the first step in the diagnosis of a pain disorder. For this diagnosis, consultation with other medical professionals (e.g., orthopedists, neurologists, gastroenterologists) is recommended.

Malingering

Plaintiffs have an obvious financial interest in malingering. As described in DSM-IV-TR, "Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as…avoiding work, obtaining financial compensation…" (American Psychiatric Association 2000). Malingering can include intentional production of symptoms ("faking bad"), intentional suppression of symptoms ("faking good"), or amplification of symptoms (exaggeration). Assessment for malingering is important, whether examining for the plain-

tiff or defendant, and is necessary to bolster the credibility of the expert's opinion in either case (see Chapter 17, "Malingering," this volume).

Complicating the assessment of malingering is the differential diagnosis that includes factitious disorders and somatoform disorders. Finding no evidence of malingering reinforces the credibility of the plaintiff's claim. Consistency among the reviewed records, clinical examination, and psychological test results can support the finding that the plaintiff is not malingering. If malingering is suspected, it may be difficult to amass the data to conclude that the plaintiff is malingering, and the psychiatrist may wish to explore the credibility of the plaintiff by reviewing inconsistencies among the record review, psychological test results, and clinical examination. Rarely does the psychiatric examiner get sufficient insight or evidence that allows definitive labeling of malingering. It is usually more accurate and less provocative to use phrases such as "symptom exaggeration" or "magnification." In the forensic report, it is often helpful to discuss the presence or absence of malingering in the Conclusion or Opinion section.

Case Vignette 3

Mr. R is a 47-year-old married laborer who, 3 years prior to the evaluation, suffered a head injury in a motor vehicle accident. At the scene, he was unconscious for 10 minutes and gradually regained consciousness over the next hour. At the emergency room, the CT (computed tomography) scan showed a "tiny cerebral contusion at the left frontal-parietal junction." He was admitted for further evaluation and treatment. After several days, Mr. R. was transferred to an inpatient brain injury rehabilitation program where, during his 10-day stay, he was described as having progressed. However, at discharge he continued to demonstrate problems with distractibility, memory, and judgment.

Three months after the motor vehicle accident, Mr. R's physician found Mr. R to show signs of a good recovery, and Mr. R successfully returned to work.

Mr. R filed in a civil action against the driver of the other vehicle. He claimed that the accident caused him to suffer significant cognitive impairment and depression. The defense attorney requested an independent psychiatric and neuropsychological evaluation.

Record review revealed that Mr. R was in special education and dropped out of school in the eleventh grade at age 18 years. When he was 28 years old, Mr. R was diagnosed with depression. His symptoms were only partially controlled with psychotherapy and pharmacotherapy. Six months prior to the motor vehicle accident, his symptoms were not well controlled.

On independent psychiatric examination, Mr. R was not forthcoming about his history of psychiatric treatment. On independent neuropsychological evaluation, Mr. R's scores on standardized measures of neuropsychiatric assessment were globally impaired; however, on each concurrently administered measure of effort, Mr. R's scores were repeatedly in the noncredible range.

The evaluators opined that Mr. R sustained a traumatic brain injury. As a result, he sustained a transient increase in his depressive symptoms but

was now back to baseline. Although it was possible that Mr. R had residual cognitive impairment from the accident, he grossly exaggerated and had a "fake-bad" profile on neuropsychological test measures, precluding valid data regarding his actual abilities.

Special Types of Examinations

Workers' Compensation Examination

In workers' compensation claims, there is a no-fault organization to the law that provides easier access to a specified amount of money for the injured worker but denies the injured party the opportunity to sue for damages (see Chapter 12, "The Workplace," this volume). The American Medical Association has published guidelines to the evaluation of permanent impairment. The vast majority of U.S. jurisdictions (46 states and the federal compensation system) mandate or recommend using the American Medical Association guidelines to evaluate workers' compensation claims. The guidelines only consider impairments for "selected well-validated major mental illnesses."

The psychiatrist strives to provide an independent, unbiased assessment of the individual's medical condition. When a mental disorder accompanies a physical impairment, the psychiatric issues are dealt with within the rating for physical impairment. When the mental disorder stands alone and is profound, the occupational impairment is clear. When the mental disorder is less severe, complicated by the potential of compensation through legal means, and/or conflated with preexisting maladaptive personality factors, assessment of occupational impairment presents a challenge.

The American Medical Association guide endorses the use of three scales to rate impairment resulting from a mental disorder: Brief Psychiatric Rating Scale (BPRS; Overall and Gorham 1962), Global Assessment of Functioning (GAF; Endicott et al. 1976), and Psychiatric Impairment Rating Scale (PIRS; Davies 2008). Psychiatric impairment is rated based on the presence of Axis I psychopathology. Axis II disorders are considered preexisting conditions and are not factored into impairment. Impairment ratings are one part of the assessment of disability. Ratings must be included in an assessment, as well as other concerns, including social, vocational, and avocational issues. The percentage of impairment ranges from normal (0%) to total dependence on others for care (90+%). The mechanism of impairment rating and case examples of rating impairment are provided in the American Medical Association guide and are beyond the scope of this chapter.

Department of Veterans Affairs Disability Examinations

The U.S. Department of Veterans Affairs provides comprehensive guidelines for disability examinations. Physicians employed or contracted by the Veterans Health Administration perform the examinations, which are then used to evaluate disability by the Veterans Benefits Administration. As of 2009, 57 separate worksheets describing disability examinations were available. Many of the separate exams can be and some must be performed by psychiatrists, including those entitled "Eating Disorders," "Mental Disorders," and "Initial and Review Examinations for PTSD" (U.S. Department of Veterans Affairs 2009).

As with other disability examinations, the focus of the examination is to determine whether an event or series of events that occurred during military service has contributed to disability and, if so, how much. Simply being in the military or in a war zone is usually not considered enough to qualify for a disability. Therefore, review of service records indicating the veteran's presence or participation in a traumatic event, medals and commendation documentation, and military and pre-military medical records that may indicate a preexisting condition are important.

Conclusion

The examination of psychic injury can be the most complex, challenging, and interesting forensic work that the psychiatrist may engage in. It requires skilled integration of clinical assessment, informed by record review and psychological or other test results. Having established the presence or absence of a mental disorder, the psychiatrist's task is to confront the questions that the court is interested in answering: did the action or event cause or exacerbate the plaintiff's psychiatric symptoms, and have those symptoms resulted or contributed to significant functional impairment?

The prognosis of the plaintiff is relevant to the injury claim, and the opinion of whether or not someone has a reasonable chance of recovery is in the purview of the psychiatric expert witness. Society has a great interest in the appropriate outcome of civil litigation. The social system—including tort litigation, insurance benefits, workers' compensation, and military disability benefits—is constructed to provide appropriate compensation to those who have been injured. Those who have not been injured or exaggerate their injuries diminish the economic vitality of the system and damage

the individuals the system has been created to reimburse. The independent psychiatric examiner should strive for objectivity.

Key Points

- Tort law provides a vehicle for an injured party to seek monetary damages.
- The psychiatric examiner should strive for objectivity.
- The forensic psychiatric examination has three parts: 1) record review, 2) psychological or other testing, and 3) the psychiatric interview.
- The psychiatric examiner should not write a psychiatric report unless requested to do so by the retaining attorney.
- Malingering is a consideration in personal injury litigation examinations.
- Personal injury litigation examinations include workers' compensation examinations and the Department of Veterans Affairs examinations. The psychiatric examiner should be familiar with the specific guidelines for these evaluations.

Practice Guidelines

1. Determine if the individual suffers from a mental disorder.
2. Opine whether the mental disorder was caused or exacerbated by the event or accident.
3. Determine in what ways the signs and symptoms of the mental disorder cause the individual to be impaired.
4. Opine on the individual's impairments.

References

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Adopted May 2005. Available at: http://www.aapl.org/ethics.htm. Accessed January 15, 2009.

American Medical Association: Glossary, in Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2009a

American Medical Association: Mental and behavioral disorders, in Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2009b, pp 347–382

American Medical Association: Pain-related impairment, in Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2009c, pp 31–46

American Medical Association: Practical application of the Guides, in Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2009d, pp 27–28

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Butcher JN, Dahlstrom G, Graham JR, et al: Minnesota Multiphasic Personality Inventory–2: Manual for Administration, Scoring, and Interpretation. Minneapolis, University of Minnesota Press, 1989

Carter v. GM, 361 Mich. 577 (1960)

Ciccone JR, Jones JCW: The forensic psychiatry report and criminal litigation, in The Psychiatric Report. Edited by Buchanan A, Norko M. Cambridge, UK, Cambridge University Press (in press)

Davies GR: The Psychiatric Impairment Rating Scale: is it a valid measure? Australian Psychologist 44:205–212, 2008

Dillon v Legg, 441 P.2d 912 (1968)

Endicott J, Spitzer RL: A diagnostic interview: the schedule for affective disorders and schizophrenia. Arch Gen Psychiatry 35:837–844, 1978

Endicott J, Spitzer RL, Fleiss JL, et al: The Global Assessment Scale: a procedure for measuring overall severity of psychiatric disturbance. Arch Gen Psychiatry 33:766–771, 1976

First MB, Spitzer RL, Gibbon M, et al: Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version: SCID-I. Washington, DC, American Psychiatric Press, 1997

Gutheil TG: The Psychiatrist as Expert Witness, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2009

Harrington R: On the tracks of trauma: railway spine reconsidered. Soc Hist Med 16:209–223, 2003

Larrabee GJ: Forensic Neuropsychology: A Scientific Approach. Oxford, UK, Oxford University Press, 2005

MacKinnon RA, Michels R, Buckley PJ: The Psychiatric Interview in Clinical Practice, 2nd Edition. Washington, DC, American Psychiatric Association, 2006

Millon T, Millon C, Davis R, et al: Millon Clinical Multiaxial Inventory–3 Manual, 3rd Edition. Minneapolis, MN, National Computer Systems, 2006

Morey LC: Personality Assessment Inventory: Professional Manual. Odessa, FL, Psychological Assessment Resources, 1991

Overall JE, Gorham DR: The Brief Psychiatric Rating Scale. Psychol Rep 10:799–812, 1962

Palsgraf v Long Island Railroad, 248 N.Y. 339 (1928)

Robins LN, Helzer JE, Croughan J, et al: National Institute of Mental Health Diagnostic Interview Schedule. Arch Gen Psychiatry 38:381–389, 1981

Sales BD, Shuman DW: Experts in Court: Reconciling Law, Science, and Professional Knowledge. Washington, DC, American Psychological Association, 2005

Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving both psychotherapist and expert witness. Am J Psychiatry 154:448–456, 1997

U.S. Department of Veterans Affairs: Compensation and pension benefits: index to disability examination worksheets. Available at: http://www.vba.va.gov/bln/21/Benefits/exams/index.htm. Updated December 9, 2009. Accessed January 15, 2010.

Weisaeth L: The European history of psychotraumatology. J Trauma Stress 15:443–452, 2002

Suggested Readings and Internet Resources

Gold LH, Davidson JE: Do you understand your risk? Liability and third-party evaluations in civil litigation. J Am Acad Psychiatry Law 35:200–210, 2007

McCaffrey RJ, Williams AD, Fisher JM, et al (eds): The Practice of Forensic Neuropsychology: Meeting Challenges in the Courtroom. New York, Plenum, 1997

Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts. New York, Guilford, 2007

Rogers R (ed): Clinical Assessment of Malingering and Deception, 3rd Edition. New York, Guilford, 2003

Rogers R (ed): Principles and Practice of Forensic Psychiatry, 2nd Edition. London, Arnold, 2003

Simon RI (ed): Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Clinicians, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2002

Slovenko R: Psychiatry in Law/Law in Psychiatry, 2nd Edition. Florence, KY, Routledge Press, 2009

Sweet JJ: Forensic Neuropsychology: Fundamentals and Practice. Lisse, Swets & Zeitlinger, 1999

Young G, Kane AW, Nicholson K: Causality of Psychological Injury: Presenting Evidence in Court. New York, Springer, 2007

Internet Resources

American Academy of Psychiatry and the Law. Access to Ethics Guidelines for the Practice of Forensic Psychiatry, Landmark Cases, at www.aapl.org

Cornell University Law School Legal Information Institute. Resource for legal definitions, including workers' compensation and negligence, at http://topics.law.cornell.edu

National Academy of Neuropsychology. Associated with the American Psychological Association, a resource for information on neuropsychological testing, at www.nanonline.org

U.S. Department of Veterans Affairs. Code of Federal Regulations Title 38, Book C: Schedule for Rating Disabilities, at http://www.warms.vba.va.gov/bookc.html

Chapter 11

Disability

Albert M. Drukteinis, M.D., J.D.

Determining disability is the most common task of forensic psychiatry performed by the practicing clinician. Routinely, clinicians are asked by patients to authorize brief or extended periods away from work because of mental symptoms. Clinicians are also typically the ones to offer initial opinions about a patient's permanent disability.

Such psychiatric disability claims are frequent and not likely to diminish. The National Institute of Mental Health Epidemiologic Catchment Area Program and the National Comorbidity Survey have estimated 1-year mental and addictive disorder prevalence rates approaching 30% and lifetime rates approaching 50% (Kessler et al. 1994; Regier et al. 1984). Most individuals with mental disorders are employed, and significant numbers of those with serious mental disorders are also employed at various times in their lives (Erickson and Lee 2008; Jans et al. 2004). Not surprisingly, psychiatric disturbances have become the largest single reason for disability awards by the U.S. Social Security Administration, accounting for 22% of all claims (Leo 2002). More than one-half of all disability recipients have a mental disorder (Kochlar and Scott 1995). Psychiatric disability claims are estimated to cost about $150 billion a year (Sederer and Clemens 2002).

In addition to Social Security disability claims, clinicians are often asked to provide opinions on short-term and long-term disability for private insurance, workers' compensation, personal injury claims, military veterans' benefits, state and federal employees' disability retirement programs, accommodations under the Americans With Disabilities Act, fitness for duty eval-

uations, and incapacity under the Family and Medical Leave Act. Often these claims are accompanied by additional issues of causation, work-relatedness, service connection, or specific occupational impairment. However, ultimately, work capacity remains the central determinant of damage or functional ability for which claims are brought and for which the clinician who treats the patient is routinely asked for input.

Therefore, clinicians can expect to confront disability issues as a routine part of their practice and should learn ways to provide objective opinions and avoid common pitfalls in the process. In forensic psychiatry, the issue of objectivity is so crucial that the *Ethics Guidelines for the Practice of Forensic Psychiatry* of the American Academy of Psychiatry and the Law recommends that the psychiatrist not serve as both treating clinician and forensic evaluator (American Academy of Psychiatry and the Law 2005). Practically, however, disability issues arise so frequently in the course of treatment that the clinician would find it impossible to recommend an independent forensic evaluation in every instance, despite recognizing that providing disability evaluations may at times raise questions about his or her objectivity.

My purpose in this chapter is to provide a basic guideline for the treating clinician, both to assess a patient's disability objectively and to understand the inherent limitations of serving in both roles. More in-depth coverage of this topic is now available in the American Academy of Psychiatry and the Law (AAPL) *Practice Guideline for the Forensic Evaluation of Psychiatric Disability* (Gold et al. 2008). In addition to a detailed analysis of disability assessment, it addresses specialized areas of disability evaluation, for example, evaluations for ability to continue working, with or without request for accommodation. Here, I begin with a case vignette that demonstrates some of the key points in disability determinations that apply to the practicing clinician.

Case Vignette

Mr. G is a 58-year-old practicing trial attorney who is claiming disability because of depression. Shortly before being referred for outpatient psychiatric treatment, Mr. G was admitted to the psychiatric unit of the local community hospital with severe suicidal ideation. He reported that he had been very depressed and had symptoms of decreased appetite and weight loss, sleep disturbance, difficulty concentrating, withdrawal from family and friends, anxiety, and anger outbursts. Mr. G was diagnosed as having recurrent, severe major depressive disorder without psychotic features.

Mr. G had a previous history of depression while in law school, for which he received counseling and a brief course of antidepressant medication. He had no other psychiatric or psychological treatment in his life. He has used alcohol regularly, more in recent months in conjunction with marital problems. Two weeks before his admission to the psychiatric unit, his wife left him, claiming that his time away from home and inattentiveness to her be-

cause of his practice had made her life miserable. With their children grown and out of the house, she claimed that she could no longer live with him.

During his 6-day hospitalization, Mr. G was placed on an antidepressant medication and directed to Alcoholics Anonymous meetings. A joint counseling session with his wife confirmed her lack of interest in maintaining the relationship. In therapy, Mr. G discussed being overwhelmed by his law practice, his inability to concentrate, his difficulty meeting a demanding schedule of depositions and trials, and his problem facing the daily stress of an adversarial process. He reported becoming panicked when anticipating a court appearance.

Mr. G's treatment team at the hospital recommended that he not return to the same work. They suggested that he apply for Social Security Disability Insurance benefits as well as benefits under a personal disability insurance policy.

Defining Disability

A mental disorder does not automatically equate to disability. As elementary as that sounds, misconception about this principle is the main source of errors in disability evaluations. The authors of the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment,* 6th Edition (American Medical Association 2008), make a distinction between impairment and disability. *Impairment* is defined as "a significant deviation, loss, or loss of use of any body structure or body function, in an individual with a health condition, disorder, or disease" (p. 5). Such alteration of an individual's health status is assessed by medical means. In contrast, *disability* is defined as "activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease" (p. 5). Disability is said to be assessed by medical and nonmedical means. Therefore, a mental disorder may or may not result in an impairment, and an impairment may or may not result in a disability.

Despite their distinction, the terms *impairment* and *disability* are often used interchangeably. For example, once a medical opinion is offered about *work* impairment, more than a medical consideration has been made, given that the nature of the work must be understood from the nonmedical facts that are available. In addition, although the final determination of disability is made by a fact-finder (e.g., the court, a governmental agency, an insurance company panel), medical opinions on disability are not necessarily inappropriate. Routinely, medical opinions are offered on disability, including both its degree and expected duration (Drukteinis 2002). Again, however, the determination of disability requires more than a medical consideration of symp-

toms and health status. How and why the capacity to meet an occupational demand has been altered must be identified.

Although the AMA *Guides to the Evaluation of Permanent Impairment*, 5th Edition (American Medical Association 2001), lists several categories of impairment in the chapter for "Mental and Behavioral Disorders," it specifically does not provide percentage estimates of mental impairments, indicating, "There are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist" (p. 361). To circumvent this in jurisdictions where a percentage impairment was required, evaluators were forced to use analogous impairment rating systems found elsewhere. The AMA *Guides,* 6th Edition (American Medical Association 2008, p. 349), has now modified its position to include percentage impairment ratings for the following limited diagnoses:

- Mood disorders, including major depressive disorder and bipolar affective disorder
- Anxiety disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive-compulsive disorder
- Psychotic disorders, including schizophrenia

The premise is that in serious mental illnesses, occupational impairment is obvious, whereas it is more difficult to assess in more subtle conditions in which litigation or personality factors may coexist. The following disorders are specifically not ratable by a percentage impairment in the AMA *Guides,* 6th Edition (American Medical Association 2008, pp. 358–360):

- Psychiatric reactions to pain
- Somatoform disorders
- Dissociative disorders
- Personality disorders
- Psychosexual disorders
- Factitious disorders
- Substance use disorders
- Sleep disorders
- Mental retardation
- Neurologically based conditions (which are covered in the chapter titled "The Central and Peripheral Nervous System," American Medical Association 2008, p. 349)

The *AMA Guides,* 6th Edition, also has revised the categories of impairment for mental and behavioral disorders to now include the following:

- Self-care, personal hygiene, and activities of daily living
- Role functioning and social and recreational activities
- Travel
- Interpersonal relationships
- Concentration, persistence, and pace
- Resilience and employability

The actual method of arriving at a psychiatric impairment rating in the AMA *Guides,* 6th Edition, is based on a median, or middle, value of percentages derived from the Brief Psychiatric Rating Scale (Hedlund and Vieweg 1980; Overall and Gorham 1988); the Global Assessment of Functioning Scale from the *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition, Text Revision (American Psychiatric Association 2000); and the Psychiatric Impairment Rating Scale found in the *Guides* (pp. 356–360). The Psychiatric Impairment Rating Scale involves first assigning a numerical value of impairment from 1 to 5 in each of the categories of psychiatric impairment and then computing a percentage. Where clinicians are required to provide a percentage of psychiatric impairment, careful reading and study of the AMA *Guides,* 6th Edition, are highly recommended (American Medical Association 2008).

However, one should not assume that in the jurisdiction where a clinician practices, percentage ratings for mental disorders are allowed or that the *AMA Guides,* 6th Edition, is recognized as the means to arrive at a rating. In addition, clinicians should be careful not to blur physical and psychiatric impairment in an attempt to demonstrate the patient's overall functional limitation. Physical impairment ratings should be assessed separately by medical specialists and not by psychiatrists.

Therefore, in the case of Mr. G, a percentage rating for psychiatric impairment may not be required or acceptable, for either Social Security Disability Insurance or a personal disability insurance policy, both of which have their own categories of impairment and may rely simply on descriptive language rather than percentages (see discussion later in this chapter). On the other hand, if Mr. G also applied for workers' compensation benefits, based on, for example, unreasonable stress placed on him by his law firm, a percentage rating might be applicable in some jurisdictions, and this should be determined before providing an opinion. In addition, if Mr. G also complained of increasing back pain because of degenerative disc disease, which he believed prevented him from carrying briefcases or enduring the physical strain of a long trial, it would be important to limit as much as possible the opinions and percentage impairment ratings that stemmed from the psychiatric portion of his condition and not from the direct consequence of his pain.

Disability determinations for the U.S. Social Security Administration (SSA) involve their own set of rules. The SSA, the largest supplier of disability ben-

efits in the country, offers benefits through Social Security Disability Insurance, supported by funds obtained from an individual's prior work (Federal Insurance Contributions Act), and through Supplemental Security Income, supported by revenued funds of the U.S. Treasury to individuals who have limited or no prior work history. For SSA purposes, a disabling psychiatric condition is one that renders an individual unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (42 U.S.C. Sec. 423(d)(1)(A)2006). The following are types of mental conditions that may qualify for Social Security benefits (Krajeski and Lipsett 1987; Leo 2002):

- Organic mental disorders
- Schizophrenic, paranoid, and other psychotic disorders
- Affective disorders
- Mental retardation
- Anxiety-related disorders
- Somatoform disorders
- Personality disorders
- Substance addiction disorders
- Autistic disorder and other pervasive developmental disorders

With regard to the mental impairment that may flow from those conditions, the following are categories of impairment that are assessed (Leo 2002; Social Security Administration 1986):

- Marked restriction in activities of daily living
- Marked difficulties in maintaining social functioning
- Deficiencies of concentration, persistence, or pace, resulting in frequent failure to complete tasks in a timely fashion in work settings
- Repeated episodes of deterioration or decompensation in work or work-like settings that cause the individual to withdraw from the situation or to experience an exacerbation of signs and symptoms (which may include deterioration of adapted behaviors)

Although the clinician may provide opinions on these impairments, the ultimate determination of disability is based increasingly on vocational considerations, that is, nonmedical factors, rather than on the nature and level of impairment. The clinician is not asked or expected to determine whether the patient is disabled but only to report on the mental disorder and level of impairment. As indicated, the SSA requires that an applicant be unable to en-

gage in work for substantial gain for at least 12 months. This means that the individual cannot work at all or, if age 55 years or older, is unable to perform past relevant work (Leo 2002). With regard to Mr. G, his claimed mental condition, major depressive disorder, would fall in the category of affective disorders; if it can be shown that he had impairment or deficiency, for example, in the impairment category of deficiencies of concentration, persistence, or pace, he may qualify for Social Security benefits. In addition, because Mr. G is 58 years old, he does not have to be impaired from all work but only past relevant work in order to qualify.

Workers' compensation disability is based on injuries or illnesses that arise from and in the course of employment. Liability on the part of the employer does not have to be shown, and psychiatric impairment generally falls under three types of claims: 1) physical-mental, 2) mental-physical, and 3) mental-mental (Gold et al. 2008). In some jurisdictions, impairment is assessed using the AMA *Guides,* 5th Edition, or AMA *Guides,* 6th Edition, including a percentage of impairment rating. In other jurisdictions, percentages are not used or required, and variable categories of impairment are addressed (Gold et al. 2008). Workers' compensation claims are also broken down further according to their degree and likely duration as follows (Metzner et al. 1994):

- Temporary partial disability
- Temporary total disability
- Permanent partial disability
- Permanent total disability

Depending on the type of mental disorder an individual has, a temporary disability may be understandable, but a permanent one would not be expected. Similarly, a given mental disorder may cause an individual to be disabled from one type of work but not another or prevented from working full time but not part time (one of the most common opinions provided by clinicians is that the patient can only work part time). Such opinions may be reasonable, but only if they are formed from a complete understanding of the specific nature of the individual's work duties. As discussed, Mr. G. is not claiming a work-related disability, only that he cannot perform that type of work any longer. Where claims of workers' compensation are made, it is often difficult to know which came first: a disorder that leads to work-related problems or work-related problems that lead to the disorder.

Another system of classifying disability was developed by an advisory committee for workers' compensation in California. The results of the committee's efforts have often been used by private disability insurance companies (Enelow 1991). In this system, the degree of disability is determined by assessing the individual's ability to do the following:

- Comprehend and follow instructions
- Perform simple and repetitive tasks
- Maintain a work pace appropriate to a given workload
- Perform complex or varied tasks
- Relate to other people beyond giving and receiving instructions
- Influence people
- Make generalizations, evaluations, or decisions without immediate supervision
- Accept and carry out responsibility for direction, control, and planning

Private disability insurance policies typically define disability narrowly as an inability to perform the work functions of the job the insured person had when he or she incurred the disability. For example, a social worker who practices psychoanalytic psychotherapy might be disabled if he or she can no longer practice this type of therapy, even if he or she can do other social work. Similarly, a vascular surgeon might be disabled even if he or she can practice another area of medicine. In the case of Mr. G, he may have difficulty in obtaining Social Security Disability Insurance benefits because he would have to be totally disabled from any past relevant work for a year. However, if he had private disability insurance, he might be eligible for benefits if he could no longer practice as a trial attorney. Whether Mr. G is, in fact, so impaired that he is partially or totally disabled requires a comprehensive and objective assessment.

The Assessment

The various classification systems for impairment that have so far been discussed, and others that may be used throughout the United States, show considerable overlap but also offer unique parameters for evaluation. The most important point to recognize in performing assessments of disability is that these classification systems provide a means of reporting impairment but not a means of actually assessing it. Even the Global Assessment of Functioning Scale on Axis V in DSM-IV-TR (American Psychiatric Association 2000) only provides a means of reporting impairment. For example, a Global Assessment of Functioning Scale score of 41–50 connotes serious symptoms or a serious impairment in social, occupational, or school-related functioning. A person's inability to keep a job would certainly garner a score in the 41–50 range and might offer a way of quantifying his or her level of impairment, but the scale itself does not help in *making* the assessment of whether the

person was, in fact, unable to keep the job, as opposed to merely not keeping it (Drukteinis 2002).

In the case of Mr. G, he reports an inability to concentrate as he should to work as a trial attorney and difficulty meeting a demanding schedule of depositions and trials. These symptoms could certainly qualify for impairment under the AMA *Guides* in the category of deficiencies of concentration, persistence, and pace. But how does the clinician know that Mr. G was, in fact, unable to concentrate as he says or that he had difficulty meeting a schedule of depositions and trials? Is it really possible to determine this by speaking to him in the office? How much does the clinician know about his actual schedule and whether or not he was keeping up with it in spite of his symptoms? It may be possible through a mental status examination to observe Mr. G's sluggish thought processes and infer that he would have difficulty concentrating as a trial attorney, but would these inferences be objective? Even if he appeared to have difficulty concentrating at the time of the mental status examination, can this performance be generalized to say that he will have this impairment indefinitely?

When Mr. G says he cannot face the stress of an adversarial process, how is it determined whether this is true? Is the mere fact of his depression enough? Is the clinician relying on an assumption that the adversarial process must be stressful? What facts support Mr. G's claim? If he says that he has turned back at the courthouse steps because he could not face going to trial, this can be reported under the SSA category of impairment, which lists decompensation in a work-like setting that causes the individual to withdraw—but is it known if, in fact, this occurred? Were Mr. G's symptoms the actual reason for his behavior?

Most of the time, clinicians make an assessment of disability that is based on the diagnosis of a sufficiently severe mental disorder and on their intuition about the credibility of the patient's self-reports. This method may have merit, but it is not particularly objective and typically relies on very scanty information about functioning and vocational abilities. In addition, because of the subjective nature of mental disorders and the investment of the patient in gaining disability status, self-reports of impairment may not be reliable. Even when those reports are reliable, they can never address the totality of the circumstances and tend to be anecdotal. Without following individuals in their everyday lives and monitoring their activities, it is impossible to completely understand their actual functioning. In that sense, all assessments of disability are only an approximation. The approximation can be made more reliable, however, by probing categories of function in detail, seeking clear examples of impairment, obtaining reliable corroboration, understanding the nature of the patient's work, using confirming clinical tools, and eliminating alternative explanations for disability claims.

Because a mental disorder does not equate to disability, clinicians should take extra steps after making a diagnosis to address whether there is a disability. Conclusory statements of the patient, such as "I can't take the stress of work anymore" or "I can't seem to function," should not be accepted at face value. The circumstances, degree, frequency, and context of those conclusory statements must be ascertained. Using the categories of functioning outlined in the AMA *Guides* or by the SSA is a reasonable way to start. The questioner should dissect each category in some detail, seeking specific examples. If the patient is unable to give reliable examples of impairment, is evasive, or can only discuss impairment in vague generalities, then he or she has not sufficiently demonstrated an impairment or disability. In contrast, concrete examples of impaired function can be compelling and are less likely to be contrived.

Corroboration of a disability can be either internal (i.e., directly heard or observed by the evaluator) or external (i.e., from outside sources, such as reports of family, friends, employers, or other witness observations). A clinician who is conducting a complete psychiatric evaluation of disability should also seek corroboration from medical and psychiatric records, employment files, and tax returns, all of which could help chronicle a person's functioning. Because a clinician may not have access to all of this information, he or she should be aware that an opinion on disability may have only a limited foundation. The reliability of all sources of information must also be taken into account. For example, family members may be as invested in a disability claim as the person asserting it and may distort the patient's mental symptoms in support of the claim. However, especially in adversarial situations such as personal injury litigation or workers' compensation, an employer or other party may be biased against a claim of disability and provide misleading information to suggest that the claim is fabricated. The inherent bias of all informants as well as the consistency of reported information must be scrutinized.

One method of obtaining internal corroboration from the patient is to survey a typical day in the patient's life. Tracing the day, hour by hour, can sometimes reveal areas of preserved functioning that demonstrate the potential for work or rehabilitation. Questioning a person in detail about his or her typical day makes it more difficult for the person to rely on sweeping descriptions of impairment. The person's hobbies, recreation, and social interactions can be rich sources of information. A full schedule of personal activities can demonstrate a lack of credible impediment to work. The absence of any activity may reveal someone who is passively accepting an invalid role.

In order to understand whether a patient is able to work or not in his or her job, there must be an adequate understanding of the nature of the job.

Often, assumptions about a patient's job are poorly founded or based on stereotypes. Patients may also sometimes misrepresent their work duties or overemphasize those duties that are particularly strenuous. Speaking to the employer, with the patient's permission, may reveal a more balanced description of what the work entails. It may also lead to an awareness of possible accommodations for the patient's mental disorder or opportunities for modified work duties. A formal job description may also be helpful. In Mr. G's case, practicing as a trial attorney sounds stressful, but when did it actually become stressful for him and why? How many depositions and trials was he facing? What income did he generate? Was he part of a law firm where there was collegial support? Is there a way to modify his work?

Clinical tools can also help objectify impairment so that an opinion is not based solely on a patient's self-report. A carefully performed mental status examination or a battery of psychological tests may reveal cognitive impairment, severity of clinical complaints, vulnerability to fragmentation under stress, exaggeration, and other useful impairment parameters. Clinical observation can also provide a wealth of information. A dramatic or histrionic presentation or one that is inconsistent with the history of complaints can raise doubt about the severity of the mental disorder. An angry, belligerent presentation can at times lead a clinician to conclude that the patient is very symptomatic, when it actually represents a defensive posture to avoid scrutiny. A patient's ease during the clinician's interview and in conversation, as well as more formal testing of mental processes, may suggest proper cognitive functioning despite claims to the contrary.

In Mr. G's case, he may present as sullen, withdrawn, and depressed, consistent with his diagnosis, but is this the presentation he maintains in his personal life, or just when he meets with the clinician? Will psychological testing demonstrate symptom exaggeration or manipulative personality traits that could cast doubt on his self-reports?

Finally, to make an objective disability assessment, the clinician must consider alternative explanations to the patient's disability claim. The most common alternative explanation to claims that are poorly supported is that the individual is choosing not to work rather than being unable to work. Because of the subjective nature of mental disorders, this is not an easy distinction for the clinician or any other evaluator to make; there is no bright line separating these two scenarios. Rather, choosing not to work and being unable to work due to impairment lie on opposite sides of a continuum in which both may be operative; it is the task of the evaluator to assess which is the more substantial factor. The best tool in this process is an accurate and reliable longitudinal history, tracing the evolution of the claimed impairment in relationship to the individual's working life. For example, did Mr. G first become depressed and then unable to work? If so, was there a time when he

was able to work through the depression? Why did the treatment he was receiving at that time fail to help him? Are there reasons why Mr. G would no longer want to pursue his trial practice, irrespective of the depression? Did he make plans to leave his profession because of personal preference prior to the depression becoming more severe? Does his age suggest an interest in early retirement?

Confounding Factors

Among the confounding factors facing the clinician in performing disability assessments, the thorniest is the potentially damaging effect on the therapeutic alliance. Can a clinician give an objective opinion on disability when the patient is convinced that disability exists and is expecting a favorable disability opinion? For example, if a clinician has been treating Mr. G for a period of time and his or her opinion on disability is now unfavorable, will Mr. G continue in therapy with that clinician? Will he regress because he has lost his trust in the clinician or has suffered a financial setback?

Because of the therapeutic alliance, most clinicians are prone to give their patients the benefit of the doubt. A variety of clinician attitudes and countertransference dynamics may also enter into the decision-making process (Mischoulen 2002). Among these are judgments about the patient's character and work ethic, feelings of envy or disgust, hostility, identification with the patient, and rescue fantasies. A clinician should attempt to recognize these potential biases in assessing disability and minimize their effect.

If an opinion on disability is favorable to the patient, then, at least in the short run, the therapeutic alliance may be strengthened and legitimate financial security for the patient achieved. If the opinion on disability is unfavorable, communicating this to the patient can be part of the therapeutic process (Mischoulen 2002). The clinician should address the underlying psychological issues leading to the patient's misperception of disability, taking care to do so in a nonjudgmental way and recognizing that the patient may genuinely perceive that he or she is disabled. It should be noted that an opinion *in favor of* disability may be considered by some patients to be *unfavorable,* given that they may not want to consider themselves disabled and will insist on continuing to work even when a mental disorder is creating a significant impairment.

An alternative method of dealing with an unfavorable opinion is to limit reporting to the diagnosis and claimed symptomatology, forgoing any conclusions about work impairment or disability. This allows the administrative

fact-finder to make the determination. This is not unlike what the SSA, for example, expects anyway. However, the method often falls short of what is sought by the inquiring party and may leave the patient stranded without the clinician's support.

In addition to the clinician's possible concern for the therapeutic alliance, malingering, symptom exaggeration, and secondary gain are other potential confounding factors in a disability claim and should be considered in the assessment. Malingering, as defined by DSM-IV-TR, is the intentional production of false or grossly exaggerated symptoms for an external incentive, such as disability payments (American Psychiatric Association 2000). The actual incidence of outright malingering is not clear, although some estimates have been as high as 30% (Mittenberg et al. 2002; Resnick 2003).

Years ago, it was already suggested that to be reasonably certain that someone is malingering almost requires an admission of faking or an observation of flagrant contradiction to claims of impairment (Hurst 1940). Neither occurs often, and making the diagnosis of malingering inevitably has a pejorative effect. On the other hand, symptom exaggeration and magnification are common and may be unintentional, substantially unintentional, or at least partially unintentional.

DSM-IV-TR indicates that among factors that could lead to the suspicion of malingering is the presence of antisocial personality disorder (American Psychiatric Association 2000). However, it is more likely that a potential sociopathic effect on disability claims is on a continuum and is parallel to symptom exaggeration and malingering (Drukteinis 2008), so the actual diagnosis of antisocial personality disorder may be less relevant. What is relevant, though, is assessing to what degree symptoms are genuine versus exaggerated, whether impairment from symptoms is substantial versus minimal, and how much can be attributed to being unable to work versus choosing not to work. Without evidence to the contrary, it is far better to explain to patients that their symptoms are inconsistent or without an adequate objective basis rather than to call them malingerers or, in effect, liars.

Because disability benefits influence the reporting and perhaps the experiencing of symptoms (Gold et al. 2008; Lloyd and Tsuang 1985; Perl and Kahn 1983), the potential for secondary gain should always be considered. *Secondary gain* refers to those possibly unexpected environmental responses to being sick that assist in reinforcing symptoms. Examples include financial reimbursement, attention from the family, or avoidance of less-than-satisfactory work conditions.

In the case of Mr. G, secondary gain issues suggest that clinicians explore his level of income prior to becoming depressed and claiming work impairment. Will his disability benefits be substantially the same? Are there reasons why not practicing as a trial attorney would be desirable for him, whether or

not he is depressed? Is he looking for a new career or overly involved with some avocation?

One way to assess the potential for symptom exaggeration or secondary gain is to explore whether there have been any rehabilitation efforts by the patient that might demonstrate the patient's motivation toward recovery. Another way is to investigate whether the decision about a disability claim, especially long-term disability, was made before a full treatment effect was known. For example, for Mr. G to have precipitously decided that he will never again practice as a trial attorney, after only a few days of hospitalization, suggests an inadequate opportunity to see the effects of longer treatment and a lack of consideration of his ability to return to work part time or in a modified capacity. In addition, questions should be raised if Mr. G has not complied with prescribed medication, has missed appointments for treatment, or is only seeking infrequent follow-up treatment.

Distortions in a patient's actual condition can also unwittingly be caused by the clinician, who at times can induce or reinforce disability, stymieing the patient's recovery and reinforcing an invalid role. Such a distortion can be as simple as overpathologizing someone's condition. It can also occur if the clinician prematurely supports a disability claim or extends it to the point that the patient cannot recover the initiative or energy to reenter the workforce. In addition, medication side effects can also create impairments and should be regularly reevaluated for their potential role in maintaining invalidism. However, there is little justification for a primary work impairment to be a side effect of medication. These iatrogenic factors can lead to a chronic, mutually reinforcing concept of invalidism between patient and clinician. Over the course of such long-term treatment, the perpetual focus on illness and impairment becomes a self-fulfilling prophecy (Seligman 2002).

Disability and Specific Mental Disorders

Although patients with even very severe mental disorders can often work in a limited capacity or in a sheltered setting, certain disorders clearly are more likely to result in work impairment. Psychotic conditions such as schizophrenia or severe bipolar disorder routinely lead to major impairment in social and occupational functioning. Similarly, certain chronic anxiety and depressive disorders that are unresponsive to treatment can be disabling, if not from all work, then perhaps for the type of work that the patient was for-

merly capable of doing. Posttraumatic stress disorder, which is the subject of much litigation involving disability claims, is known to produce chronic and long-lasting symptoms. It may be quite disabling for people who do certain types of work, particularly if the trauma occurred in a work-like setting. However, there are few objective data to support chronic total disability from posttraumatic stress disorder (Drukteinis 2002).

Somatoform disorders present a unique conundrum in disability claims, in that the impairment is purportedly due to physical symptoms but the underlying pathogenesis is substantially psychological. In some of these cases, such as chronic pain disorders, a peculiar disability issue has emerged. Although the disability is said to be caused by physical symptoms and is not, therefore, technically a mental health issue, a secondary psychological reaction is asserted as an independent impairment (Drukteinis 2000). So, for example, patients may claim disability due to back pain, but the medical evidence shows that a sedentary work capacity is still possible. Then, with what amounts to circular logic, patients say that it is their depression caused by an inability to work that makes them totally disabled. This scenario is often seen in situations where percentage ratings of permanent impairment are required as part of settlement negotiations.

Even more controversial are disability claims for addictive and personality disorders (Frisman and Rosenheck 2002). Should disability be granted for an individual's maladaptive behaviors, or are these conditions over which an individual has no control? Political, philosophical, public policy, and social science considerations have been involved in this controversy, with often contradictory research results. Practically, however, if a period of disability can be used to help with psychological growth and recovery even in these conditions, it may very well be justified. Permanent disability, on the other hand, should be more carefully examined.

In general, disability determinations should take into account the natural course of a mental disorder, the expected effects of adequate treatment, and a realistic prognosis. Work, by and large, is healthy and restorative for most people, even those with mental disorders, and should be encouraged. Disability, in contrast, can have an eroding effect on the individual. As a consequence, opinions about disability should be judiciously considered and sparingly made. It may be that Mr. G cannot practice as a trial attorney any longer because his age and increased vulnerability to depression make placing him in a high-stress work environment undesirable. However, Mr. G's years of practice as a trial attorney were a resource for not only financial reward but also replenishment of self-esteem. Where is he to find that now if he remains totally disabled? Can he find a new source for intellectual stimulation and challenge? Every type of work has its drawbacks, stresses, and negative aspects, but the net product of Mr. G's practice may have been more

valuable to him than he realizes. From the standpoint of his own recovery from depression, it should not be taken away casually.

Conclusion

Disability determination is particularly challenging for the clinician and is an area of forensic psychiatry that probably cannot be avoided. Clinicians should refer to accepted categories of potential impairment in addition to reporting symptoms and making a diagnosis. Assessing whether an impairment exists according to these categories is difficult, but it can be accomplished by a careful and detailed survey coupled with reliable corroboration. Disability must be demonstrated, not just presumed. The therapeutic alliance with the patient and its accompanying bias are challenging, but they are not insurmountable. If disability status can be seen as providing both a benefit and potential harm to the patient, then a more objective judgment will be easier to make and communicate to the patient as part of the therapeutic process.

Key Points

- A mental disorder does not automatically equate to a disability.
- Disability determinations must involve nonmedical and vocational considerations.
- Disability must be demonstrated, not presumed.
- All disability determinations are an approximation, given that it is impossible to completely know a person's functioning.
- Therapeutic alliance and countertransference issues can create an inherent bias for the clinician when evaluating patients for disability.
- Disability benefits can be an important safety net for a patient with a mental disorder, but they can also have an eroding effect that is unhealthy.

Practice Guidelines

1. Address the various categories of function that can result in disability, in addition to diagnosing a mental disorder and assessing its severity.
2. Take into account the natural course of the mental disorder, the expected effect of adequate treatment, and a realistic prognosis.
3. Ensure that the patient convincingly demonstrates impairment by asking him or her to provide specific examples rather than generalized assertions of incapacity.
4. Enhance disability determinations by probing categories of function in some detail, obtaining reliable corroboration, understanding the nature of the individual's work, using confirming clinical tools, and eliminating alternative explanations for the disability claim.
5. Consider if and to what degree choosing not to work, rather than being unable to work, is motivating the disability claim.

References

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry (adopted May 1987; revised October 1989, 1991, 1995, and 2005). Bloomfield, CT, American Academy of Psychiatry and the Law, 2005

American Medical Association: Guides to the Evaluation of Permanent Impairment, 5th Edition. Edited by Cocchiarella L, Landersson GBJ. Chicago, IL, American Medical Association, 2001

American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2008

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Drukteinis AM: Overlapping somatoform syndromes in personal injury litigation. Am J Forensic Psychiatry 21, 4:37–66, 2000

Drukteinis AM: Disability determination in PTSD litigation, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002, pp 67–190

Drukteinis AM: Disability and sociopathy, in International Handbook of Psychopathic Disorders and the Law. Edited by Felthous A, Sass H. Chichester, UK, Wiley, 2008, pp 137–154

Enelow AJ: Psychiatric disorders and work function. Psychiatric Annals 21:27–35, 1991

Erickson W, Lee C: 2007 Disability Status Report: United States. Ithaca, NY, Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics, 2008

Frisman LK, Rosenheck R: The impact of disability payments on persons with addictive disorders. Psychiatr Ann 3:303–307, 2002

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL Practice guideline for the forensic evaluation of psychiatric disability. J Am Acad Psychiatry Law 36 (suppl 4):S3–S50, 2008

Hedlund JL, Vieweg BW: Brief Psychiatric Rating Scale: a comprehensive review. J Operational Psychiatry 11:48–65, 1980

Hurst AF: Medical Diseases of War. London, Arnold, 1940

Jans L, Stoddard S, Kraus L: Chartbook on Mental Health and Disability, An InfoUse Report. Washington, DC, U.S. Department of Education, National Institute on Disability and Rehabilitation Research, 2004

Kessler RC, McGonagle KA, Zhao S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psychiatry 51:8–19, 1994

Kochlar S, Scott CG: Disability patterns among SSI recipients. Soc Secur Bulletin 58(1):3–14, 1995

Krajeski J, Lipsett M: The psychiatric consultation for Social Security Disability Insurance, in Psychiatric Disability: Clinical, Legal, and Administrative Dimensions. Edited by Meyerson AT, Fine T. Washington, DC, American Psychiatric Press, 1987, pp 287–311

Leo RJ: Social Security disability and the mentally ill: changes in the adjudication process and treating source information requirements. Psychiatr Ann 32:284–292, 2002

Lloyd DW, Tsuang MT: Disability and welfare—who wants it? J Clin Psychiatry 46:273–275, 1985

Metzner JL, Struthers DR, Fogel MA: Psychiatric disability determination and personal injury litigation, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. London, Arnold, 1994, pp 232–241

Mischoulen D: Potential pitfalls to the therapeutic relationship arising from disability claims. Psychiatr Ann 32:299–307, 2002

Mittenberg W, Patton C, Canyock EM, et al: Base rates of malingering and symptom exaggeration. J Clin Exp Neuropsychol 24:1094–1002, 2002

Overall JE, Gorham DR: Brief Psychiatric Rating Scale: recent developments in ascertainment and scaling. Psychopharmacol Bull 24:97–99, 1988

Perl J, Kahn M: The effects of compensation on psychiatric disability. Soc Sci Med 17:439–443, 1983

Regier DA, Meyers JK, Kramer M, et al: The NIMH Epidemiologic Catchment Area Program: historical context, major objectives, and study population characteristics. Arch Gen Psychiatry 41:934–941, 1984

Resnick PJ: Guidelines for evaluation of malingering in PTSD, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2003, pp 187–205

Sederer LI, Clemens NA: The business case for high-quality mental health care. Psychiatr Serv 53:143–145, 2002

Seligman MEP: Authentic Happiness. New York, Free Press, 2002

Social Security Administration: Disability Evaluation Under Social Security (SSA Publ No 64-039). Washington, DC, U.S. Government Printing Office, 1986

Suggested Readings

American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th Edition. Edited by Rondinelli RD. Chicago, IL, American Medical Association, 2008

Bonnie RJ (ed): Mental Disorder, Work Disability and the Law. Chicago, IL, University of Chicago Press, 1997

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability. J Am Acad Psychiatry Law 36 (suppl 4):S3–50, 2008

Liberman RP: Recovery From Disability: Manual of Psychiatric Rehabilitation. Washington, DC, American Psychiatric Publishing, 2008

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Chapter 12

The Workplace

Liza H. Gold, M.D.

Forensic psychiatrists and psychologists are called on with increasing frequency to offer expert opinions regarding medicolegal issues in legal and administrative claims relating to the workplace. Psychiatric testimony may form the crux of arguments regarding causation, damages, and eligibility for benefits, as well as other issues that may affect the outcome of a claim or litigation. For example, mental and emotional injuries constitute the bulk of exposure in much federal and civil litigation related to employment claims (Lindemann and Kadue 1992; McDonald and Kulick 2001). Virtually every federal employment discrimination lawsuit contains an allegation that the plaintiff suffered mental and emotional distress at the hands of the defendant employer (McDonald and Kulick 2001). Eligibility for public and private insurance benefits or workers' compensation benefits may hinge on a claim of psychiatric illness or disability as certified by an independent psychiatric evaluation.

An individual's relationship with his or her workplace is as complex as the laws, agencies, regulations, and contracts that govern the workplace (Gold and Shuman 2009). When problems arise and individuals believe they have been wronged or psychologically injured, or when they become disabled due to psychiatric illness, they may make claims against employers under federal statutes such as the Americans With Disabilities Act (ADA) of 1990, the antidiscrimination laws enacted through the Civil Rights Act of 1964, or parallel state statutes. Claims can be brought through the federal Equal Employment Opportunity Commission (EEOC) or state equivalents, public or private disability insurance, and workers' compensation boards.

Employment-related claims can also be brought under civil law, through torts such as premises liability, negligence, wrongful termination, wrongful retention or supervision, and negligent or intentional infliction of emotional distress. Workplace claims can result in large damage awards, huge legal and administrative fees, administrative and court costs, and lost work time for both employees and employers. Many employment claims are filed jointly, with multiple complaints arising from the same incident(s). Psychiatrists may be involved in various stages and aspects of all these claims.

Passions involved in employment and basic concepts of fairness in the workplace have generated one of the most dynamic areas of legal activity in American law. Just 5 days after taking office in January 2009, President Obama signed the Lilly Ledbetter Fair Pay Act into law. This act amended the Civil Rights Act of 1964, essentially relaxing the statute of limitations under various civil rights laws and giving people more time to file charges for pay discrimination and other civil rights employment violations. The law was enacted in direct response to the 2007 Supreme Court decision in *Ledbetter v. Goodyear Tire & Rubber Co.* (2007), in which the Court ruled in a 5–4 vote that Ledbetter's 1998 complaint of pay discrimination was time-barred because the initial decision to pay her less than men performing similar work had occurred before the 180-day statutory time limit (Pear 2009).

Also in January 2009, the Americans With Disabilities Amendment Act (ADAA) went into effect. Signed into law in September 2008, Congress enacted this amendment to the ADA in large part in response to strong reaction to several Supreme Court and EEOC decisions in recent years that had narrowed the ADA's protection. The ADAA rejected the strict construction of the ADA by the Supreme Court and the EEOC, and enlarged the reach of the ADA by expanding the interpretation of key terms in its definition of disability (Dielman et al. 2009).

Employment litigation has increased in recent years, as has the legal system's request for psychiatric assessment of workplace disabilities and injuries. The number of employment discrimination charges under all statutes filed with the EEOC has increased from approximately 80,000 in 1998 to more than 95,000 in 2008 (Equal Employment Opportunity Commission 2009). The EEOC statistics obviously do not include private or public disability insurance conflicts, workers' compensation claims, or private employment litigation. The largest increases in complaints over this time period are for charges filed for age discrimination (19.1% of all charges in 1998 and 25.8% of all charges in 2008) and retaliation for filing complaints (24.0% in 1998 and 34.3% in 2008).

The increase in employment litigation reflects the dynamic nature of workplace legal and administrative systems. For example, changes in the law in recent years have allowed for jury trials and large damage awards. The increase

in employment litigation also reflects the changing relationship of employees and employers. With job security and guaranteed pensions quickly disappearing, people who feel "burned out" or mistreated are often less hesitant to bring a suit or claim against an employer. A large company or corporation is easily perceived and portrayed as an impersonal entity that should bear responsibility for injustice or harm incurred in the workplace. People also often hold the belief that unlike individual defendants, businesses can afford to pay large awards or bear disability costs without incurring undue financial hardship.

Psychiatrists who provide evaluations in workplace litigation or claims involving psychiatric disability or injury should therefore understand the complexities and requirements of such assessments. The following case vignettes will illustrate aspects of workplace assessments. In each, both parties in the litigation or claim have retained a mental health expert to provide an evaluation of psychiatric claims. The relevant psychiatric issues raised by these vignettes will be discussed as they arise in the course of the discussion in this chapter on workplace assessments.

Case Vignettes

Vignette 1

Ms. S, an administrative assistant in a large company, was in the process of obtaining a divorce. She had obtained a restraining order against her husband, who had been violent toward her in the past. Despite the order, he had been calling and threatening Ms. S at work. The calls became more frequent and more threatening. Mr. S also began to call and threaten one of Ms. S's coworkers, who was a close friend of Ms. S. Ms. S and the coworker advised the company's security officer of the calls and of Mr. S's history of violence. The security officer dismissed the problem as Ms. S's personal problem and told Ms. S and her coworker to keep their "drama" out of the workplace.

A few days later, Mr. S entered the office, shot his wife and three other employees, and then shot and killed himself. Ms. S and one coworker were killed. The two wounded employees, one of whom was the coworker who had spoken with the security officer, brought suit against their employer for premises liability, negligent supervision and retention of the security officer, and negligent infliction of emotional distress. Both employees claimed to have developed posttraumatic stress disorder (PTSD) in addition to their physical injuries as a result of the incident.

Vignette 2

Ms. A was one of a few female officers on a small city police force. Shortly after her employment began, she became the butt of jokes and insults regarding women. She frequently found pictures of naked women with graphic commentary taped to her locker. Male coworkers often commented that police work was "man's work" and that Ms. A did not belong on the police force. Ms. A reported this behavior to her supervisor, who told her to ignore it.

When the verbal behavior continued and escalated, Ms. A complained to her supervisor again. This time he told her that she was making things difficult for everyone and that she would be doing herself a favor if she quit. Ms. A was very upset but refused to quit her job. Shortly following her second complaint, Ms. A's supervisor began to berate her routinely for minor or perceived infractions. After several months, Ms. A began to dread coming into work and eventually went out on medical leave. She brought a suit for sexual harassment and retaliation against her employer, the city government, and claimed that she suffered severe emotional injuries, including PTSD, as a result of sexual harassment and workplace discrimination.

Vignette 3

Dr. B was a physician who owned his own practice, employing himself and a few other physicians. Dr. B had become increasingly dysfunctional as a result of alcohol dependence. He denied that he had a problem with alcohol but stopped providing routine clinical care to patients. For approximately 2 years, he worked primarily as the administrator of his practice. His caseload was taken over by his physician employees. However, Dr. B continued to provide patient care occasionally—for example, when another physician in the practice was unexpectedly unavailable. Concerned about Dr. B's increasingly poor clinical judgment, one of the physician employees reported Dr. B to the state's impaired physicians program. Dr. B agreed to enter treatment for alcohol dependence to avoid losing his license.

Dr. B also applied for disability payments as per his private disability insurance plan. After 1 year, Dr. B let his medical license expire, stating he had no desire to return to providing clinical care. He also refused ongoing treatment and claimed 1 year of complete sobriety. However, he also claimed he was completely disabled because of cognitive impairments that he ascribed to the effects of years of alcohol dependence. Neuropsychological testing revealed no evidence of cognitive deficits. Dr. B's insurance company referred him for independent medical evaluation to determine whether he was still eligible for his private disability benefits. The company noted that at the time of his claim, Dr. B was functioning primarily as an administrator rather than as a clinical physician.

Legal and Psychiatric Issues in Employment Claims

Psychiatrists asked to provide opinions in workplace claims should begin by familiarizing themselves with the legal and psychiatric issues relevant to the specific type of employment litigation in question. This information will allow experts to focus on those aspects of the case that will be most helpful to the individuals responsible for making the required legal or administrative determinations. Psychiatrists should also bear in mind that the people who make these determinations are typically not medical professionals. Reports should communicate essential information without the use of complicated medical or psychiatric jargon.

Detailed review of the legal aspects of all types of employment claims is beyond the scope of this discussion. Regardless of the type of legal claim in employment-related claims of emotional injury or disability, and despite the wide scope of legal, administrative, or regulatory issues involved, psychiatric issues typically involve at least one of the following three areas of assessment (Brodsky 1987a; Metzner and Buck 2003):

1. Whether the employee has a psychiatric diagnosis, and if so, its duration, symptoms, and prognosis
2. The etiology or causation of the disorder and, specifically, its relationship to work
3. Whether the disorder has resulted in a work-related impairment

As each of these issues relates to specific types of claims, the legal standards involved will be discussed.

Diagnosis

In all types of workplace claims, examiners should first establish whether an emotional injury or disorder exists. The legal standard that must be met regarding diagnosis varies depending on the type of litigation involved. For example, in harassment or discrimination claims brought under Title VII of the Civil Rights Act of 1964, emotional injury, let alone a specific diagnosis, does not have to be established for alleged discriminatory or harassing behavior to be actionable (*Harris v. Forklift Systems, Inc.* 1993). Similarly, common-

law causes of action do not require that emotional distress be diagnosable as a mental disorder to be compensable. In contrast, entitlement to Social Security Disability Insurance (SSDI) benefits generally depends on establishing a disability based on a recognized category of mental disorder as defined by the current edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) criteria (American Psychiatric Association 2000).

Nevertheless, even when not specifically required, retaining parties often request a formal diagnostic assessment. It may be difficult to establish damages or entitlement to compensation without a formal DSM diagnosis. This is particularly important in claims of emotional harm of disability as a result of emotional injury or psychological disorder. Such claims, when unaccompanied by physical injury, have historically been viewed with suspicion by the legal system. Recovery or award of benefits in such cases has been particularly problematic (Metzner and Buck 2003; Shuman 2002).

In Case Vignette 2, for example, the psychiatrist retained by Ms. A's attorney opined that Ms. A developed generalized anxiety disorder, not PTSD, as a result of her workplace experiences, raising questions about the credibility of both her injury and her legal claim. This led jurors to question whether the psychiatrist retained by Ms. A's employer, who opined that she did not meet the criteria for any DSM diagnosis, was in fact correct, especially given that Ms. A had not suffered any physical harm. The emotional injury damages awarded by the jury were minimal. When questioned afterward, some of the jurors reported that although Ms. A had proven both the discrimination and harassment, and although she was emotionally affected by her experiences, the defense had successfully demonstrated that she did not have a "real" psychiatric disorder, despite the fact that establishing a psychiatric diagnosis is not required in discrimination cases.

The DSM diagnostic categories were never intended for use in nonmedical circumstances. The imperfect fit between diagnostic emphasis in research and treatment and diagnostic emphasis in legal and administrative systems (see Chapter 6, "Psychiatric Diagnosis in Litigation," this volume) legitimately raises the question of how useful psychiatric diagnoses are in workplace evaluations. In some cases, diagnosis may actually become an impediment to understanding the nature of an impairment or its relationship to the workplace (Gold 2002b; Gold and Shuman 2009; Greenberg et al. 2004). Evaluators, employers, insurance companies, and litigators often focus on diagnosis rather than the relationship between symptoms, impairments, and specific work skills. Legal arguments may become centered on the accuracy or appropriateness of the diagnosis rather than the relevant functional capacity and its relationship to the disability or legal issue in question.

Despite these issues, diagnoses are relevant and appropriate for use in workplace evaluations for a variety of reasons (Gold and Shuman 2009; see

also Chapter 6, "Psychiatric Diagnosis in Litigation," this volume). Certain statutorily defined programs, such as Social Security disability programs, require the presence of a diagnosis for eligibility for benefits (discussed later in this chapter). Most other legal and administrative systems do not technically rely on formal psychiatric diagnosis to come to decisions for eligibility for benefits or other types of action. Nevertheless, these systems typically request and frequently rely informally on diagnosis as an indication of severity of emotional injury or distress. Absent a psychiatric diagnosis, employers, insurance companies, and courts rarely consider claims of impairment due to mental illness severe enough to warrant compensation or accommodation.

The formal diagnosis of a psychiatric illness supports arguments that a severe injury entitling a claimant to damages or benefits actually occurred. For example, under workers' compensation statutes, claims in which a worker seeks compensation for a mental injury caused by a mental stimulus remain controversial. Many jurisdictions now find such claims compensable, although recovery for such claims is often limited in ways that recovery for physical injury is not (Brodsky 1987b; Gold and Shuman 2009; Metzner and Buck 2003).

Similarly, in tort claims, both liability and damages may hinge on the existence of a DSM diagnosis. In claims of infliction of emotional distress, the element of severe emotional distress is required to prevail (see Chapter 10, "Personal Injury Litigation and Forensic Assessment," this volume). It is difficult, if not impossible, to establish severe distress if the plaintiff does not meet the criteria for a formal DSM diagnosis. Even in a discrimination claim such as Ms. A's in Case Vignette 2, in which psychological injury and, therefore, a DSM diagnosis are not required for a plaintiff to prevail, the EEOC will compute compensatory damages on the basis of a consideration of the severity and duration of harm (Strubbe et al. 1999). A formal diagnosis strengthens such damage claims.

Diagnostic categories serve practical purposes as well. The use of an established diagnosis can serve as a point of reference that enhances the value and reliability of psychiatric testimony (Gold 2002a; Gold and Shuman 2009; Gold et al. 2008; Halleck et al. 1992; Shuman 1989). In making a diagnosis, evaluators identify a range of precipitants or possible symptoms that, in turn, may direct evaluations of causation or associated impairments. Diagnoses share symptom profiles that can direct an examiner to explore relevant psychiatric issues in the related research, such as patterns of symptom presentation.

In addition, when a diagnosis is established, the subject of the evaluation can be assessed in relation to other elements of the same diagnostic category. Establishing a diagnosis also can allow experts to draw reasonable connections, restrain ungrounded speculation, or refute unreasonable claims between symptoms associated with a diagnosis and arguments regarding causation, impairment, and damages or disability. The longitudinal course of certain

disorders, for example, can provide essential information relevant to legal issues. The identification of a chronic, episodic, or progressively deteriorating course of mental illness associated with various diagnostic categories provides a framework for assessment of causation or impairment.

Ultimately, the relevance and importance of a psychiatric diagnosis depend on what types of evaluation and information are requested. Diagnostic categories in legal or administrative workplace claims might best be considered as a means of organizing thinking and as a way of using evidence-based data to evaluate claims of causation and impairments associated with that diagnosis and the types of disability that may be related to those impairments.

In workplace evaluations, examiners should be careful to distinguish psychiatric illnesses from nonpathological emotional reactions. Clinicians have a bias toward identifying distress as pathology (Gold and Shuman 2009). Most individuals experience workplace problems and conflicts as stressful, especially if they result in adverse financial or social consequences or in the development of disability and the losses associated with that status. Adverse employment events and impairments, and the stress and distress that accompany them, may precipitate or exacerbate illness in individuals with preexisting diagnoses or vulnerability to psychiatric disorders. Nevertheless, intense and distressing feelings and complaints associated with them, such as anxiety, insomnia, tearfulness, or irritability, which are often precipitated by workplace stress or problems, do not, in and of themselves, amount to diagnosable psychiatric disorders. As Savodnik (1991) observed, "Though it may be stressful, unhappiness is not a psychiatric condition; neither is injustice. One may be miserably and justifiably unhappy about a work experience and not be psychiatrically injured" (p. 188).

If examiners determine that psychological symptoms rise to the level of a mental disorder, diagnoses should be made according to DSM criteria. Psychiatrists should be certain to use standard methods of evaluation and differential diagnosis. They should also be prepared to support diagnostic conclusions with specific information gathered from both the psychiatric interview and record review. Clinical experience is a crucial element in evaluating psychiatric illness and formulating diagnoses. However, clinical experience will vary from practitioner to practitioner and is subject to personal interpretation of its relevance and meaning. Thus, it cannot form the basis of a scientific methodology of diagnostic classification.

Causation

Not every employment claim or legal case requires a finding of causation for the determination of awards or eligibility. For example, an individual's enti-

tlement to public or private disability insurance benefits does not require the existence of a causal nexus between the injury alleged to be the source of disability and the individual's employment. In contrast, in both workers' compensation and tort law, causation is a central and often hotly contested issue. However, the issue of causation in workers' compensation differs to some degree from that of causation in tort law.

Workers' compensation is an administrative remedy that was designed as an alternative to filing other types of claims and, when used, is typically considered an exclusive remedy. It is a "no-fault" system intended to provide medical treatment and disability benefits for workers who have suffered a work-related injury or illness. The no-fault component of workers' compensation means only that a finding of fault is not required as a prerequisite to awarding benefits. All other aspects of a claim may be and often are disputed and litigated, including the issue of causation. To receive compensation, workers must demonstrate by a preponderance of evidence that they have suffered an injury or disability arising out of and in the course of employment. This requirement involves establishing the causal relationship between the employment and the injury (see Chapter 11, "Disability," this volume).

In tort law, the requirement that an injury or event is demonstrated to be the proximate cause of harm can be central to a plaintiff's case. Without causation, or liability, there can be no award of damages. Unlike workers' compensation, in tort law the injury does not necessarily have to arise out of the plaintiff's employment. Nevertheless, whether conduct is intentional or negligent and leads to direct or indirect infliction of emotional distress, emotional harm damages will not be awarded unless the conduct "proximately" causes injury.

Complicating this assessment even further, the legal concept of causation and the medical concept of causation are not congruent, creating problems in forensic assessment and communication with legal or administrative systems. The concept of proximate cause is an elusive one, even within the law, which seeks to determine whether one particular event precipitated, hastened, or aggravated the individual's current condition. The legal requirement for establishing proximate cause is generally not scientific certainty but, rather, "probability"—"50.1%," "more likely than not," or "reasonable medical certainty" (Danner and Sagall 1977). The traditional legal method of determining whether one event is the proximate cause of another is to ask whether one could "reasonably foresee" that the former would lead to the latter. In other words, the fact-finder has to determine whether the initial event was the proverbial straw that broke the camel's back (Shuman 2002; Simon 1992).

In contrast, all behavioral and medical theory accepts as axiomatic that multiple factors may contribute to a negative psychological outcome or the

development of a psychiatric or medical illness. Psychiatrists examine and weigh many causative elements in the development of a theory of the etiology of any disorder. Although certain factors may be more significant, a mental disorder may be precipitated by the interaction of preexisting vulnerability, substance use, genetic predisposition, and other causes that often have nothing to do with the workplace.

Despite the conflicts inherent in the legal and psychiatric principles of causation, psychiatrists recognize that external events can precipitate psychological injury or emotional harm that falls within both legal and psychiatric parameters of causation. By definition, PTSD and adjustment disorders develop in response to an external event. Traumatic stressors such as those listed in DSM-IV-TR as possible causation for PTSD have also been associated with the development of depression, panic disorder, generalized anxiety disorder, and substance abuse or dependence (Briere 1997; Green and Kaltman 2002; Yehuda and Wong 2001).

In addition, considerable research has demonstrated that stressful life events that would not necessarily be considered traumatic stressors also have a substantial causal relationship with the onset of episodes of major depression (Keller et al. 2007; Kendler et al. 1999; Mitchell et al. 2003; Monroe et al. 2007; Muscatell et al. 2009; Shalev et al. 1998). Genetic risk is a well-described factor in the development of depressive disorder. Those at highest genetic risk have a considerably weaker association between stressful events and a first episode of depression than do those at low genetic risk. Nevertheless, both initial and recurrent episodes of depression can be precipitated by stressful experiences.

Many potentially psychologically damaging events can arise out of or during the course of employment or can be caused by events in the workplace. Traumatic exposure in the workplace is not uncommon. Witnessing or experiencing events such as motor vehicle accidents, industrial accidents, or violence can result in both physical and psychological injuries. Uncommon but dramatic events, such as terrorist attacks in the workplace (e.g., the Oklahoma City bombing in 1995 and the World Trade Center and Pentagon attacks in 2001), are readily acknowledged to potentially cause emotional injury to individuals in their workplaces (Galea et al. 2002; North et al. 1999; Schlenger et al. 2002).

More typically, however, traumatic exposure in the workplace occurs in the course of routine activities and occurrences. From 2003 to 2007, the average incidence of nonfatal workplace injury and illness was 4.6 per 100 full-time workers, and injury accounted for approximately 95% of these incidents. Generally, more than 75% of these injuries are attributed to contact with objects or equipment, such as being struck by a falling tool or caught in machinery; bodily reaction or exertion resulting in musculoskeletal injury; and falls (Bureau of Labor Statistics 2009).

Workplace violence is also, unfortunately, not uncommon. Violence in the workplace, including assaults and suicides, accounted for 15% of all work-related fatal occupational injuries in 2007. An estimated 1.7 million workers are injured each year during workplace assaults. Workplace violence accounted for 18% of all violent crime between 1993 and 1999 (U.S. Department of Justice 2001). Between 1993 and1999, approximately 12% of nonfatal violent workplace crimes resulted in an injury to the victim (U.S. Department of Justice 1998). In 2005, half of the largest employment establishments in the United States reported at least one incident of workplace violence in the previous 12 months. In workplaces employing more than 1000 people, approximately 25% reported violent incidents associated with domestic violence (Bureau of Labor Statistics 2005). Employees in 36% of the establishments having an incident of workplace violence in the previous 12 months were negatively affected (Bureau of Labor Statistics 2005).

Homicides, often involving injury to others or witnessed by others, are perennially among the top four causes of workplace fatalities for all workers (Bureau of Labor Statistics 2009). Homicide was the second leading cause of death in the workplace between 1992 and 1996, exceeded only by motor-vehicle-related deaths (U.S. Department of Justice 1998). During the 12-year period from 1992 to 2004, an average of 807 workplace homicides occurred annually in the United States (Bureau of Labor Statistics 2005). Women are more likely to die as victims of violence than from any other type of work-related injury, as the case of Ms. S in Case Vignette 1 illustrates. These incidents occur typically in the larger context of domestic violence or stalking and account for about 5% of all workplace homicides (National Institute for Occupational Safety and Health 2006).

Despite the stereotype of a disgruntled employee "going postal," the vast majority of workplace homicides (85%) are committed by a perpetrator who has no legitimate relationship to the business or its employees. The individual involved is usually committing a crime in conjunction with the violence. Only 7% of people murdered at work are killed by another employee (National Institute for Occupational Safety and Health 2006). Nevertheless, when such incidents occur, the degree of injury may be extreme. It is fairly common for the intended victim to escape harm while others are killed or injured (Merchant and Lundell 2001; National Institute for Occupational Safety and Health 1996; Southerland et al. 1997).

Claims of emotional injury caused by employment-related events, particularly when accompanied by physical injury, may be quite straightforward. Terrorist attacks, violence, and accidents are readily acknowledged to cause or precipitate psychiatric harm under certain circumstances. No one would be surprised if Ms. S's surviving coworker developed PTSD or some other anxiety or mood disorder. Causation may be more difficult to establish if a preexisting

diagnosis of PTSD was present (see e.g., Breslau et al. 2007), but even so, any exacerbation or aggravation of the preexisting disorder could be easily understood to result from an additional traumatic exposure in the workplace.

Unlike Ms. S's coworker in Case Vignette 1, Ms. A did not experience any direct physical harm. Psychological harm absent physical injury is a real, possible, and at times compensable outcome of a traumatic experience, but it is certainly more difficult to demonstrate legally. Experiences beyond those described as traumatic stressors in DSM, including workplace events, can cause PTSD, depression, and other psychiatric disorders (Breslau and Alvarado 2007; Lancaster et al. 2009). Research supporting these findings has led to debate about broadening the DSM definition of a traumatic stressor (Bedard-Gilligan and Zoellner 2008; Breslau and Alvarado 2007).

Nevertheless, examiners should not be too quick to assume a causal nexus between an employment-related incident, however traumatic, and a psychiatric disorder. Psychiatric theory does not propose or conclude that the inevitable outcome of any event is the development of a mental disorder. When evaluations are made retrospectively, as is often the case in litigation, estimates of pathology are inflated (Melton et al. 2007) and diagnosis of psychiatric illness is common (Long 1994; Rosen 1995). For example, epidemiological studies indicate that only 15%–24% of adults exposed to a traumatic event develop PTSD (see Breslau 2001; Kessler et al. 1995; Yehuda and Wong 2001). For individuals exposed to violent crimes, deaths, or accidents, the PTSD lifetime prevalence rate is 7%–12% (Breslau 2001).

How an individual responds to any experience, no matter how traumatic, depends on a variety of factors. These include duration, complexity, content, qualities, and kinds and amounts of associated losses. The dimensions of threat to life, severe physical harm or injury, exposure to grotesque death and loss, and the injury of a loved one are correlated to the likelihood of developing PTSD. The existence of a directly proportional dose-response relationship between stressor magnitude and subsequent risk of developing PTSD is well established (Briere 1997; Green and Kaltman 2002). In addition, the availability of support from friends, family, professionals, and institutions as well as therapeutic interventions can mitigate the effects of traumatic or adverse experiences.

The evaluation of causation in workplace claims becomes even more complex because individuals and, often, their clinical treatment providers equate adverse employment experiences, and the distress associated with them, with traumatic experiences. Claims of PTSD from nontraumatic stressors are common (Gold 2002a), as the case of Ms. A in Case Vignette 2 describes. Employees and their attorneys, often supported by clinicians, will argue that unfair treatment in the workplace was so stressful and psychologically harmful that it resulted in PTSD.

Job loss, unfair or discriminatory treatment, and employment-related conflict, whether real or perceived, are without doubt stressful. Psychiatric illness can result from chronic work-related stress (Gold and Shuman 2009). However, clinicians who assess individuals involved in workplace conflict often mistake the stress and distress that follow exposure to any adverse event for psychiatric illness (Long 1994; Rosen 1995). Although psychiatric illness may result from severe workplace stress that may be associated with adverse workplace experiences, such as discrimination, interpersonal conflict, and job loss, absent a traumatic stressor, such experiences do not typically cause PTSD (Gold and Simon 2001).

If Ms. A did meet DSM criteria for a diagnosis of PTSD, alternate causation of this disorder should be evaluated. Evaluations of causation in workplace claims and litigation should always consider the following:

- Exposure to another non-work-related stressor, either in the past or concurrent with present events, as the cause of a new disorder
- Extent to which the current exposure caused a new disorder or exacerbated a preexisting disorder
- Whether a disorder would have occurred at all but for the event in question
- Presence and course of a preexisting disorder, with and without exposure to the events in question
- Whether the dynamics of the individual or the workplace are contributing to either the perception of causation or the attribution of preexisting problems to conflict in the workplace

Conclusions that a psychiatric disorder is causally related to the workplace events therefore require careful evaluation. Failure to consider the contribution of earlier or concurrent unrelated traumatic events or stressors to the evaluee's illness, regardless of the alleged precipitant, may result in the false attribution of current symptoms to the employment events being litigated. Alternative sources of an individual's psychological problems may include past or present exposure to traumatic experiences other than the events involved in the current claim.

Many mood and anxiety disorders are common in the general population (American Psychiatric Association 2000). Many of these individuals experience exacerbations or new episodes of their disorder when exposed to stressors, including traumatic stressors, and such exposure is not uncommon. More than one-half of all adults respond positively to questions regarding traumatic exposure (Kessler et al. 1995). Other problems that can result in new-onset disorders include domestic abuse and violence, substance abuse disorders, medical conditions, and psychosocial stressors such as marital problems. Ar-

eas of inquiry should include family and personal relationships, financial problems, illness, death or loss of significant others, other job-related stress, and any other possible sources of trauma or stress. The possibility of undiagnosed preexisting disorders should also be considered. If the individual has not been previously diagnosed or has been diagnosed but not treated, or if an adequate history is not obtained, exacerbations may appear to be new-onset disorders.

Evidence of preexisting disorders will not prevent individuals from prevailing in their claims. Tortfeasors must take their victims as they find them. An individual with a history of prior illness or trauma may have a more profound reaction to stressful events or conflict than would another individual without such a history (Breslau et al. 2007). The law recognizes that relatively little trauma may cause injury to someone who is vulnerable to harm. Such a plaintiff is often referred to as having a "glass jaw" or "eggshell skull." However, the presence of another major life stressor or trauma, or a disorder predating the employment events in question, will make proof of a causal connection between the employment events and the mental injury more difficult.

In such cases, an accurate evaluation may require some apportionment of causation, whether an individual has experienced a recognized traumatic exposure in the workplace or an extreme reaction to a relatively minor workplace event. In tort claims, causation may affect findings of liability and awards of damages. In workers' compensation claims, an employee may only be entitled to benefits if workplace events "aggravated" or "accelerated" the course or severity of the preexisting disorder. If the injury existed or worsened independent of work, the claimant is not entitled to compensation (American Medical Association 2008; Melton et al. 2007).

In some cases, individuals with little or no insight into preexisting problems may genuinely but erroneously consider the workplace to be the cause of their psychological problems. This type of situation tends to arise in the context of adverse employment events or interpersonal conflict in the workplace, as often occurs when employees have substance abuse problems or personality disorders. Individuals with these Axis I or II disorders often have markedly limited insight into their role in creating the problems in the workplace that can lead to adverse outcomes.

In addition, personality disorders are commonly associated with Axis I mood and anxiety disorders. Personality disorders and their associated cognitive distortions, emotional reactivity, and maladaptive coping often worsen when compounded by adverse events such as lack of promotion, reprimand for poor performance, or job termination. Such work-related stress can also precipitate or exacerbate associated Axis I disorders to which a person may be vulnerable. Nevertheless, in these cases, the personality disorder rather than the workplace may actually be the cause of both the conflict and the Axis I disorders.

In making a diagnosis of a preexisting personality disorder, experts should be careful to distinguish the personality traits that define these disorders from characteristics that emerge in response to specific situational stressors. Clinicians are generally warned against the error of making a diagnosis of a personality disorder in the context of a specific external event or stressor (American Psychiatric Association 2000); this is particularly true in the context of workplace conflict and litigation.

The accurate diagnosis of a personality disorder requires an evaluation of the individual's long-term patterns of functioning. Evaluation of the individual's longitudinal history across his or her life span, beginning with early adulthood, is essential. Much of the evaluation involves analysis of the individual's documented life history and clinical presentation in comparison with self-report and information gathered from third parties. Evidence of repetitive patterns and symptoms that would be indicative of a chronic, rather than an acute, pattern of maladaptive coping should be identified. These patterns should be evident in multiple spheres of functioning.

Finally, the identification of a history of alternative trauma exposure, preexisting psychiatric history, or a personality disorder should not be used to discount the stressful and, at times, traumatic nature of many events that may occur in the workplace. Individuals can experience new-onset disorders or exacerbations of previous disorders as a result of single or cumulative work-related stress, distress, or traumatic exposure. Regardless of preexisting vulnerabilities, psychiatric illness can develop in individuals without obvious risk factors in the face of a high-magnitude or high-intensity stressor. Previously well-functioning adults can experience a sharp deterioration in functioning after exposure to severe trauma (van der Kolk and McFarlane 1996).

Nevertheless, examiners should not assume that any stressful, distressful, or even traumatic workplace event is causally related to any psychiatric diagnosis. The key to the evaluation of causation in any type of workplace claim or litigation lies in a thorough assessment of the workplace events, the circumstances surrounding these events, and the individual's life history. Psychiatrists should actively avoid making the common error of assuming a causal nexus between an event and a psychiatric presentation.

Impairment and Disability

Degrees of impairment and disability are relevant and often central issues in almost all types of employment claims or litigation. The American Academy of Psychiatry and the Law has published guidelines to assist psychiatrists in providing comprehensive disability evaluations consistent with professional

standards (Gold et al. 2008). The evaluation of disability is also reviewed in Chapter 11, "Disability," in this volume.

Eligibility for public or private disability insurance on the basis of a mental disorder requires a demonstration of disability. In workers' compensation claims, the benefit schedule hinges on the degree of disability and, specifically, on how the particular impairment affects earning capability. The nature of an accommodation that an employer is reasonably expected to make for a disabled employee under the ADA depends on the disability and how it specifically affects a work-related function. In tort law, an individual's level of impairment is the aspect of any psychiatric disorder most closely associated with assessment of damages (McDonald and Kulick 2001).

Medical Definitions

The terms *impairment* and *disability*, although often used interchangeably, describe two different concepts (Gold and Shuman 2009; Gold et al. 2008). Impairment is defined as "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder or disease" (American Medical Association 2008, p. 5). Disability is described as "activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease" (American Medical Association 2008, p. 5). Psychiatric symptoms may cause mental impairment, and mental impairment may reduce work functioning. Impairments may or may not result in a disability.

The assessment of impairment due to illness is a medical assessment; determination of the presence of work-related disability involves a more complex evaluation based on both medical and nonmedical factors. An individual who is impaired as the result of a mental illness may have no work-related disability or may be disabled relative to some occupations and not others. *Disability* is a legal term of art defined differently in various legal or administrative contexts.

Physicians may be asked in some types of evaluations whether an individual is disabled. However, in many evaluations, physicians are specifically directed to limit their opinions to diagnosis and assessment of impairment and are instructed not to opine on whether the individual is disabled. When undertaking a disability-related evaluation, psychiatrists should be clear as to whether they are being asked to provide an opinion regarding disability, and if so, what definition of disability is being used.

Legal and Administrative Definitions

Assessments of functional impairment and disability should be structured to meet the requirements and definitions of the type of claim or litigation in-

volved. Civil claims such as those involving discrimination or personal injury may include claims of disability. However, these claims do not require any specific degree of impairment or disability, and any degree of impaired function, even if not related to workplace capacities, may be compensable. Therefore, in these cases, examiners are free to assess any and all types of dysfunction in relation to damages. In contrast, workers' compensation requires that the injury must affect earning capacity and, therefore, specific work-related functions. Other types of claims may expand or narrow the definition of a disability.

Definitions or applicable standards of impairment and disability vary widely among legal and administrative systems. For example, the definition of disability in a private disability insurance policy is defined by the insurer and presented on a take-it-or-leave-it basis. In contrast, Congress has statutorily defined disability for purposes of determining eligibility both for Social Security disability benefits and for protection under the ADA. Moreover, even though both Social Security benefits and the ADA's terms are defined by federal statute, the definition of disability for purposes of the Social Security Act and the ADA are different, and, of course, both differ significantly from the definitions used in any private insurance policy.

Thus, an individual with a diagnosis of depression or attention-deficit/hyperactivity disorder may be eligible for accommodations under the definition of disability in the ADA. The same individual may not qualify as disabled according to the definition applied by the Social Security Administration in determining eligibility for Social Security disability income or by a private insurer in determining eligibility for benefits. The applicable definitions of disability in disability programs and the ADA are reviewed here briefly.

Disability Definitions: Private Insurance, Public Insurance, and the Americans With Disabilities Act

Private Insurance

Some insurance companies offer individual policies designed to provide a disabled worker financial benefits, often based on a significant percentage of the income of the policyholder. These policies are generally expensive and are typically purchased by self-employed professionals rather than by employees of large organizations, due to the significant payroll deductions needed to cover the premium expense. The policies are contracts between the insurance agency and the individual purchasing disability insurance.

Disputes regarding coverage and benefits, if litigated, are decided by principles of contract law.

The standard for disability varies among such policies. Certain policies define disability with specific reference to the policyholder's regular occupation. The policy may even supply definitions of "regular occupation" to identify particular professional subspecialties. Other policies may define disability more generally as the inability to perform one's regular occupation on a full-time basis or in terms of significantly decreased earning capacity related to injury or sickness.

In Vignette 3, Dr. B's insurance policy covered his "regular occupation," which at the time he filed his claim was administrative, not clinical, medicine. As a result, his insurance company concluded he was not disabled for the purposes of his private policy. Dr. B hired an attorney and litigated to contest the finding. The proceedings included expert testimony regarding Dr. B's psychiatric condition and functioning. The experts for each side agreed that Dr. B had a diagnosis of alcohol dependence that would raise serious concerns if he were to treat patients, especially since he was refusing ongoing treatment.

However, both experts also agreed that he had no deficits that would impair his ability to manage administrative tasks, especially because he claimed to no longer be using alcohol. Dr. B's suit was ultimately unsuccessful and he was unable to collect his private disability insurance benefits. This decision would not preclude Dr. B from filing for SSDI benefits, nor would it prevent him from collecting such benefits if he were found eligible under SSDI's statutory definitions.

Public Insurance: Social Security Disability Insurance

The SSDI program, administered by the Social Security Administration, is a public disability insurance program. It provides benefits for those disabled workers and their dependents who have contributed to the Social Security Trust Fund through the Federal Insurance Compensation Act tax on their earnings. Its terms are defined by federal statutory law. To qualify for benefits, the individual must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (42 U.S.C. § 423[d][1][A] [1991]).

This disability typically must be based on a recognized or "listed" disorder to meet the definition of a medical impairment. The Social Security Administration has nine listed diagnostic categories of mental disorders that are de-

fined by DSM criteria. Under SSDI regulations, individuals will not be eligible for benefits unless the impairment is so severe that claimants not only are unable to do their previous work but cannot "engage in any other kind of substantial gainful work which exists in the national economy" (42 U.S.C. § 423[d][2][A] [1991]). In contrast, as noted previously, private disability policies often require that individuals demonstrate only that they are disabled in relation to their specific occupation in order to be eligible for benefits.

Americans With Disabilities Act

Most disability claims are brought by individuals seeking compensation because they can no longer work due to impairment. In contrast, individuals invoking the protection of the ADA are attempting to remain in the workforce despite impairment. The ADA requires employers to provide reasonable accommodations to enable a qualified individual with a disability to perform essential job functions unless such an accommodation imposes an undue hardship on the employer. The ultimate determination of whether a particular condition is covered under the ADA is a complex legal process that requires a multistep analysis. A variety of issues related to the interpretation the ADA's definitions of terms such as disability, substantial limitation or impairment, and reasonable accommodation are subject to legal dispute.

Employers may refer individuals for psychiatric evaluation in an attempt to determine the nature of their legal obligations under the ADA in regard to an employee's request for reasonable accommodations due to disability resulting from mental disorder. By statutory definition, a covered disability is one that substantially limits one or more major life activities as a result of a physical or mental impairment. Individuals may also qualify for protection if they have a record of such impairment or of being regarded as having such impairment. The claimed disability must have a substantial effect on an essential function to qualify for protection under the ADA. Thus, psychiatrists should provide a careful assessment of the individual's degree of impairment resulting from the mental disorder and how it affects all spheres of the individual's functioning.

Diagnosis and Disability

Diagnosis is only one factor, and often not the most significant factor, in assessing the severity and possible duration of impairment associated with psychological symptoms (American Medical Association 2008; Gold and Shuman 2009; Gold et al. 2008). A psychiatric diagnosis will not explain the specific effect on work functioning. The condition of the claimant before and after the occurrence of the incident or illness in question is more rele-

vant to the assessment of impairment and loss of function in workplace claims than is any diagnosis alone.

Just as examiners should avoid the error of assuming a causal connection between a workplace event and a psychological outcome, they should avoid assuming that any diagnosis is automatically associated with loss of function (Gold et al. 2008). The presence of a psychiatric diagnosis does not necessarily equate with functional impairment or disability. As DSM-IV-TR warns: "It is precisely because impairments, abilities and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability" (American Psychiatric Association 2000, p. xxxiii).

The relationship between diagnosis and associated impairments is far from straightforward. Although a given illness may be more typically associated with certain types of impairments, a potentially wide range of functional difficulties is associated with any diagnostic category (Gold 2002a; Gold and Shuman 2009; Halleck et al. 1992). Not everyone with a specific disorder will have all the possible impairments associated with that disorder. In addition, the loss of function may be greater or less than the diagnostic label or associated impairment might imply, and the individual's performance may fall short of or exceed that usually associated with the impairment. In fact, in studies examining disability and its association with various disorders, there were some participants without disability for all types of disorders (Sanderson and Andrews 2002).

For example, although depression is widely acknowledged to be a major source of disability (Jans et al. 2004; Murray and Lopez 1996), not all individuals with depression experience symptoms that cause functional impairment. Symptoms associated with depression, such as psychomotor retardation, insomnia, and impaired memory and concentration, can be disabling. However, depression can be experienced as an uncomfortable or distressing mood state whose symptoms do not create impairment that significantly interferes with work function (Gold and Shuman 2009).

Even the severity of psychiatric symptoms and illness does not necessarily equate with functional impairment. Some individuals experiencing significant functional impairments are able to prioritize work functioning and continue to perform adequately in the workplace. Such individuals will often preserve working ability even when doing so causes increased impairment in other important spheres, such as physical health or family relationships. In some circumstances, individuals are often able to utilize work settings to maintain or improve their functioning (Straus and Davidson 1997).

The relationship between any psychiatric diagnosis and a work-related impairment depends on the employment environment and the demands of particular jobs, as well as on the abilities and functional limitations of the

individual (Bonnie 1997; Gold and Shuman 2009). In disability evaluations, the ability to assess and explain how symptoms associated with a diagnosis affect a specific set of work skills is often more important than a diagnostic label and more relevant to the parties involved. An individual with attention-deficit/hyperactivity disorder may function without any significant impairment in a job that involves completion of a task at his or her own pace by no particular deadline or may be totally disabled in a job that requires long periods of sustained attention to detail or the ability to multitask under time pressures.

Despite these issues, diagnoses are relevant and often necessary (Gold and Shuman 2009; see also Chapter 6, "Psychiatric Diagnosis in Litigation," this volume). As in Social Security disability programs, statutes or regulations may require that a diagnosis be present for eligibility. In addition, diagnoses that share symptom profiles can direct an examiner to explore areas of possible impairment associated with each diagnosis. As with causation, identification of a diagnosis assists in evaluating the proportionality of claims of impairment. Nevertheless, evaluators should be certain not to assume a level of impairment as part of any diagnosis but should specifically assess symptoms and related workplace impairments.

Assessment of Disability

Once psychiatrists understand the legal or administrative context of the assessment and the relevant definitions of terms associated with each type of assessment, they are ready to undertake the actual assessment of impairment and opine, if requested, on the presence of disability. Regardless of diagnosis, the relationship between impairment and disability depends on the abilities and functional limitations of the individual, the employment environment, and the demands of a particular job (Bonnie 1997; Gold and Shuman 2009). Some workers who suffer an injury or develop an impairment become and remain disabled. Others with comparable injuries either do not seek disability status or recover much earlier if they are deemed disabled. No single factor can explain this or differentiate prognostically between such individuals (Brodsky 1987a).

Examiners should begin by analyzing the pattern associated with the development of impairment and compromised work function (see Gold and Shuman 2009 for a detailed discussion). Psychiatric disability rarely develops overnight. Examiners should carefully review the history of the mental disorder, the history of the individual's ability to function over time, his or her response to treatment or to rehabilitation, and the influence of other work- and non-work-related factors. The evaluation of impairment also requires consideration of the individual's skills, education, work history, adaptability,

age, job requirements, response to treatment, and medical status, including other medical problems.

Psychiatrists should compare the individual's functioning before and after the development of the claimed disability. Only this type of comparative evaluation will allow examiners to arrive at a reasonable determination of severity of impairment and disability. Careful examination of the individual's personal, work, and medical history should allow examiners to determine baseline function, whether it has been deteriorating steadily over time regardless of job demand or whether job demand has played a significant factor in developing disability. Other significant events unrelated to the workplace, such as medical illness or family problems, may precipitate psychiatric symptoms and compromise function.

In disability claims where causation is relevant, claimants and plaintiffs tend to assert that all functional difficulties began after the employment events in question. Regardless of current functional status, such assertions should not be initially accepted as factual (Simon 2002). An assessment of the pattern of development of disability can help clarify such claims.

The evaluation of disability resulting from psychiatric injury or impairment should include an assessment of the severity of symptoms and the effect of these symptoms in all spheres of the claimant's functioning. Psychiatrists should find a reasonable and proportional relationship between the active symptoms and claims of impaired function. Familiarity with the literature and research on impairments associated with various psychiatric disorders is essential, as are the specific circumstances involving the injury or illness. The relationship between the claimant's occupation and the nature and severity of his or her symptoms will also be a major determinant in the assessment of work impairment and, ultimately, disability.

Other medical and psychiatric problems in addition to the primary psychiatric disorder in question can result in work-related disabilities. Examiners should consider whether individuals have work-related impairments resulting from their psychiatric illness or another concurrent illness, such as substance abuse or depression. In addition, individuals involved in employment litigation or making disability claims are often not working. Secondary damaging effects typically arise when the beneficial personal, social, and financial aspects of work become unavailable. Often, financial and marital difficulties ensue. Examiners should distinguish impairment related to psychiatric illness from the consequences of not working (Gold and Shuman 2009).

Nonmedical, psychiatric, or psychological factors can also profoundly influence whether impairment results in disability. Such factors may in fact be the deciding features in the development of a disability from an impairment. Assessments should therefore include consideration of the interaction of personal, work-related, and non-work-related factors. These include job

burnout, family conflicts or other dynamics, poor remuneration or high-risk jobs, poor working conditions, personality or interpersonal conflicts on the job, and perceptions of inequitable treatment by management (Axelrod 1999; Brodsky 1987a; Gold and Shuman 2009).

Even if an examiner includes all this information, translating specific impairments directly and precisely into functional limitations is a complex process. Little is known about many crucial issues relating to work disabilities arising from mental disorders. Psychiatric symptoms, even at a mild or moderate level, can create impairment and, at times, disability. Individuals who develop psychiatric illnesses, particularly if resulting from employment-related events, may suffer a degree of functional impairment as a result of their psychological symptoms, such that their ability to work is severely compromised. Cultural factors may also play a significant role in the development of disability due to psychiatric impairments (Tseng et al. 2004).

Nevertheless, not every psychiatric symptom will cause work-related impairment in every individual, and not every individual who has a psychiatric symptom, or even a psychiatric disorder, will necessarily experience work impairment or disability. Someone suffering insomnia may have impaired judgment; if his or her job involves flying planes or carrying a weapon, he or she may be functionally disabled, even if other prominent symptoms of depression are not present. Conversely, a sales representative or administrative assistant experiencing insomnia may be able to function adequately, even if not at the highest level of productivity, without creating undue risk to himself or herself or the public.

Psychiatrists should not rely on interviews and mental status examinations alone to determine degree of impairment. Although limited, studies exploring the association among psychiatric disorders, symptoms, and impairments are available and provide the bases for reasoned mental health opinions regarding employment-related work issues such as impairment or need for accommodations (Gold and Shuman 2009). For example, PTSD and depression at 3 months after injury in the workplace significantly increase the risk of disability at 12 months post-injury (O'Donnell et al. 2009).

Opinions based solely on an evaluee's reports or on the evaluator's personal experience do not constitute an adequate basis for conclusions. Familiarity with research literature helps evaluators avoid relying only on an evaluee's reports, stereotypic beliefs, or their own limited clinical experience. However, evaluators should bear in mind that such data comprise only one source of information on which they should rely. Although research points out commonalities among large groups, it cannot provide a description of an evaluee in any individual case.

Extensive review of relevant documentation is also an essential part of the evaluation of impairment and disability related to the events or illness in

question. An individual's level of functioning may vary considerably over time. Thus, evidence of functioning over a sufficiently long period of time before the date of examination should be obtained. Identification of the pattern of the development of disability is based on longitudinal information. Relevant documents include treatment notes, hospital discharge summaries, work evaluations, and rehabilitation progress notes, if they are available. Clinicians should describe the length and history of the impairment, points of exacerbation and remission, any history of hospitalization or outpatient treatment, and modalities of treatment used in the past.

Assessments of all impairments should be as specific and detailed as possible. Psychological testing can be an important adjunct in this process. It may provide additional useful data, particularly regarding cognitive impairments such as attention, comprehension, or memory (Gold and Shuman 2009; Gold et al. 2008).

Assessment of functional impairment should also include, if requested, use of one or more of the widely available scales designed for this purpose. The most commonly used scale in most types of assessment is the Global Assessment of Functioning Scale provided in DSM. DSM also provides a newer rating scale, the Social and Occupational Functioning Assessment Scale. However, this scale is less frequently used in clinical practice and its utilization in disability evaluations is rarely requested (American Psychiatric Association 2000). The sixth edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (2008) provides a new but complicated rating system for psychiatric impairment based on the combined score of three measures of psychiatric symptomatology and functioning. The utility of this newly devised system has yet to be demonstrated. The most structured guidelines for rating of impairment and disability are those delineated by the Social Security Administration, and their use is required in SSDI claims. Limitations on functioning caused by the impairment must meet at least one of the "Paragraph B" criteria to qualify as a disability for purposes of these determinations.

The evaluation should also consider the role of litigation, workplace conflict, or a protracted administrative conflict or delay in filing a claim in the clinical presentation and assessment of functional impairment (Gold and Simon 2001). Workplace claims, whether involving civil law, the ADA, or disability, can become just as contentious as divorce or custody proceedings. Individuals who file legal or insurance claims are often unaware of and unprepared for the financial and emotional toll involved in proving their cases.

Involvement in the litigation process is an extremely stressful experience and is widely acknowledged to exacerbate psychological symptoms regardless of diagnosis (Strasburger 1999). Extended litigation or delay in final decisions regarding entitlement to benefits can also be disruptive to work

functioning and can prove emotionally draining and demoralizing. In addition, these factors can lead to an interruption of treatment or therapy and may combine to result in the appearance of severe impairment and disability. After the litigation or claim is resolved and the stress associated with the process is ended, the individual's functioning may improve significantly. Thus, those aspects of functional impairment related to the stress of litigation or proving a claim of entitlement to benefits should be identified separately from those of the underlying psychiatric disorder.

Finally, psychiatrists should bear in mind that evaluations of impairment and disability are subject to the influence of an examiner's beliefs about work ethic, choice, and responsibility (Gold et al. 2008; Gold and Shuman 2009; Tseng et al. 2004). Examiners should remain sensitive to the influence of their own beliefs regarding choices involving work, as well as cultural factors that may influence their own and claimants' attitudes toward work. Evaluators should also be aware of and guard against the historical tendency of physicians and others to minimize psychiatric impairment because of lack of visibility, and therefore recognition, of the significant symptoms associated with some mental disorders.

Disability and Prognosis

Prognostic assessments may also inform certain aspects of the claim or litigation, including award of damages or entitlement to benefits specifically for treatment. In workers' compensation cases, prognosis is a key factor in the determination of the likely duration of the impairment caused by the injury (Melton et al. 2007). The prognosis of the individual's illness is closely related to the degree and duration of an impairment or disability. Determination of the future degree of disability should be based on the assessment of current impairment and comparative assessment of functioning before and after the events in question. The assessment of prognosis should be informed by a thorough clinical evaluation as well as epidemiological data regarding the natural course of the disorder. Again, the pattern of disability development may be informative, given that it may indicate a deteriorating course over many years or an individual who has a history of regaining function in between episodes of acute illness (Gold and Shuman 2009).

In formulating opinions regarding prognosis, examiners should evaluate the extent to which treatment will restore the person's capacity to work (American Medical Association 2008). The effects of treatment can be a major factor in the course of the disorder and, therefore, in the determination of prognosis. An individual who is quite symptomatic and impaired but has not obtained treatment may be someone whose condition will improve with appropriate treatment and, thus, have a good prognosis. The assessment of permanent

impairment or disability should not be attempted until the claimant has received a sufficient trial of appropriate treatment.

However, prognostic assessments are also complex. Acute psychiatric disorders, even with the best treatment, demonstrate many variations in the course of recovery, ranging from complete remission to the development of a chronic illness. In addition, examiners should consider the presence or severity of factors that significantly worsen prognosis. Comorbid psychiatric disorders, such as substance abuse or personality disorders, complicate recovery or remission. The individual's life history, the availability of personal and social support, and the status of other related medical or psychosocial problems may play a role in prognostic assessment.

The relationship among prognosis, functional impairment, and long-term disability also requires assessment of issues such as secondary gain, malingering, and lifestyle (Gold and Shuman 2009). It may be difficult to untangle the effects of characterological depression, poor motivation, personality conflicts, the secondary gain of unemployment, and lack of opportunity. Perhaps the most significant factor in recovery from impairment is motivation. Regardless of the claimant's occupation, even minimal impairment may lead to permanent disability when the claimant is not motivated to obtain appropriate treatment or to recover previous level of functioning. Lack of motivation may be hard to distinguish from mental impairment, such as depression or avoidance, and requires careful assessment.

Conclusion

Psychiatrists have become increasingly involved in workplace claims, employment litigation, and disability evaluations in recent years. Expert testimony may be a critical component in legal arguments or administrative decisions regarding damages, disability, prognosis, causation, and eligibility for private or public insurance benefits. Workplace evaluations begin with identification of the legal issues relevant to the specific type of claim or lawsuit involved. The three most common issues in such assessments relate to diagnosis, causation, and disability. Psychiatrists providing such assessments should familiarize themselves with the facts and the legal or administrative requirements of the specific case and provide opinions based on a thorough assessment of all aspects relevant to the claimant's psychiatric status, related impairments, and functioning.

Key Points

- The three opinions most often requested in psychiatric evaluation of workplace claims are diagnosis, causation, and impairment/disability.
- Diagnosis should not be automatically equated with causation or any level of impairment of disability.
- Assessments of causation should always consider preexisting illness, alternate causation, and prior history of trauma.
- Assessments of disability should correlate impairments expressly related to psychiatric illness with specific work-related functions and should consider other nonmedical or nonpsychiatric factors that could contribute to impairment or disability.

Practice Guidelines

1. Determine the legal issues relevant to the type of evaluation, and structure the evaluation accordingly.
2. Establish or refute a diagnosis based on DSM criteria.
3. Base opinions regarding causation on a thorough evaluation of the incident in question as well as prior psychiatric and trauma history. Consider the possibility of a preexisting disorder and past or present alternate trauma exposure.
4. Base opinions regarding impairment on a comparison of the individual's level of function before and after the onset of the disorder. Assess the individual's longitudinal functioning, current impairments, occupational requirements, and multiple other factors.
5. Offer opinions regarding disability only when requested, and if requested, make certain the opinion is based on the definition specific to the evaluation.
6. Avoid overreliance or exclusive use of psychiatric or medical jargon, because fact-finders in workplace claims are rarely psychiatric or medical professionals.

References

American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th Edition. Chicago, IL, American Medical Association, 2008

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Axelrod, SD: Work and the Evolving Self: Theoretical and Clinical Considerations. Hillsdale, NJ, Analytic Press, 1999

Bedard-Gilligan M, Zoellner LA: The utility of the A1 and A2 criteria in the diagnosis of PTSD. Behav Res Ther 46:1062–1069, 2008

Bonnie RJ: Work disability and the fabric of mental health law: an introduction, in Mental Disorder, Work Disability and the Law. Edited by Bonnie RJ, Monahan J. Chicago, IL, University of Chicago Press, 1997, pp 1–12

Breslau N: Outcomes of posttraumatic stress disorder. J Clin Psychiatry 62 (suppl 17):55–59, 2001

Breslau N, Alvarado GF: The clinical significance criterion in DSM-IV post-traumatic stress disorder. Psychol Med 37:1437–1444, 2007

Breslau N, Peterson EL, Schultz LR: A second look at prior trauma and the posttraumatic stress disorder effects of subsequent trauma: a prospective epidemiological study. Arch Gen Psychiatry 65:431–437, 2009

Briere J: Psychological Assessment of Adult Posttraumatic States. Washington, DC, American Psychological Association, 1997

Brodsky CM: Factors influencing work-related disability, in Psychiatric Disability: Clinical, Legal, and Administrative Dimensions. Edited by Meyerson AT, Fine T. Washington, DC, American Psychiatric Press, 1987a, pp 49–65

Brodsky CM: The psychiatric evaluation in workers' compensation, in Psychiatric Disability: Clinical, Legal, and Administrative Dimensions. Edited by Meyerson AT, Fine T. Washington, DC, American Psychiatric Press, 1987b, pp 313–332

Bureau of Labor Statistics: Census of fatal occupational injuries (CFOI), 2005. Available at http://www.bls.gov/iif/oshcfoi1.htm. Accessed April 4, 2009.

Bureau of Labor Statistics: Survey of workplace violence prevention, 2005. Available at: http://www.bls.gov/iif/osh_wpvs.htm. Accessed April 4, 2009.

Bureau of Labor Statistics: Occupational injuries and illness and fatal injuries profiles, 2009. Available at: http://data.bls.gov:8080/GQT/servlet/InitialPage Accessed April 4, 2009.

Danner D, Sagall EL: Medicolegal causation: a source of professional misunderstanding. Am J Law Med 3:303–308, 1977

Dielman SK, Morgan MA, Winkelman CL: Labor and employment law. Texas Bar Journal 72:27–28, 2009

Equal Employment Opportunity Commission: Available at: http://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm. Accessed April 4, 2009.

Galea S, Ahem J, Resnick H, et al: Psychological sequelae of the September 11 terrorist attacks in New York City. N Engl J Med 346:982–987, 2002

Gold LH: Posttraumatic stress disorder in employment litigation, in Posttraumatic Stress Disorder in Litigation, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002a, pp 163–186

Gold LH: Psychiatric diagnoses and retrospective assessment of mental states, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002b, pp 335–368

Gold LH, Shuman DW: Evaluating Mental Health Disability in the Workplace: Model, Process and Analysis. New York, Springer, 2009

Gold LH, Simon RI: Posttraumatic stress disorder in employment cases, in Mental and Emotional Injuries in Employment Litigation, 2nd Edition. Edited by McDonald JJ, Kulick FB. Washington, DC, Bureau of National Affairs, 2001, pp 502–573

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL Practice guideline for the forensic evaluation of psychiatric disability. J Am Acad Psychiatry Law 36 (4 suppl):S3–S50, 2008

Green BL, Kaltman SI: Recent research findings on the diagnosis of posttraumatic stress disorder: prevalence, course, comorbidity and risk, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002, pp 19–40

Greenberg SA, Shuman DW, Meyer RG: Unmasking forensic diagnosis. Int J Law Psychiatry 27:1–15, 2004

Halleck SL, Hoge SK, Miller RD, et al: The use of psychiatric diagnoses in the legal process: task force report of the American Psychiatric Association. Bull Am Acad Psychiatry Law 20:481–499, 1992

Harris v Forklift Systems Inc, 510 U.S. 17, 114 S.Ct. 367 (1993)

Jans L, Stoddard S, Kraus L: Chartbook on mental health and disability in the United States: an InfoUse report. Washington, DC, National Institute on Disability and Rehabilitation Research, 2004

Keller MC, Neale MC, Kendler KS: Association of different adverse life events with distinct patterns of depressive symptoms. Am J Psychiatry 164:1521–1529, 2007

Kendler KS, Karkowski LM, Prescott C: Causal relationship between stressful life events and the onset of major depression. Am J Psychiatry 156:837–841, 1999

Kessler RC, Sonnega A, Bromet E, et al: Posttraumatic stress disorder in the national comorbidity survey. Arch Gen Psychiatry 52:1048–1060, 1995

Lancaster SL, Melka SE, Rodriguez BF: An examination of the differential effects of the experience of DSM-IV defined traumatic stressors and life stressors. J Anxiety Disord 23:711–717, 2009

Ledbetter v Goodyear Tire & Rubber Co, 550 U.S. 616 (2007)

Lindemann B, Kadue DD: Sexual Harassment in Employment Law. Washington, DC, Bureau of National Affairs, 1992

Long BL: Psychiatric diagnoses in sexual harassment cases. Bull Am Acad Psychiatry Law 22:195–203, 1994

McDonald JJ, Kulick FP: The rise of the psychological injury claim, in Mental and Emotional Injuries in Employment Litigation, 2nd Edition. Edited by McDonald JJ, Kulick FB. Washington, DC, Bureau of National Affairs, 2001, pp xxxvi–xlv

Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluation for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007

Merchant JA, Lundell JA: Workplace Violence: A Report to the Nation. Iowa City, University of Iowa Injury Prevention Research Center, 2001

Metzner JL, Buck JB: Psychiatric disability determinations and personal injury litigation, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. London, Arnold, 2003

Metzner JL, Buck JB: Psychiatric disability determinations and personal injury litigation, in Principles in Practice of Forensic Psychiatry. Edited by Rosner R. London, Arnold, 2003, pp 260–272

Mitchell PB, Parker GB, Gladstone GL, et al: Severity of stressful life events in first and subsequent episodes of depression: the relevance of depressive subtype. J Affect Disord 73:245–252, 2003

Monroe SM, Slavich GM, Torres LD, et al: Major life events and major chronic difficulties are differentially associated with history of major depressive episodes. J Abnorm Psychol 116:116–124, 2007

Murray C, Lopez AD (eds): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020. Cambridge, MA, Harvard University Press, 1996

Muscatell KA, Slavich GM, Monroe SM, et al: Stressful life events, chronic difficulties, and the symptoms of clinical depression. J Nerv Ment Dis 197:154–160, 2009

National Institute for Occupational Safety and Health: Violence in the Workplace: Risk Factors and Prevention Strategies (Current Intelligence Bulletin 57). Washington, DC, National Institute for Occupational Safety and Health, 1996

National Institute for Occupational Safety and Health 2006: Workplace Violence Prevention Strategies and Research Needs. NIOSH Publ No. 2006-144, September 2006. Available at: http://www.cdc.gov/niosh/docs/2006-144. Accessed April 20, 2009.

North CS, Nixon SJ, Shariat S, et al: Psychiatric disorders among survivors of the Oklahoma City bombing. JAMA 282:755–762, 1999

O'Donnell ML, Holmes AC, Creamer MC, et al: The role of post-traumatic stress disorder and depression in predicting disability after injury. Med J Aust 190:S71–S74, 2009

Pear R: Justices' rule in discrimination case may draw quick action by Obama. New York Times, January 5, 2009. Available at: http://www.nytimes.com/2009/01/05/us/politics/05rights.html. Accessed April 18, 2009.

Rosen GM: The Aleutian Enterprise sinking and posttraumatic stress disorder: misdiagnosis in clinical and forensic settings. Prof Psychol Res Pr 26:82–87, 1995

Sanderson K, Andrews G: Prevalence and severity of mental health-related disability and relationship to diagnosis. Psychiatr Serv 53:80–86, 2002

Savodnik I: The concept of stress in psychiatry. Western State University Law Review 19:175–189, 1991

Schlenger WE, Caddell JM, Ebert L, et al: Psychological reactions to terrorist attacks: findings from the National Study of Americans' Reactions to September 11. JAMA 2888:581–588, 2002

Shalev AY, Freedman MA, Peri T, et al: Prospective study of posttraumatic stress disorder and depression following trauma. Am J Psychiatry 155:630–637, 1998

Shuman DW: The Diagnostic and Statistical Manual of Mental Disorders in the courts. Bull Am Acad Psychiatry Law 17:25–32, 1989

Shuman DW: Persistent reexperiences in the law and psychiatry: current and future trends for the role of PTSD in litigation, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002, pp 1–18

Simon RI: Clinical Psychiatry and the Law, 2nd Edition. Washington, DC, American Psychiatric Press, 1992

Simon RI: Forensic psychiatric assessment of PTSD claimants, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2002, pp 41–90

Southerland MD, Collins PA, Scarborough KE: Workplace Violence: A Continuum From Threat to Death. Cincinnati, OH, Anderson Publishing, 1997

Strasburger LH: The litigant-patient: mental health consequences of civil litigation. J Am Acad Psychiatry Law 27:203–212, 1999

Straus JS, Davidson L: Mental disorders, work and choice, in Mental Disorder, Work Disability and the Law. Edited by Bonnie RJ, Monahan J. Chicago, IL, University of Chicago Press, 1997, pp 105–130

Strubbe MR, Lindemann B, Kadue DD: Sexual Harassment in Employment Law: 1999 Cumulative Supplement. Washington, DC, Bureau of National Affairs, 1999

Tseng WS, Matthews D, Elwyn TS: Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists and Attorneys. New York, Brunner-Routledge, 2004

U.S. Department of Justice, Bureau of Justice Statistics: National Crime Victimization Survey: workplace violence, 1992–96 (NCJ 168634). Bureau of Justice Statistics Special Report. Washington, DC, U.S. Department of Justice, July 1998

U.S. Department of Justice, Bureau of Justice Statistics: National Crime Victimization Survey: violence in the workplace, 1993–99 (NCJ 190076). Bureau of Justice Statistics Special Report. Washington, DC, U.S. Department of Justice, December 2001. Available at: http://www.ojp. usdoj.gov/index.cfm?ty=pbdetail&iid=693. Accessed April 4, 2009.

van der Kolk BA, McFarlane AC: The black hole of trauma, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. Edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996, pp 3–23

Yehuda R, Wong CM: Etiology and biology of posttraumatic stress disorder: implications for treatment. Psychiatr Clin North Am Annual of Drug Therapy 8:109–134, 2001

Suggested Readings

American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th Edition. Chicago, IL, American Medical Association, 2008

Bonnie RJ, Monahan J (eds): Mental Disorder, Work Disability, and the Law. Chicago, IL, University of Chicago Press, 1997

Danner D, Sagall EL: Medicolegal causation: a source of professional misunderstanding. Am J Law Med 3:303–308, 1977

Gold LH, Shuman DW: Evaluating Mental Health Disability in the Workplace: Model, Process and Analysis. Springer, New York, 2009

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability. J Am Acad Psychiatry Law 36 (4 suppl):S3–S50, 2008

PART III

Issues in Criminal Justice

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Chapter 13

Competency to Stand Trial and the Insanity Defense

Charles L. Scott, M.D.

Evaluations of a defendant's competency to stand trial and sanity are among the most common examinations that a forensic psychiatrist will conduct in the criminal justice system. Although both examinations are often requested for the same defendant, the nature and type of these two evaluations are vastly different. A psychiatrist's failure to understand these differences can result in an inadequate evaluation of the defendant and potential legal and ethical difficulties for the psychiatrist. In this chapter, I provide the psychiatrist with key principles related to both competency to stand trial and sanity, and I include practical guidelines on how to prepare for and conduct each evaluation.

Case Vignette 1

Mr. C has been charged with the murder of a random stranger during broad daylight at a local mall. The entire crime was captured on videotape, which shows Mr. C rushing over and stabbing to death a 28-year-old woman coming

out of a department store while pushing a baby carriage carrying her one-year-old daughter. After stabbing the woman 13 times, Mr. C walks to the food court a few feet away to buy a chocolate-chip ice cream cone. He is arrested within minutes and fully cooperates with the arresting officers. The officers learn that Mr. C recently traveled across country after leaving a psychiatric facility against medical advice. Mr. C is appointed a public defender, who interviews Mr. C the next morning. During his attorney's visit, Mr. C is virtually mute and provides only minimal answers to his attorney's questions. Mr. C demonstrates odd facial grimaces and is observed by his attorney to whisper incomprehensible statements. At other times, he stares in a bizarre manner at his attorney while clenching his jaw. Over the next several months, Mr. C's appointed attorney repeatedly attempts to interview his client, who refuses to provide any information about his thoughts or actions related to this crime. Although Mr. C understands that he is charged with murder, he tells his attorney that he will be found innocent and "fires" his attorney because he has not yet been released from jail. Mr. C is adamant that he does not have any mental disorder and refuses all psychiatric medications offered at the jail. He also tells his attorney that he would never consider an insanity defense because he is not mentally ill and therefore will be found innocent. Mr. C's attorney requests an evaluation of his client's competency and sanity based on his interactions with Mr. C and the bizarre nature of the crime.

Competency to Stand Trial

Competency to stand trial (CST) represents the basic principle that defendants should have the ability to participate in their own trial process. CST evaluation requests are the most common referrals for criminal forensic examination (Rogers et al. 2001). Surveys indicate that public defenders have concerns regarding CST in approximately 10%–15% of their clients' cases (Melton et al. 2007) and that there are nearly 60,000 evaluation requests each year (Poythress et al. 2002). These assessments are conducted in a variety of settings that include local jails, community mental health facilities, outpatient treatment centers, court clinics, and inpatient psychiatric settings. Once defendants are adjudicated incompetent to stand trial (IST), they are often involuntarily hospitalized in a psychiatric facility where treatment programs designed to restore competency are offered. Significant amounts of mental health resources are allocated for inpatient competency-restoration programs. As many as 9,000 inpatient psychiatric beds are reserved for IST defendants (McGarry 1973), with more than 3,000 of those provided by forensic psychiatric facilities (Way et al. 1991).

Legal Standard

The constitutional standard for CST was first established by the U.S. Supreme Court in *Dusky v. United States* (1960). Milton Dusky was a 33-year-old man who was charged with assisting in the kidnapping and rape of an underage female. A pretrial psychiatric evaluation determined that Mr. Dusky suffered from a "schizophrenic reaction, chronic undifferentiated type." At trial, another psychiatrist testified that Dusky could not properly assist his attorney because of his paranoid thoughts, which included a belief that he was being framed. The trial court noted that Mr. Dusky was oriented and could recall events. These observations served as the basis for finding him competent to stand trial. After being found guilty of rape, he appealed the lower court's finding that he was trial competent. The U.S. Supreme Court enunciated the following as a minimum constitutional standard for trial competency: "whether he [had] sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he [had] a rational as well as factual understanding of the proceedings against him" (*Dusky v. United States* 1960).

Melton and colleagues (2007) outlined the following five important components embedded within the *Dusky* CST standard:

- The competency to stand trial (CST) standard involves two prongs:
  1. The ability of the defendant to understand the criminal process
  2. The ability of the defendant to assist their attorney in their own defense
- CST evaluations focus on a defendant's *present* ability. The evaluation focus is on the defendant's current mental state in contrast to sanity evaluations discussed below that represent a retrospective analysis of the defendant's mental state at the time of the alleged crime.
- The CST evaluation examines a defendant's capacity to stand trial, as opposed to their willingness to stand trial. Not wanting to go to trial does not mean a person is unable to do so.
- The CST standard requires only that the person have a reasonable degree of rational understanding, not an absolute, perfect, or complete capacity in this regard.
  - The presence of a mental illness alone does not automatically equate with a finding of trial incompetency. The evaluator must show the relationship, if any, of the mental disorder to trial competency deficits.

Conducting the Evaluation

Although the federal *Dusky* standard does not specifically state that a mental disease or defect is necessary to find trial incompetency, the vast majority of state statutes require some type of mental disorder as the predicate basis for an IST finding. As each state statute has slight variations in their CST standard, the examiner should be familiar with the precise defining language in his or her jurisdiction. Prior to conducting the evaluation, it is strongly suggested that the examiner be familiar with the charges the defendant is facing, as well as the police report and witness statements regarding the alleged offense. This information is important to help assess the defendant's understanding of his or her legal situation and the relationship, if any, of his or her mental state to a finding of trial incompetency. Additional documents that may be helpful include jail treatment records, prior psychiatric records, medical records, educational records, and the criminal rap sheet. In addition to a relevant record review, the evaluator should understand what difficulties, if any, the defense attorney has noted in the client's ability to assist the attorney.

Prior to beginning the interview, the forensic evaluator should educate the defendant regarding the nature and purpose of the evaluation. The American Academy of Psychiatry and the Law Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial suggests that the examiner provide the information outlined in Table 13–1 to the defendant before beginning the evaluation (Mossman et al. 2007).

The importance of providing the defendant informed consent regarding the CST evaluation was highlighted in the 1981 Supreme Court case of *Estelle v. Smith* (1981). Ernest Smith was charged with capital murder when his accomplice shot a Texas grocery store clerk during their botched armed robbery of the store. The trial judge ordered a CST evaluation after Mr. Smith was indicted and had obtained an attorney. Texas psychiatrist Dr. James Grigson evaluated Mr. Smith and found him competent. In his psychiatric report, Dr. Grigson also noted that Mr. Smith was a "severe sociopath" but made no specific comment regarding his risk of future dangerousness. Mr. Smith was subsequently tried and found guilty.

At the sentencing phase, when the death penalty was being considered, Dr. Grigson was called as a prosecution witness over defense counsel's objection. One of the requirements to impose the death penalty under the Texas statute was a finding that the defendant represented a future risk of danger. Based on information gathered during his competency evaluation, Dr. Grigson testified that Mr. Smith represented a continued danger to society. The jury sentenced Mr. Smith to death.

TABLE 13–1. Informed consent components of a competency-to-stand-trial evaluation

Reason for the evaluation
Party who has appointed or retained the psychiatrist
Lack of confidentiality of the interview and findings
Persons who will receive the psychiatrist's report
Possibility that the psychiatrist will testify about the results
Right of the defendant to decline to answer particular questions, with a warning that the psychiatrist may have to report noncooperation or refusal to answer questions to the retaining attorney or to the court

Source. Mossman et al. 2007.

On appeal, Mr. Smith claimed that he was not warned by Dr. Grigson that statements he made during the pretrial competency evaluation could be used against him in subsequent phases of the trial, thereby representing a violation of his Fifth Amendment right to remain silent. He also asserted that Dr. Grigson violated his Sixth Amendment right to the effective assistance of counsel. In particular, he alleged that had Dr. Grigson warned his attorney that statements made during the pretrial competency evaluation would be used at later stages of the trial, his attorney could have advised him not to participate in the examination. The U.S. Supreme Court agreed and held that Mr. Smith's Fifth and Sixth Amendments rights had been violated because Mr. Smith had not been warned about the possible use of his statements in subsequent phases of the trial (*Estelle v. Smith* 1981).

Does this ruling mean that any statements made by a defendant during the course of a competency evaluation can never be introduced at a subsequent phase of the trial? Apparently not. In the subsequent U.S. Supreme Court case of *Buchanan v. Kentucky* (1987), David Buchanan, a juvenile, was tried as a codefendant for the 1981 rape and murder of Barbel Poore, a 20-year-old gas station attendant. At trial, the affirmative mental defense of "extreme emotional disturbance" was introduced by Mr. Buchanan's attorney. The sole witness on Mr. Buchanan's behalf was Martha Elam, a social worker who had evaluated him for juvenile court in the context of a prior 1980 burglary charge. In rebuttal, the prosecution asked Ms. Elam to read from a competency evaluation conducted by Dr. Robert Lange at the joint request of the defense and prosecution after Mr. Buchanan's arrest for murder. Mr. Buchanan objected to the introduction of statements he had made to Dr. Lange, asserting that this evaluation had nothing to do with his emotional disturbance and, therefore, would violate his Fifth and Sixth Amendments rights as prohibited by the prior *Estelle v. Smith* ruling. The *Buchanan* Court

held that the introduction of information gleaned from Dr. Lange's competency evaluation at a later trial phase did not violate his Fifth or Sixth Amendments rights. The Court noted that in contrast to the facts in *Estelle v. Smith*, Mr. Buchanan had requested a psychological evaluation and sought to introduce psychological evidence in court. As a result, the prosecution had a right to rebut this presentation with the report of the requested examination. Furthermore, unlike the situation in *Estelle v. Smith,* Mr. Buchanan's attorney himself had requested Dr. Lange's evaluation and presumably discussed it with his client. Therefore, Mr. Buchanan and his attorney were on notice that if they intended to introduce a mental status defense, they could anticipate the use of psychological evidence in rebuttal (*Buchanan v. Kentucky* 1987).

Diagnostic Considerations

Psychotic disorders are the most common diagnoses among criminal defendants referred for CST evaluations and subsequently found IST. In assessing the frequency of an IST finding with defendants referred for an evaluation, research indicates that between 45% and 65% of defendants with schizophrenia or other psychotic illnesses are found incompetent (Nicholson and Kugler 1991; Reich and Wells 1985; Roesch et al. 1981; Warren et al. 1991); between 23% and 37% of defendants with affective disorders are found incompetent (Miller and Germaine 1988; Rogers et al. 1988; Warren et al. 1991), and between 12.5% and 36% of individuals with mental retardation are found incompetent (Miller and Germaine 1988; Reich and Wells 1985; Warren et al. 1991). In a study published by the MacArthur Foundation Research Network on Mental Health and the Law (Hoge et al. 1997), 65% of defendants hospitalized as IST had a diagnosis of schizophrenia and 28% had a diagnosis of affective disorder. Research indicates that active psychotic symptoms (such as hallucinations and conceptual disorganization) are strongly correlated with impairments in trial-related abilities (Hoge et al. 1997; James et al. 2001).

Although psychotic disorders, severe mood disorders, and cognitive impairments represent the most common diagnoses associated with a finding of trial incompetency, a less severe diagnosis could potentially render a defendant incompetent. However, the examiner must understand that many defendants may feel sad or anxious about their legal situation and such adjustment reactions are not usually of the type or severity that actually impairs a defendant's ability to participate in the legal process. Likewise, personality disorders alone are not typically considered as a predicate diagnosis responsible for rendering a defendant trial incompetent. For example, a defendant with antisocial personality disorder who threatens his attorney and

lies to the examiner may have difficulties working with counsel, but such antisocial behaviors are generally not accepted as sufficient support for a finding of trial incompetency. However, some personality disorders, such a schizoid or paranoid personality disorder, may impact a defendant's psycholegal abilities, and trial courts have allowed consideration of such disorders when determining trial competency (*State v. Stock* 1971; *U.S. v. Veatch* 1993).

What if a defendant claims amnesia for the crime and asserts that he or she cannot assist his or her attorney as a result? According to Cima and colleagues (2004), 23% of male forensic inpatients charged with serious crimes claimed either partial or total amnesia for their alleged crimes. Is a defendant unable to assist the attorney in his or her own defense if he or she cannot even remember his or her role, if any, in the crime? Two circuit courts have addressed this very question.

In the case of *Wilson v. United States* (1968), Mr. Wilson and a codefendant robbed a pharmacy store and were subsequently pursued in a high-speed police chase that ultimately resulted in the getaway car crashing into a tree. Mr. Wilson suffered a skull fracture and ruptured blood vessels and his partner-in-crime died. After awakening from a 3-week coma, Mr. Wilson could not recall anything that happened on the afternoon of the robberies and his mental status was otherwise basically normal. Despite his amnesia for the day of the crime, he was found competent and subsequently found guilty. Mr. Wilson appealed, claiming that his amnesia prevented him from testifying on his own behalf (in violation of the Fifth Amendment) and effectively assisting his attorney (in violation of the Sixth Amendment). The D.C. Court of Appeals held that amnesia was not an automatic bar to a defendant being found incompetent and remanded the case back to the trial court to carefully review if Mr. Wilson's amnesia had negatively impacted his trial competency. The D.C. Court outlined a two-stage process for consideration of an amnestic defendant. First, the trial court must predict if the defendant's reported amnesia would render him or her competent or incompetent. If the defendant is found competent, the court must then conduct a post-trial stage, where six factors are reviewed to evaluate if the defendant's amnesia actually impaired his or her capacity to participate during the trial process. The six factors to be considered in this post-trial analysis are outlined in Table 13–2.

Not all circuits follow the process outlined by the *Wilson* Court when evaluating the impact of amnesia on trial competency. For example, in the Seventh Circuit case of *U.S. v. Andrews*, the court held that if an amnestic defendant is determined competent to stand trial, then a subsequent post-trial review of how amnesia impacted the trial process is not required (*U.S. v. Andrews* 2006).

TABLE 13–2. Wilson factors to evaluate amnesia impact on competency-to-stand-trial capacity

Effect of the amnesia on the defendant's ability to consult with and assist his lawyer
Effect of the amnesia on the defendant's ability to testify
How well the evidence could be extrinsically reconstructed, including evidence relating to the alleged offense and any plausible alibi
Extent to which the government assisted the defense in this reconstruction
Strength of the prosecution's case, including the possibility that the accused could, but for his or her amnesia, establish an alibi or other defense
Any other facts and circumstances that would indicate whether or not the defendant had a fair trial

Source. *Wilson v. United States* 1968.

The forensic evaluator should also consider the possibility that the defendant may malinger psychiatric symptoms to avoid potential prosecution. Approximately 10% of defendants referred for a competency evaluation are noted to feign or exaggerate mental symptoms in an attempt to appear trial incompetent (Gothard et al. 1995; Rogers et al. 1994). In evaluating the possibility of malingering, the examiner should consider following standard approaches to the assessment of malingered psychiatric symptoms, as outlined in Chapter 20, "Personal Violence," this volume. Factors that increase the likelihood of malingering related to trial competency are outlined in Table 13–3.

Forensic Evaluation Specific to Competency to Stand Trial

The examiner should first consider obtaining basic information from the defendant about his or her prior history and level of functioning before immediately proceeding to competency-specific questions. For example, if a biopsychosocial history is taken and the defendant has an excellent memory with no evidence of a cognitive deficit, then a sudden loss of memory related only to questions about the legal process suggests malingering. Conducting a baseline mental status examination *before* inquiring about the defendant's understanding of legal matters allows the examiner to test the defendant's memory capacity, basic fund of knowledge, and ability for immediate recall—all relevant areas in evaluating a defendant's actual abilities.

TABLE 13–3. Factors suggesting malingered competency-to-stand-trial (CST) evaluation

Atypical presentation of psychiatric symptoms
Malingering indicated on psychological testing
Malingered responses on structured CST evaluation instruments
Mental disorder symptoms appearing only during a CST evaluation
Defendant's level of functioning declining only during CST evaluation
Markedly impaired cognitive ability only when CST questions are asked
Excellent abilities to work on other legal cases (such as a civil lawsuit)

After establishing a baseline regarding the defendant's general abilities and functioning, questions specifically related to trial competency are usually asked. Such questions typically ask the defendant to demonstrate an understanding of the following (Resnick and Noffsinger 2004) legal areas:

- *Legal charges.* The defendant should be asked to describe what he or she has been charged with, his or her understanding of the seriousness of the charges, and potential sentences for each charge. If the defendant is unable to name the precise penal code term for the charge, the examiner should assess whether the defendant possesses an appropriate understanding of the elements of the charge. For example, if the defendant does not state precisely that he or she is charged with first-degree homicide but does tell the examiner that the defendant is charged with a premeditated murder, then he or she has demonstrated a basic understanding of this charge.
- *Roles and responsibilities of courtroom participants.* The defendant can be asked to explain the role of the defense attorney, prosecuting attorney, judge, witness, and jury, as well as the defendant. In addition to understanding the defendant's rational knowledge of the courtroom participants, the examiner should also evaluate if the defendant has any irrational beliefs associated with these individuals that negatively impact the defendant's trial competency. Consider the facts outlined in Case Vignette 1, in which Mr. C refuses to speak with his attorney. If this behavior is due to an irrational belief that his attorney has been hired by the FBI to steal his money by holding him in jail, then this delusional belief is likely to impact his ability to have a rational understanding of his attorney's role.
- *Available pleas.* The examiner should inquire into the defendant's knowledge of various pleas, which should include the plea of guilty, not guilty, not guilty by reason of insanity (if available in the governing jurisdiction), and no contest. In addition, the defendant should understand the

concept of plea-bargaining, which generally involves a reduced sentence for the defendant in exchange for a conviction (without going to trial) for the prosecution. If a defendant refuses to consider a plea bargain, the forensic psychiatrist should evaluate if this refusal results from irrational thinking due to a mental disorder. For example, in the case of Mr. C, if he delusionally believes that he could never be found guilty because he is Jesus Christ and above all laws of the land, he would likely be found incompetent as a result. Likewise, if Mr. C refuses to even discuss a plea of insanity due to his irrational and persistent belief that he does not have a mental disorder and as Jesus Christ he could never be found insane, then this belief system would be likely to significantly impair his ability to rationally assist counsel.

In some situations, a defendant may provide inadequate answers about the legal process because of a lack of knowledge about the justice system, as opposed to an impaired understanding due to a mental disorder. A lack of knowledge alone does not equate with trial incompetency. In these situations, the evaluator should educate the defendant about the court and later ask the defendant about the provided information to determine if he or she has the capacity to retain and apply this new knowledge.

In addition to the trial-related areas described, the examiner should also gather information regarding the defendant's ability to assist in his or her defense. Important areas to consider in this regard are outlined in Table 13–4.

Asking the defendant to provide his or her account of the crime may assist the expert in evaluating the defendant's understanding of the charges, potential witnesses who might testify for or against the defendant, the presence of incriminating or exculpatory evidence, his or her ability to communicate key information to counsel, and an understanding of available pleas based on the offense circumstances (to include a plea of insanity). If a defendant refuses to discuss the facts of the crime, the expert should ask the defendant to explain why he or she wishes to withhold this information. Some defendants refuse to provide the facts of the crime based on their attorneys' instructions not to discuss the offense with anyone but legal counsel. The defendant in this situation may be demonstrating a rational ability to follow legal guidance, an important aspect of CST. In contrast, another defendant may refuse to discuss his or her offense based on paranoia about the examiner or the trial process, indicating an irrational belief system and possible incompetence (Mossman 2007).

Although the defendant's account of the crime is relevant in evaluating trial competency, the expert should determine if there is any prohibition in the defendant's jurisdiction from gathering the account of the crime. Potential concerns about taking a defendant's crime account as part of a trial com-

TABLE 13–4. Areas to evaluate defendant's ability to assist in his or her defense

Ability to work with defense counsel
Ability to appreciate his or her legal situation as a criminal defendant
Ability to rationally consider a mental illness defense
Ability to appraise evidence and estimate likely outcome of a trial
Ability to have sufficient memory and concentration to understand trial events
Ability to maintain appropriate courtroom behavior
Ability to provide a consistent and organized account of the offense (although reported amnesia of offense does not necessarily prevent a finding of competency)
Ability to formulate a basic plan of defense

Source. Resnick and Noffsinger 2004.

petency evaluation include the possibility that this information will be used against the defendant at a later stage of the trial or expose likely future legal strategies to the prosecution. To minimize this risk, the expert should consider including only a general statement in the report that the defendant was able to discuss his or her whereabouts on the day of the crime and his or her version of events surrounding the alleged offense. If the expert is later asked to testify about specific information about the crime provided by the defendant during the CST evaluation, the expert can seek guidance from the court about whether the expert is allowed to discuss any potentially incriminating information before answering this question (Mossman 2007).

Psychological Testing and Structured Evaluation Instruments

For defendants who may have a developmental disability or mental retardation, intelligence testing is often utilized to assess the degree, if any, of cognitive impairment. Psychological tests, such as the Structured Interview of Reported Symptoms, Structured Inventory of Malingered Symptomatololgy, Miller Forensic Assessment of Symptoms Test, Test of Memory Malingering, and the Minnesota Multiphasic Personality Inventory–2 (MMPI-2), may be particularly helpful in determining if the defendant is feigning or exaggerating symptoms. Projective tests, such as the Rorschach, are generally not relevant to assessing a defendant's psycholegal abilities. In regard to the limited role of psychological testing in CST evaluations, Melton and colleagues (2007)

expressed the following observation: "the routine administration of conventional psychological tests is unlikely to be a cost-efficient means of gathering information in most competency cases. Because the nature of the cognitive deficits in such cases is relatively specific, generalized measures of intelligence or personality are unlikely to be very helpful" (Melton et al. 2007, p 161). This position is also emphasized in the Practice Guideline for Trial Competency that reads, "Psychiatrists can usually ascertain the crucial psychological data relevant to functioning as a competent criminal defendant directly from interviewing defendants and evaluating information provided by collateral sources" (Mossman et al. 2007, p. S36).

Several structured evaluation instruments designed to evaluate a defendant's CST have emerged and can serve as a useful guide for the evaluator. A summary of the most common structured evaluation instruments is highlighted in Table 13–5.

Case Vignette 2

Mr. J is a 48-year-old defendant who has been charged with making terrorist threats against his wife. A community evaluator found him incompetent to stand trial, opining that Mr. J was so depressed that he could not assist in his own defense. Mr. J was subsequently committed to a state psychiatric facility for trial competency restoration. Several months after his admission, treatment team members observe that Mr. J is very outgoing, is appropriately engaged with peers and staff, and has excellent attention and concentration, noted in various rehabilitation and treatment groups. He is elected "ward president," effectively runs meetings, and is extremely articulate. The treatment team observes no signs of depression. However, whenever the unit psychologist attempts to speak with him about his potential trial, he tells her that he is "too depressed" to talk about his legal situation and refuses to participate in formal competency assessments. The psychologist is unclear as to how to proceed.

Assessment of Defendants Who Refuse a Competency-to-Stand-Trial Evaluation

Evaluators may encounter situations when a defendant refuses to participate in the competency assessment. An evaluation refusal alone does not equate with trial incompetency. Otherwise, all defendants could simply maintain their silence during an evaluation, thereby preventing their cases from moving forward. How might an examiner assess a person's competency to stand trial when he or she refuses to answer questions to ascertain understanding of the trial process and/or his or her current legal situation?

First, the examiner should remember that he or she is attempting to determine if the defendant has a mental disorder that actually interferes with

TABLE 13–5. Competency-to-stand-trial (CST) structured evaluation formats

Instrument and description	Pros/cons
Competency Screening Test	
Screening instrument	*Pros:*
22-item sentence completion test	Standardized administration and scoring
	Cons:
	Written administration may be problematic in low literacy and cognitively impaired offenders
	Scoring system may bias toward incompetency
	Does not measure specific CST psycholegal abilities
Georgia Court Competency Test	
Screening instrument	*Pros:*
Includes picture of courtroom layout where participants sit	Explicit scoring system
	Quick and easy to administer
Asks questions about roles of courtroom participants and defendant's relationship with counsel	*Cons:*
	May not adequately evaluate understanding and participation in legal process, including ability to assist counsel
Competency Assessment Instrument	
Nonstandardized, semistructured interview	*Pros:*
Uses 5-point Likert ratings to evaluate 13 court-related abilities	Provides organized format to focus interview with numerous sample questions
	High face validity
	Cons: Neither administration nor scoring is standardized

TABLE 13–5. Competency-to-stand-trial (CST) structured evaluation formats *(continued)*

Instrument and description	Pros/cons
MacArthur Competency Assessment Tool—Criminal Adjudication	
Semistructured interview format that utilizes 22 items	*Pros:*
Utilizes a hypothetical vignette to assess a defendant's psycholegal abilities	Provides explicit scoring criteria
Yields information on understanding, appreciation, and reasoning competency-related abilities	Unique format allows assessment of defendant's ability to process and understand relevant information
	Component measures closely related to *Dusky* criteria
	Cons:
	Hypothetical vignette used to assess understanding, and reasoning abilities do not pertain to defendant's own case
Evaluation of Competency to Stand Trial—Revised	
Semistructured interview format	*Pros:*
Contains three scales: Consult with Counsel; Factual Understanding of Courtroom Proceedings; and Rational Understanding of Courtroom Proceedings	Component measures closely related to *Dusky* criteria
	Includes a brief measure to screen for possible feigning
	Excellent psychometric properties
Scale scores can be converted to T-scores used to assess degree of functional capacity impairment with comparison norms from offender samples	*Cons:*
	Limited range of potential psychopathologies to evaluate and rate
	Gradations of psychopathology do not clearly translate to effect on CST
	Internal validity issues regarding item ratings and scale interpretations

TABLE 13–5. Competency-to-stand-trial (CST) structured evaluation formats *(continued)*

Instrument and description	Pros/cons
Competence Assessment for Standing Trial for Defendants With Mental Retardation	
Contains 50 items in three sections	*Pros:*
Sections I and II use multiple-choice questions at 4th grade reading level to evaluate understanding of legal terms and ability to assist defense. Section III includes oral questioning to elicit narrative answers	Scoring guidelines provided Satisfactory psychometric properties *Cons:* Competence assessment is limited to defendant's "understanding" abilities Multiple-choice recognition format does not allow in-depth evaluation of defendant's understanding of legal issues.

Source. Melton et al. 2007.

his or her *capacity* to stand trial. Although Mr. J reports to the unit psychologist that he is "too depressed" to return to court and face his charges, the actual objective evidence does not support his claim. He is noted to joke, smile, and effectively manage his role as ward president in the absence of any depressive or other mental health symptoms. Objective evidence should not be ignored when conducting an evaluation of a defendant's mental state. Second, Mr. J has demonstrated highly organized capacities that are relevant in assessing his trial competency, even if he refuses to answer specific questions about his case. For example, he has been observed to learn new material, to have sustained concentration on various tasks assigned to him, and to advocate for other patients' rights—all important capacities relevant to working with an attorney and facing trial. The examiner should collect objective evidence to determine if an evaluation refusal is due to a mental disorder or is more consistent with voluntary noncooperation. It is possible that a defendant could refuse an examination due to severe paranoia regarding the examiner and his or her role in the legal system. However, this is not the situation outlined in the case vignette regarding Mr. J.

Competence to Represent Oneself

Although the Sixth Amendment to the U.S. Constitution guarantees a criminal defendant the right to assistance of counsel, defendants may desire to represent themselves. This approach has also been referred to as a *pro se* defense, a Latin phrase that translates as "for oneself." Two landmark U.S. Supreme Court cases have upheld a defendant's right to self-representation. In the 1975 case of *Faretta v. California*, the U.S. Supreme Court held that a court cannot automatically force an attorney upon an unwilling defendant. Mr. Faretta was charged with grand theft in Los Angeles County, California. Well before the trial, he requested that the judge allow him to represent himself. The judge questioned Mr. Faretta about his decision and learned that he had a high school education, had previously represented himself in a criminal prosecution, and did not want an appointed public defender because of his concerns about the heavy workload in the public defender's office. In addition, there was no evidence that Mr. Faretta suffered from any type of mental disorder. Although the judge originally granted Mr. Faretta's request, he later reversed his own decision and appointed a public defender. The judge ruled that Mr. Faretta had no constitutional right to represent himself. At trial and with forced legal representation, Mr. Faretta was found guilty and the judge sentenced him to prison. On appeal, the U.S. Supreme Court held that a defendant has a constitutional right to self-representation when he or she voluntarily and intelligently elects to represent himself or herself (*Faretta v. California* 1975).

In the subsequent case of *Godinez v. Moran* (1993), the U.S. Supreme Court continued to uphold the right of a defendant to waive assistance by counsel. Richard Allan Moran was charged with three counts of first-degree murder after he walked into the Red Pearl Saloon and shot the bartender and a customer prior to robbing the cash register. Nine days later, he shot and killed his ex-wife and then unsuccessfully attempted suicide by shooting himself and slitting his wrists. He later confessed to the killings, yet pleaded not guilty to his charges. Although two court-ordered psychiatrists noted that he was depressed, he was found competent to stand trial. Mr. Allen subsequently informed the court that he wanted to change his plea to guilty and discharge his attorneys. After being found guilty and sentenced to death, Mr. Allen appealed, claiming that he was mentally incompetent to represent himself. The trial court dismissed Mr. Allen's petition and he appealed this decision to the U.S. Supreme Court. The Supreme Court ruled that the competency standard to waive the right to counsel and plead guilty is the same as the standard for determining CST. The *Godinez* Court also noted that whether or not the defendant could represent himself adequately was irrelevant to his decision to forego legal counsel (*Godinez v. Moran* 1993).

Does the *Godinez* ruling prohibit a state from ever adopting a higher standard for competency to represent oneself than the competency-to-stand-trial standard? The answer to this question appeared in the 2008 U.S. Supreme Court *Indiana v. Edwards* ruling. Ahmed Edwards attempted to steal a pair of shoes from an Indiana department store. When discovered by a department store security officer, he fired three shots, one of which wounded a bystander. He was charged with attempted murder, battery with a deadly weapon, criminal recklessness, and theft. Edwards was found incompetent to stand trial and committed to a state hospital for competency restoration. After 5 years, he was found trial competent, and then asked to serve as his own attorney. The court appointed an attorney who acted on Mr. Edwards' behalf and the jury deadlocked on some of the charges. At his retrial, Mr. Edwards again asked to represent himself. The trial judge ruled that although Mr. Edwards was competent to stand trial, he was not competent to represent himself. Mr. Edwards was tried and convicted of battery and attempted murder. He ultimately appealed the case to the U.S. Supreme Court, alleging that his rights had been violated because he had not been allowed to represent himself, even though he had been found competent to stand trial. The U.S. Supreme Court majority held that a court may deny a mentally ill defendant found competent to stand trial the right to self-representation. However, the Court did not articulate any standard to determine a defendant's competency to act as his or her own legal counsel, nor did they overrule the prior *Faretta* holding that addressed a non-mentally ill defendant's right to self-representation (*Indiana v. Edwards* 2008).

Juveniles and Competency to Stand Trial

Grisso and colleagues (1987) recommend that a juvenile's trial competency be questioned if any one of the following conditions is present: 1) age 12 years or younger; 2) prior diagnosis/treatment for a mental illness or mental retardation; 3) borderline intellectual functioning or learning disability; and 4) observations that youth has deficits in memory, attention, or interpretation of reality. In a descriptive review of 136 juveniles ages 9–16 years who were referred for evaluation of trial competency in South Carolina, Cowden and McKee (1995) found that 80% of youths ages 9–12 years were incompetent to stand trial, nearly 50% of those ages 13 and 14 years were trial incompetent, and approximately 25% of 15- to 17-year-olds were incompetent to stand trial. Cooper (1997), in another study of juvenile offenders in South Carolina, found that a majority of juvenile offenders of all ages had significant deficits in their competence-related abilities. Juveniles ages 13 years and under and those with low-average or below average IQ scores were particularly at risk.

How do juveniles differ from adults in regard to understanding the legal process? Particular concerns involve a youth's naïve views that the judge or probation officer will always be able to determine the truth, even without the child's involvement; an internalized belief system that the youth must always admit any mistakes or wrongdoing; and little, if any, experience with the criminal justice system (Mossman et al. 2007).

Grisso and colleagues (2003) compared the adjudicative competence abilities among 927 adolescents in juvenile detention facilities and community settings to 466 young adults in jails and in the community. Key findings from this study were as follows:

1. In general, juveniles 15 years or younger performed more poorly than adults.
2. When presented with hypothetical decision-making vignettes, adolescents were more likely than young adults to make choices that indicated they were more compliant with authority figures.
3. Younger adolescents were less likely to recognize the long-term inherent risks in the legal process, such as answering questions when interrogated by the police, not consulting with an attorney, or evaluating the pros and cons of a plea agreement.

Many of the deficits noted are due to psychosocial immaturity rather than a specific mental disorder. Because lack of social or emotional maturity does not qualify as a mental disease or defect, what happens if a child is not competent to participate in juvenile proceedings or in adult court due to psychosocial imma-

turity? In other words, how does the court manage those youth whose trial competency deficits are related to their young age alone rather than any mental health diagnosis? There is no one consistent approach to address this situation. Interventions vary according to jurisdiction, age of the child, and severity of the crime. Potential options include dismissing the charges, civil commitment for youth who are a danger to self or others, or social service, educational, and treatment interventions if further adjudication is not feasible (Grisso et al. 2003).

Competency-to-Stand-Trial Evaluation Outcomes

Once an evaluator has rendered his or her CST opinion, a court hearing is usually held to make a legal determination of the defendant's competency to stand trial. In some cases, the attorneys stipulate to a finding without a formal hearing. If a defendant is found IST, he or she is usually involuntarily committed to an inpatient psychiatric facility for competency restoration. Inpatient competency restoration typically involves a combination of treatment for the defendant's underlying mental illness and education regarding the legal system (Noffsinger 2001).

A treating psychiatrist may encounter a defendant who refuses to take the psychiatric medication prescribed to treat the underlying mental disorder, thereby delaying or preventing competency restoration. There are three approaches to consider when faced with this situation. First, in most jurisdictions, the psychiatrist can involuntarily medicate an individual whose mental disorder requires emergency treatment. However, continued involuntary medication is generally not authorized once the emergency situation has passed. Second, pretrial detainees may be involuntarily medicated under criteria found constitutionally acceptable, as outlined in the case of *Washington v. Harper* (1990). In this case, Washington state prison officials involuntarily medicated inmate Walter Harper. This decision was in accordance with a prison policy that authorized forced medication after a prison committee determines that the following two conditions are present:

1. The inmate suffers from a "mental disorder"; and
2. The inmate is "gravely disabled" or poses a "likelihood of serious harm" to himself or others.

In many jurisdictions, hospitals have created their own review committee, commonly referred to as a "*Harper* panel," that follows the Washington state policy just described to determine when to involuntarily medicate an incompetent pretrial defendant.

Third, in the case of *Sell v. United States* (2003), the U.S. Supreme Court outlined conditions regarding when an incompetent defendant may be involuntarily medicated when the defendant's mental condition does not result in an acute emergency, a grave disability, or a likelihood of serious harm to self or others. Charles Sell was a St. Louis dentist who had a longstanding history of delusional disorder. He was charged with multiple counts of Medicaid fraud and one count of money laundering. While released on bail, his mental status reportedly deteriorated and he was eventually charged with one count of conspiring to commit murder of the FBI agent who had arrested him.

Dr. Sell was found incompetent to stand trial and was involuntarily committed to a hospital for competency restoration. He refused to take the antipsychotic medication prescribed for his delusional disorder. Dr. Sell's condition did not represent a psychiatric emergency, nor did he meet the involuntary medication criteria outlined by the *Harper* Court. Dr. Sell challenged any involuntary medication administration, and the case was appealed to the U.S. Supreme Court. The issue before the court was whether the U.S. Constitution permits the government to involuntarily administer antipsychotic drugs to a mentally ill criminal defendant for the purpose of rendering the individual competent to stand trial. The U.S. Supreme Court outlined conditions that must be met prior to the involuntary administration of medication. These factors are sometimes referred to as the "*Sell* criteria" and are stated in Table 13–6 (*Sell v. United States* 2003).

Studies examining variables that predict successful restoration of competency in IST defendants yield mixed findings. Research indicates that increased impairment in psycholegal ability, aggression toward others after arrest, and greater psychopathology are associated with a negative outcome regarding restoration to competency and length of hospital stay, whereas a history of criminality and substance abuse at the time of the offense are associated with a positive outcome (Nicholson and McNulty 1992; Nicholson et al. 1994). In contrast, other research indicates that the use of psychotropic medications to treat psychotic symptoms is the only reliable correlate of competency restoration (Carbonell et al. 1992). For mentally retarded defendants found IST, treatment is generally focused on gaining competency, rather than on competency restoration (Anderson and Hewitt 2002). Once mentally retarded defendants are adjudicated incompetent, they are not likely to gain competency after competency restoration treatment (Daniel and Meninger 1983; Ellis and Luckasson 1985; C. Everington, R. Luckasson, "Competence Assessment for Standing Trial for Defendants With Mental Retardation: CAST-MR," unpublished manuscript, 1987).

Because disabilities associated with mental retardation may be more resistant to traditional treatments, specialized training or individualized programs may be necessary to maximize opportunities for competency res-

TABLE 13–6. Sell criteria for involuntarily medicating a defendant found incompetent to stand trial

1. The court must find an important government interest is at stake. Both person and property crimes can be viewed as serious offenses that justify the government's interest in adjudicating criminality.
2. The court must find that the medication significantly furthers the state's interests. For example, the medication should likely render the defendant competent to stand trial and not have such severe side effects that this would interfere with the trial competency.
3. The medication must be the most appropriate method of restoring trial competency, which cannot be achieved with less intrusive treatments.
4. The medication must be medically appropriate, which takes into consideration the efficacy of the medication as well as its side effects.

toration. Some defendants found incompetent to stand trial do not respond to treatment and may be determined nonrestorable to trial competency. In this situation, the defendant charges may be dismissed or held in abeyance. Incompetent defendants found nonrestorable can be involuntarily hospitalized if they meet the civil commitment criteria outlined by their jurisdiction (Resnick and Noffsinger 2004).

Case Vignette 3

Ms. G is a 49-year-old woman whose schizophrenic illness causes her to believe that she has been chosen by God to rid the world of evil. She also has the delusional belief that the local school principal is selling hundreds of innocent children into a slave trade where they are raped, tortured, and eventually killed. Ms. G makes repeated reports to the local police regarding her delusional fears and they reassure her that the school principal is not harming children. They also warn her that if she attempts to go near the principal or threatens to harm him, they will arrest her for stalking and/or making a terrorist threat. Even though Ms. G has been told by law enforcement to stay away from the school principal, she continues to fear that more children will be murdered and, therefore, she must keep a close watch on his activities. One morning at 7:55 A.M., Ms. G is slowly driving by the school where she scans the doors seeking "warning signs." She sees an 8-year-old girl standing outside the front door next to the principal. She believes the principal is preparing the young girl for "hypnotic imminent execution," which will occur at the very moment the 8:00 A.M. school bell rings. She stops her car suddenly, jumps out, and frantically rushes toward the principal with a large hunting knife, screaming, "No more sex slaves! Stop the child murderer. Stop him!" She stabs the principal directly in the heart where he collapses at the front door and dies, mere moments before the morning bell rings.

The Insanity Defense

Insanity is a legal but not a psychiatric term. The insanity evaluation determines whether the defendant is so mentally disordered that he or she is not blameworthy or criminally responsible for his or her behavior. This evaluation is also known as a criminal responsibility evaluation. In contrast to CST evaluations that focus on a defendant's *present* mental capacity as related to his or her understanding and participation in the legal process, an insanity evaluation involves a retrospective evaluation of a person's *past* mental state at the time of the alleged offense. The general public's view that the insanity defense is frequently used to avoid criminal prosecution is incorrect; only 1% of defendants charged with a felony actually plead insanity (Callahan et al. 1987). Steadman and colleagues (1983) estimated that when the insanity defense was raised, the defense was successful only 25% of the time. Over 70% of insanity acquittals are the result of a plea bargain, indicating that only a small number of insanity cases are actually heard by a jury (Cirincione 1996). The majority of individuals who are found criminally insane are involuntarily committed to a psychiatric facility, where periodic reports regarding their status are forwarded to the responsible court. Individuals found insane may be released when the court has determined that they have met their jurisdictional requirements for a safe release into the community, a process commonly known as "restoration to sanity."

Insanity Tests

The most common test of insanity in the United States is known as the M'Naghten standard, which was developed in 1843 following the trial of Daniel M'Naghten. Mr. M'Naghten was found not guilty by reason of insanity after he attempted to assassinate the prime minister of Britain and instead shot his secretary Edward Drummond. Queen Victoria, angered by the legal outcome in this case, ordered her 15 law lords to draft a new standard of criminal responsibility. The new standard recommended by the Lords was as follows:

> To establish a defence on the ground of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was labouring under such a defect of reason, from the disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong. (M'Naghten's Rule 1843)

This test is often referred to as the *right/wrong* test or *cognitive* test because of its emphasis on the defendant's ability to know, understand, or appreciate the nature and quality of his or her criminal behavior or the wrongfulness of his or her actions at the time of the crime.

A second insanity test used in some jurisdictions is known as the *irresistible impulse* test. In essence, this test asks the evaluator to determine if the defendant's mental disorder rendered him or her unable to refrain from his or her behavior, regardless of whether the defendant knew the nature and quality of his or her act or could distinguish right from wrong. A major criticism of this test has been the broadness of its scope. In other words, because a defendant did not refrain from a particular criminal behavior, mental health evaluators could use this as evidence that the defendant could not resist his or her impulse, thereby concluding that all criminal behavior not resisted equals insanity. Despite its current unpopularity as a measure of criminal responsibility, this test survives, in part, because both Virginia and New Mexico combine the irresistible impulse test with the M'Naghten test (Giorgi-Guarnieri et al. 2002).

A third test is known as the *Durham rule* or *product test* (*Durham v. United States* 1954). This insanity test derived from a D.C. Circuit case in which Judge Bazelon allowed a finding of insanity if the defendant's unlawful act was a "product of a mental disease or defect." As with the irresistible impulse test, the product test expanded the category of those who were eligible for a finding of insanity and rapidly fell out of favor. It is currently used in only two jurisdictions in the United States: New Hampshire and the Virgin Islands (Giorgi-Guarnieri et al. 2002).

Another final test of insanity was developed in 1955 by the American Law Institute when it was formulating the Model Penal Code. This test is stated as follows:

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. (American Law Institute Model Penal Code 1985, §4.01)

This test involves both a cognitive arm ("appreciates the criminality of his conduct") and a volitional arm (ability to conform behavior).

Preparing for the Sanity Evaluation

When preparing for an evaluation of a defendant's criminal responsibility, the expert should first clarify if he or she is court appointed or retained by the defense or prosecution. Although the examiner should always strive for

honesty and objectivity regardless of the retaining party, opinions rendered by a psychiatrist hired by the defense are not always disclosed to other parties. Prior to conducting the evaluation, the defense attorney should be notified of the impending interview. In some situations, the defense attorney may request to be present during the assessment and may obtain a court order allowing defense counsel to do so. If this situation occurs, the evaluator should request that the defense counsel not interrupt the examination or instruct the defendant how to respond to questions.

Second, the evaluator should request the exact language of the jurisdiction's insanity statute and any relevant case law. Third, it is important to understand how mental disorders or defects are statutorily defined. The exact definitions of mental disease and mental defect are usually found in either case law and/or and statutes. The examiner should carefully review if any disorders are prohibited from consideration for the insanity defense. Diagnoses commonly excluded include voluntary intoxication with alcohol or other drugs, personality disorders, and adjustment disorders. Psychotic disorders, such as schizophrenia, schizoaffective disorder, or mood disorders with psychotic features, are the most common diagnoses that qualify for an insanity defense.

Fourth, the examiner should review collateral records that may assist in evaluating the mental state of the defendant at the time of the offense. If the defendant refuses to sign a release for records, the expert can request the court to order the release of records important in conducting the insanity analysis. Collateral records that may assist in the sanity evaluation are noted in Table 13–7.

The forensic expert should pay particular attention to those records that describe the defendant's mental state close to the time of the crime. Specific areas to review in the collateral records are

- Defendant's exact statements before and after the offense
- Defendant's various offense accounts to police and others
- Presence of any mental health symptoms near the time of the offense, particularly psychotic symptoms such as paranoia, delusions, and/or hallucinations
- Presence or absence of substance use prior to the offense
- Presence of antisocial personality traits or disorder
- Presence of a rational alternative motive rather than a psychotic motive
- History of a similar offense indicating a possible pattern of criminal behavior
- History of malingering psychiatric symptoms before or after the offense

In addition to collateral records, other evaluators' opinions may also assist in reviewing the consistency of the defendant's presentation and account

TABLE 13–7. Collateral records to consider in a sanity evaluation

Defendant's account of crime to police or other witnesses
Audio- or videotaped statements from defendant
Witness and victim statements
911 calls (if available)
Videotape of crime or crime scene (if available)
Jail booking and treatment records following the defendant's arrest
Prior psychiatric records
Prior psychological testing
Prior drug and alcohol treatment records
Prior medical records
Any writings from defendant that may reflect his or her mental state or motive
Computer hard drive and communications, where appropriate
Rap sheet and records of prior arrests/convictions
Prior prison records
Prior educational records
Prior work records

of the crime. However, the examiner should first determine if any prior psychological examinations are prohibited from his or her review. Finally, the examiner may find it helpful to take a detailed social background history from family members and individuals who know the defendant, paying particular attention to the defendant's mental state in the days and hours prior to the crime.

Sanity Evaluation of Defendant

The forensic expert should evaluate the defendant as soon as possible in order to assess the defendant's mental state close to the time of the crime and to minimize the risk that he or she will learn how to malinger mental illness (Resnick and Noffsinger 2004). As with CST evaluations, the forensic evaluator should explain to the defendant the nature and purpose of the interview. The American Association of Psychiatry and the Law's Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense provides the following quoted language to explain the limits of nonconfidentiality to a defendant (Giorgi-Guarnieri et al. 2002, p. S20):

> I am a physician and psychiatrist who has been asked [by the court or the prosecuting attorney] to answer three questions:

1. What was your mental state at the time of the crimes you have been charged with committing?
2. Did you have a mental disorder?
3. At the time of the crime you are charged with committing, were you so mentally ill that the court should find you not criminally responsible?

After providing the initial informed consent, the evaluator usually conducts a biopsychosocial psychiatric interview. Key areas to review include past psychiatric history and prior hospitalizations, family psychiatric history, educational history, any history of learning disabilities or mental retardation, and the defendant's social and relationship history, particularly as related to any of their crime victims.

The examiner must give particular attention to obtaining the defendant's account of the crime in an open-ended manner that does not suggest to the defendant what he or should say. For example, the evaluator might say, "What happened on the day of the offense? Tell me everything that you remember, starting with the day before this happened." The evaluator should ask the defendant to describe his or her thoughts, feelings, and exact behaviors before, during, and after the alleged crime. After obtaining the defendant's initial account, the evaluator may need to ask more detailed specific questions to evaluate the defendant's sanity. In addition, the examiner should clarify with the defendant any inconsistent offense accounts that he or she has provided either during the interview or to other individuals (Resnick and Noffsinger 2004). Questions an evaluator should consider asking to help obtain the defendant's account of the crime are listed in Table 13–8.

The evaluator will also need to consider the possibility that the defendant may malinger psychiatric symptoms in an attempt to avoid criminal prosecution. The examiner should be particularly familiar with characteristics of faked hallucinations or delusions (Resnick 1999). The use of psychological tests designed to assess malingered psychiatric symptoms (previously described for CST evaluations) may also be useful. However, the evaluator should also appreciate that these tests do not specifically evaluate the defendant's mental status at the time of the crime. Therefore, a finding on a psychological test that the defendant is not currently malingering symptoms does not necessarily mean that he or she is not feigning symptoms about his or her mental state in the past.

The Sanity Opinion

There are three important areas to review when rendering an opinion on a defendant's criminal responsibility. First, the evaluator must establish if the individual had a mental disease or defect at the time of the crime. The expert

TABLE 13–8. Sample questions to help evaluate mental state at time of offense

What was your relationship to the victim [if the crime involved a victim]?
When did you first have the thought to commit your offense?
Did you prepare for this? If so, how?
Had you ever tried to do this before? If so, what stopped you or why did it not work out?
What did you do immediately following this offense?
Why did you take those particular actions following the offense?
Prior to your committing this crime, did you know that this was against the law?
At the time that you committed this crime, did you know it was against the law?
Would you have done this if a police officer was near or at the scene? If yes, why? If no, why not?
Would you have done this if someone unexpected arrived at the scene? If yes, why? If no, why not?
Is there anything that made you think what you did was a right thing to do? If so, what?
When was the last drink of alcohol or use of any other drugs you took prior to this crime?
Were you experiencing any type of mental health symptom at the time of the crime? If so, what? When did these symptoms start? When did these symptoms end? [The examiner may need to ask specific questions regarding the presence of hallucinations, delusions, paranoia, or other mental health symptoms.]

should determine what mental disorders qualify for consideration of insanity after reviewing the governing statute and relevant case law. Even if a defendant meets the jurisdictional criteria for a mental disorder or defect, having a mental disorder does not equate with the legal definition of insanity.

Second, the evaluator must determine the relationship, if any, between the mental illness or defect and the alleged crime. Understanding the motivation behind the person's actions is a critical component of the insanity evaluation. It is important that the evaluator consider all rational, rather than psychotic, motives for the criminal offense. For example, if an individual commits an armed robbery solely to obtain money for a drug purchase, the fact that he or she is depressed will unlikely establish a sufficient relationship between the mental state and the criminal behavior for purposes of the insanity defense.

Third, the examiner must apply the relevant insanity test when evaluating the relationship between the person's mental disorder and his or her alleged acts. Under the M'Naghten test of insanity (i.e., cognitive standard), the evaluator reviews if the defendant knew what he or she was doing or understood that the actions were wrong, even if the defendant had a qualifying mental disorder. In those jurisdictions that use some form of the M'Naghten test, the examiner should carefully review if the defendant meets the criteria for each component of this test according to the precise governing language (Giorgi-Guarnieri et al. 2002).

In some states, the person must be so impaired from a mental illness that he or she is unable to know the nature and quality of his or her actions or is unable to distinguish right from wrong. In general, an individual would have to be extremely impaired to not be aware of or know his or her actions. The more easily met component of the M'Naghten test involves whether the defendant was able to know or distinguish right from wrong at the time of the offense. In general, there are two broad categories related to a defendant's knowledge of the "wrongfulness" of his or her behavior: 1) legal wrongfulness; and 2) moral wrongfulness. Jurisdictions vary as to whether both types of wrongfulness are allowed for consideration when determining a defendant's sanity.

An assessment of a person's understanding of the legal wrongfulness of his or her actions involves determining if the defendant understood *at the time of the crime* that what he or she did was against the law. Resnick (2007) has provided examples of potential behaviors to help evaluate if a person understands the wrongfulness of his or her behavior, which are outlined in Table 13–9.

In some jurisdictions, a person may be found insane if his or her mental disorder resulted in being unable to know or understand that the individual's actions were *morally* wrong, even if he or she knew that society would legally sanction his or her actions. When evaluating whether a defendant's mental disorder rendered him or her unable to know or understand the moral wrongfulness of his or her conduct, the examiner should specifically ask if there was any reason he or she thought the actions were morally justified at the time of the offense. Consider the circumstances of Ms. G described earlier, in Case Vignette 3. Ms. G had been warned to stay away from the principal and not to threaten him or she could be arrested. Ms. G likely understood that the police would view her killing of the school principal as unlawful, particularly because she had been told by local law enforcement to have no contact with the principal. However, due to her psychosis, Ms. G delusionally believed that her actions were morally right. In other words, she may have understood her actions were legally wrong, but as a result of her mental disorder, she believed her actions were morally justified to save the life of an innocent young girl from an imminent execution.

The insanity standard in some jurisdictions requires an analysis of the individual's ability to refrain from his or her actions or to conform his or her

TABLE 13–9. Evidence that may indicate a defendant's knowledge of legal wrongfulness

Efforts to avoid detection
Wearing gloves during a crime
Waiting until the cover of darkness
Taking a victim to an isolated place
Wearing a mask or disguise
Concealing a weapon on the way to a crime
Falsifying documents (passport or gun permit)
Giving a false name
Threatening to kill witnesses
Giving a false alibi
Disposing of evidence
Wiping off fingerprints
Washing off blood
Discarding a murder weapon
Burying a victim secretly
Destroying incriminating documents
Efforts to avoid apprehension
Fleeing from the scene
Fleeing from the police
Lying to the police

Source. Resnick 2007.

conduct to the requirements of the law. This analysis focuses on how the person's mental disorder or defect affected, if at all, his or her ability or capacity to control his or her behavior. In this context, the forensic examiner is evaluating if the defendant had the ability to refrain from the behavior but chose not to. Evidence that may indicate that the defendant had the ability to refrain includes him or her stopping the actions when detected by someone during the course of the crime or deferring the actions until the arrival of a more advantageous opportunity.

Diminished Capacity Evaluations

Unlike the insanity defense, which utilizes a specific test to evaluate one's criminal responsibility, a diminished capacity defense examines if the defen-

dant had the capacity to form the requisite intent for the crime. To illustrate the difference, consider the case of Mr. E, a 50-year-old man with schizophrenia who believes that his next-door neighbor is about to start World War III with nuclear weapons because the neighbor's car license plate tag contains the number three. As a result, Mr. E decides that he must kill the neighbor in order to save the entire planet. He carefully loads his .357 magnum, waits for his neighbor to return home, calmly walks over to his neighbor's house, rings the doorbell, and shoots the neighbor directly in the heart when the neighbor opens the door.

At trial, Mr. E may be found legally insane under the M'Naghten insanity test if it is proved that his schizophrenia resulted in the belief that his actions were morally right, thereby rendering him unable to distinguish right from wrong. Mr. E, however, may *not* meet the standard for diminished capacity, *despite* his mental illness, if it is proved that he purposefully walked over to his neighbor's house with a loaded gun with the specific intent to kill the neighbor. Therefore, diminished capacity defenses are focused on the degree, if any, to which a person's mental disorder influenced his or her ability to form the specific intent to commit a crime.

Not all degrees of intent are viewed the same in the eyes of the law. Under a diminished capacity defense, the forensic expert evaluates if the defendant had a particular culpable state of mind. To illustrate, consider the case of Joe, a 24-year-old man who becomes intoxicated for the first time from alcohol while drinking with his best friend Michael. After consuming 10 beers, Joe starts to argue with Michael over a seemingly trivial matter and they become involved in a fistfight. Joe repeatedly punches Michael in the face, causing Michael to have an unexpected fall that results in a severe head injury and subsequent death. Joe is subsequently charged with first-degree murder, which in his jurisdiction is defined as the deliberate and purposeful taking of another human's life.

Did Joe have the level of specific intent as defined by that state's penal code to deliberately and purposely cause his friend's death? A successful diminished capacity defense in this case would demonstrate that due to Joe's marked intoxication, his level of consciousness was so impaired that he did not have the capacity to form the requisite intent. Even if his defense is successful, however, Joe could still face charges that involve a lesser degree of intent, such as a charge of involuntary manslaughter.

The doctrine of diminished capacity is considered controversial, and not all states allow mental health testimony in this regard. A state's decision to bar such testimony in regard to the effects of intoxication has been upheld by the U.S. Supreme Court in the 1996 case of *Montana v. Egelhoff*. In this case, James Egelhoff had been camping and partying with friends in the Yaak region of northwestern Montana. During the course of the day he consumed

psychedelic mushrooms and a substantial amount of alcohol. Later that evening, Mr. Egelhoff was found severely intoxicated in the back seat of a car, with his two friends dead in the front seat as a result of a single gunshot wound to the back of the head. He was subsequently charged with two counts of deliberate homicide. At trial, Mr. Egelhoff was not allowed to present evidence regarding the impact of his intoxication on his specific intent to kill. After he was found guilty on both counts, he appealed his case to the U.S. Supreme Court, which upheld the trial court's decision to exclude mental health testimony related to the effects of intoxication on Mr. Egelhoff's specific intent (*Montana v. Egelhoff* 1996).

Likewise, testimony on the effects of severe mental disorders on *mens rea* (the defendant's "guilty mind") may also be limited. In the 2006 case of *Clark v. Arizona,* the U.S. Supreme Court was asked to review an Arizona trial court decision that prohibited mental health testimony regarding the impact of a psychotic disorder on a defendant's ability to form the required specific intent to kill. Eric Clark was an undisputed paranoid schizophrenic who was charged with the first-degree murder of a police officer in the line of duty. At trial, Clark was not allowed to present evidence regarding the impact of his psychosis on his alleged intent to kill. On appeal, the U.S. Supreme Court upheld the trial court's decision to prohibit, at the guilt phase, any mental health testimony regarding Mr. Clark's intent to kill the officer (*Clark v. Arizona* 2006).

Conclusion

Competency to stand trial and sanity evaluations represent two of the most routinely requested examinations of forensic psychiatrists. In both types of evaluations, the evaluator must review relevant key documents to render an objective opinion that is not based solely on the defendant's self-report. Each evaluation requires a distinct skill set that involves an analysis of the defendant's mental state at a particular point in time.

Key Points

- Competency-to-stand-trial evaluations focus on the defendant's *present ability* to assist his or her legal counsel and his or her understanding of the legal process.

- Criminal responsibility evaluations focus on the defendant's *past mental state* at the time of the alleged offense.
- The presence of a mental disorder does not automatically equate with a finding of incompetency to stand trial or insanity.
- The definition of insanity varies by jurisdiction.
- The forensic evaluator should carefully consider the possibility of malingering in both competency-to-stand-trial and sanity evaluations.

Practice Guidelines

1. Be familiar with the exact statutory language in your jurisdiction for both competency-to-stand-trial and insanity evaluations.
2. Provide informed consent to the evaluee with regard to the purpose of the evaluation and limits of confidentiality.
3. Review relevant collateral records in addition to the forensic interview for both competency-to-stand-trial and insanity evaluations. Do not rely solely on self-report in reaching a forensic opinion.

References

American Law Institute: Model Penal Code, § 4.01 (1985)

Anderson SD, Hewitt J: The effect of competency restoration training on defendants with mental retardation found not competent to proceed. Law Hum Behav 26:343–351, 2002

Buchanan v Kentucky, 483 U.S. 402 (1987)

Callahan L, Meyer C, Steadman HJ: Insanity defense reform in the United States—post Hinckley. Ment Phys Disabil Law Rep 11:54–59, 1987

Carbonell JL, Heilbrun K, Friedman FL: Predicting who will regain trial competency: initial promise unfulfilled. Special issue: psychopathology and crime. Forensic Reports 5:67–76, 1992

Cima M, Nimjan H, Merckelbach H, et al: Claims of crime-related amnesia in forensic patients. Int J Law Psychiatry 27:215–221, 2004

Cirincione C: Revisiting the insanity defense: contested or consensus? Bull Am Acad Psychiatry Law 24:165–166, 1996

Clark v Arizona, 548 U.S. 735 (2006)

Cooper D: Juveniles' understanding of trial-related information: are they competent defendants? Behav Sci Law 15:167–180, 1997

Cowden VL, McKee GR: Competency to stand trial in juvenile delinquency proceedings: cognitive maturity and the attorney-client relationship. University of Louisville Journal of Family Law 33:629–690, 1995

Daniel AE, Meninger K: Mentally retarded defendants: competency and criminal responsibility. Am J Forensic Psychiatry 4:145–156, 1983

Durham v United States, 94 U.S. App. D.C. 228, 214 F.2d 862 (1954)

Dusky v United States, 362 U.S. 402 (1960)

Ellis JW, Luckasson RA: Mentally retarded criminal defendants. George Washington Law Rev 53:414 –493, 1985

Estelle v Smith, 451 U.S. 454 (1981)

Faretta v California, 422 U.S. 806 (1975)

Giorgi-Guarnieri D, Janofsky J, Keram E, et al: American Academy for Psychiatry and the Law practice guideline for forensic psychiatric evaluation of defendants raising the insanity defense. J Am Acad Psychiatry Law 30:S3–S40, 2002

Godinez v Moran, 509 U.S. 389 (1993)

Gothard S, Rogers R, Sewell KW: Feigning incompetency to stand trial: an investigation of the Georgia Court Competency Test. Law Hum Behav 19:363–373, 1995

Grisso T, Miller M, Sales B: Competency to stand trial in juvenile court. Int J Law Psychiatry 10:1–20, 1987

Grisso T, Steinberg L, Woolard J, et al: Juveniles' competence to stand trial: a comparison of adolescents' and adults' capacities as trial defendants. Law and Human Behavior 27:333–363, 2003

Hoge SK, Poythress N, Bonnie RJ, et al: The MacArthur Adjudicative Competence Study: diagnosis, psychopathology, and competence-related abilities. Behav Sci Law 15:329–345, 1997

Indiana v Edwards, 128 S. Ct. 2379 (2008)

James DV, Duffield G, Blizard R, et al: Fitness to plead: a prospective study of the inter-relationships between expert opinion, legal criteria and specific symptomatology. Psychol Med 31:139–150, 2001

McGarry AL: Competency to Stand Trial and Mental Illness (DHEW Pub No ADM-77-103). Rockville, MD, National Institute of Mental Health, 1973

Melton GB, Petrila J, Poythress NG, et al (eds): Competency to stand trial, in Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007, pp 125–200

Miller R, Germaine E: The retrospective evaluation of competency to stand trial. Int J Law Psychiatry 11:113–125, 1988

M'Naghten's Rule, 8 Eng. Rep. 718, 8 Eng. Rep. 722 (1843)

Montana v Egelhoff 518 U.S. 37 (1996)

Mossman D, Noffsinger SG, Ash P, et al: Practice guideline: forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law 35 (suppl 4):S1–S72, 2007

Nicholson R, Kugler KI: Competent and incompetent criminal defendants: a quantitative review of comparative research. Psychol Bull 109:355–370, 1991

Nicholson RA, McNulty JL: Outcome of hospitalization for defendants found incompetent to stand trial. Behav Sci Law 10:371–383, 1992

Nicholson RA, Barnard GW, Robbins L, et al: Predicting treatment outcome for incompetent defendants. Bull Am Acad Psychiatry Law 22:367–377, 1994

Noffsinger SG: Restoration to competency practice guidelines. Int J Offender Ther Comp Criminol 45:356–362, 2001

Poythress NG, Bonnie RJ, Monahan J, et al (eds): Adjudicative competence in legal theory and practice, in Adjudicative Competence: The MacArthur Studies. New York, Kluwer Academic/Plenum Publishers, 2002, p 50

Reich J, Wells J: Psychiatric diagnosis and competency to stand trial. Compr Psychiatry 26:421–432, 1985

Resnick PJ: The detection of malingered psychosis. Psychiatr Clin North Am 22:159–172, 1999

Resnick PJ: 28th Annual Forensic Psychiatry Review Course Syllabus at the 38th annual meeting of the American Academy of Psychiatry and the Law, Miami Beach, FL, October 2007

Resnick PJ, Noffsinger S: Competency to stand trial and the insanity defense, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 329–347

Roesch R, Eaves D, Sollner R, et al: Evaluating fitness to stand trial: a comparative analysis of fit and unfit defendants. Int J Law Psychiatry 4:145–157, 1981

Rogers R, Gillis JR, McMain S, et al: Fitness evaluations: a retrospective study of clinical, criminal, and sociodemographic characteristics. Can J Behav Sci 20:193–200, 1988

Rogers R, Sewell KW, Goldstein AM: Explanatory models of malingering: a prototypical analysis. Law Hum Behav 18:543–552, 1994

Rogers R, Grandjean N, Tillbrook CE, et al: Recent interview-based measures of competency to stand trial: a critical review augmented with research data. Behav Sci Law 19:503–518, 2001

Sell v United States, 539 U.S. 166 (2003)

State v Stock, 463 S.W.2d 889 (Mo. 1971)

Steadman HJ, Keitner L, Braff J, et al: Factors associated with a successful insanity plea. Am J Psychiatry 140:401–405, 1983

U.S. v Andrews, 469 F.3d 1113 (7th Cir. 2006)

U.S. v Veatch, 842 F. Supp. 480 (W.D. Okla. 1993)

Warren JI, Fitch L, Dietz PE, et al: Criminal offense, psychiatric diagnosis, and psycholegal opinion: an analysis of 894 pretrial referrals. Bull Am Acad Psychiatry Law 19:63–69, 1991

Washington v Harper, 494 U.S. 210 (1990)

Way B, Dvoskin J, Steadman H: Forensic psychiatric inpatients in the United States: regional and system differences. Bull Am Acad Psychiatry Law 19:405–412, 1991

Wilson v United States, 391 F.2d 460 (D.C. Cir. 1968)

Suggested Readings

Giorgi-Guarnieri D, Janofsky J, Keram E, et al: American Academy of Psychiatry and the Law practice guideline for forensic psychiatric evaluation of defendants raising the insanity defense. J Am Acad Psychiatry Law 30:S3–S40, 2002

Melton GB, Petrila J, Poythress NG, et al (eds): Competency to stand trial, in Psychological Evaluations for the Courts. A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007, pp 125–200

Mossman D, Noffsinger SG, Ash P, et al: Practice guideline: forensic psychiatric evaluation of competence to stand trial. J Am Acad Psychiatry Law 35 (suppl 4):S1–S72, 2007

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Chapter 14

Forensic Assessment of Sex Offenders

John Bradford, M.D., FRCPC

Brad Booth, M.D., FRCPC

Michael C. Seto, Ph.D.

Sexual offending is, unfortunately, a common occurrence. Although likely to be underreported, rates of child sexual abuse range internationally from 7% to 36% for girls and from 3% to 29% for boys (Finkelhor 1994). Rates of rape and sexual assault are similarly high, with 0.8 in 1,000 persons in the United States over the age of 12 being victims in 2008 (Rand 2008).

Sexual offenses include hands-off offenses such as exhibitionism, voyeurism, and child pornography. They may also involve more serious offenses, including hands-on crimes against children, sexual assault of adults, and sexual homicide. Although some sexual offenders may have a variety of psychiatric diagnoses, including paraphilia, some may not have any diagnoses.

Typically, the criminal justice system deals with sexual offenders. However, forensic psychiatrists are increasingly part of the criminal justice system's assessment of the sexual offender. The courts often ask psychiatric experts to diagnose comorbid conditions, assist in understanding motivations behind

offending, estimate risk, and comment on management options for offenders in the community.

The shift to include psychiatrists in legal proceedings involving sexual offenders can be traced to the 1930s. The legislation and jurisprudence have evolved; now the courts often require psychiatric input, particularly when they are examining possible civil commitment of sexually violent predators in the United States or imposing indefinite sentencing in the case of dangerous offenders in Canada.

In this chapter we focus on the forensic assessment of sexual offenders involved in sexually violent predator and dangerous offender proceedings, which can be extended, in a simplified form, to any other sexual offender assessment. We discuss the legal background and basic issues involved, such as how to get started on conducting evaluations, collecting collateral information, and interviewing. We then review specific key issues related to providing assessments of sexual offenders for the courts, including standardized testing, the role of paraphilias in offending, risk assessment, concerns regarding special populations, and the role of treatment in reducing and managing risk and recidivism. The information offered will provide the clinician with introductory knowledge regarding forensic assessment in this population.

Legal Background

Although one of the purposes of the legal system is to deter individuals from committing offenses, some individuals do not seem to respond to legal consequences for socially proscribed behavior. Repeat sexual offenders appear to fall into this category. Despite repeated incarceration and attempts at treatment, some high-risk individuals continue to offend. Repeat sexual offenders are "neither deterred nor changed by incarceration because their actions were driven by an uncontrollable impulse to commit their horrible crime" (Chenier 2003, p. 76). To deal with these individuals, in 1937, Michigan was the first of many states to enact sexual psychopath laws. In 1939, Minnesota followed suit and enacted the "psychopathic personality" law. It allowed the commitment of people with "emotional instability" or "lack of customary standards of good judgment" that rendered them irresponsible for conduct related to sexual matters and, thereby, dangerous (Minnesota Statute 26.10, 1941).

Sexual psychopath laws were premised on the idea that deviant behavior was caused by illness and that repeat sexual offenders could be treated and cured to allow them to return to society safely (La Fond 1998). One important

case from that era was *Specht v. Patterson* (1967). In a unanimous decision, the U.S. Supreme Court found that the Fourteenth Amendment due process clause was violated by not giving Mr. Specht the right to be present with counsel, to confront the evidence against him, to cross-examine witnesses, and to offer his own evidence and be heard. However, as explained by La Fond (1998, p. 472), these laws were, for the most part, repealed: "Most experts and policymakers had concluded that sex offenders were not mentally ill and that involuntary, indeterminate treatment was ineffective in changing their criminal behavior. Mental health experts could not identify or diagnose mentally ill sex offenders, nor could they provide effective treatment for them. Coercive rehabilitation simply did not work."

Despite the fate of this first attempt at addressing the problem of repeat sexual offenders with involuntary treatment laws, there has been a second generation of "sexually violent predator" laws in the United States, which seek to civilly commit individuals who commit multiple or particularly heinous sexual crimes. Several attempts to have these laws overturned by the Supreme Court have been unsuccessful. In *Allen v. Illinois* (1986), the Court held in a 5–4 decision that forcing Mr. Allen to submit to psychiatric evaluation that could be used against him in the commitment hearing did not violate his Fifth Amendment right against self-incrimination. The judges reasoned that the Illinois Sexually Dangerous Persons Act was civil in nature, not criminal. As such, the Fifth Amendment protections did not apply.

In *Kansas v. Hendricks* (1997), the U.S. Supreme Court found in a 5–4 decision that the Kansas Sexually Violent Predator Act was constitutional. The rather vague term "mental abnormality" did not violate the substantive due process clause. Further, the application of the civil commitment after Hendricks had served most of his prison sentence did not violate double jeopardy or *ex post facto,* because the Kansas Sexually Violent Predator Act was civil in nature and not punitive. The Washington Supreme Court offered similar findings in the cases of *In re Young and Cunningham* (1993), in which the court decided that The Community Protection Act of 1990 was constitutional because the Act was civil in nature. Again, *ex post facto* and the prohibition against double jeopardy did not apply. Further, the substantive due process clause was not violated.

This trend in legal opinions was seen again in *Seling v. Young* (2001), in which Young sought relief from his civil commitment, arguing that his conditions were so restrictive that they were punitive. The U.S. Supreme Court noted once more that the Act was civil, and the "punitive" conditions of his commitment would not qualify for a separate analysis "as applied" to him. Again, *ex post facto* and double jeopardy would not apply.

The string of landmark cases demonstrates that the courts currently view the sexually violent predator laws as civil laws that are constitutional. Real-

istically, such a view indicates that the role of psychiatric forensic assessment of sexual offenders is likely to increase.

Basic Issues in the Forensic Assessment of Sexual Offenders

Preparation for the Psychiatric Interview

The psychiatrist may be called upon by the defense or prosecution or as *amicus curiae* to evaluate individuals with sexual offenses. As with any forensic evaluation, the evaluator should initially clarify the nature of the legal question and the relevant legislation and jurisprudence. The evaluator should also ensure that he or she is appropriately qualified for and experienced in the legal issue at hand. Qualifications for conducting sexually violent predator or dangerous offender evaluations would usually include completion of a fellowship in forensic psychiatry that includes exposure to and supervised completion of this type of assessment. The psychiatrist should also be very familiar with the literature and current methods used within the field to conduct evaluations, including the limitations of any diagnostic and predictive measures.

Case Vignette 1

A defense lawyer contacts Dr. S to request a "forensic assessment" of a three-time offender, Mr. J. Mr. J is 40-year-old accountant who was convicted of sexual assault on his 11-year-old daughter. He has two previous convictions, including charges of sexual interference at age 18 years against his 6-year-old sister and a conviction at age 30 years for possession of child pornography. The contact offenses came to light after his conviction for child pornography. They occurred repeatedly over a 2-year period, initially involving fondling and progressing to coerced fellatio and vaginal intercourse.

Before the forensic psychiatric assessment in Case Vignette 1 can proceed, the psychiatrist should flesh out details about the contract, including payment, estimated time required, any limits to the time available, expenses, and obtaining a retainer. Once these details are explained, the psychiatrist should clarify the legal issue at hand. In the case of Mr. J, the evaluee is facing civil commitment as a sexually violent predator. The psychiatrist must clarify the specific legal test and the relevant jurisprudence. Invariably, these features will

also include definitions of terms such as "mental condition" and "reduced capacity to resist," or whatever terminology is used in the legislation.

The next step is to obtain and review *all* information available prior to meeting with the evaluee. Sources of information will comprise official details of any current and previous offenses, institutional records, transcripts from court proceedings, collateral information, mental health and treatment records, school records, and other information that might be available. Often, lawyers will attempt to send only partial records, which can cause problems with the accuracy of the assessment. Learning that only some of the records have been provided for review is not something a psychiatrist wants to realize while on the stand during testimony.

Given the volume of information that is often available, some clinicians will employ trained individuals to review and summarize relevant information. However, this practice, if employed, should be made clear in the report, and the clinician should be familiar with the salient points of the available information. Further, individuals who have known the evaluee, such as family members or a partner/spouse, should be contacted so that the evaluator can gain insight about lifelong patterns of behavior. As is the case when collecting information from any third party, the psychiatrist should bear in mind that some of these individuals may be advocating on behalf of the person being evaluated rather than providing accurate reports.

Prior to starting the evaluation, the clinician should ensure that he or she has reviewed the available information. The evaluee should be asked to give informed consent and warned about any legislative limitations of confidentiality of the assessment (for example, if defense assessments are discoverable). We routinely inform the evaluee that we are completing an independent assessment that may be harmful, neutral, or helpful to the person's legal case. We also advise the evaluee that all information disclosed should be considered not confidential. Finally, we warn the evaluee that any attempts to mislead will likely be detected and may harm his or her legal case.

The Psychiatric Interview

Once the clinician is familiar with the available information, he or she will interview the evaluee. The interview should include enough details to allow completion of the Hare Psychopathy Checklist—Revised (PCL-R; Hare 2003), which should be part of any sexually violent predator or dangerous offender assessment (Barbaree 2005; Bradford 2008; Brown and Forth 1997; Langton et al. 2006). The evaluee's history should include a review of early childhood issues, sexual and physical abuse history, academic history that encompasses behavioral problems, relationship history, occupational history, substance use history, financial history, and medical history.

The evaluee's legal history should also be considered in detail. Each previous and current offense should be reviewed with the evaluee. It is not unusual for the client to disagree with parts of the "official version." However, any glaring differences should be explored and may represent minimization of the offenses. It is important to clarify the evaluee's motivations for offending and whether substance use played a role. Institutional behavior should also be discussed, including any misconduct or offenses committed while incarcerated. Finally, it is vital to explore whether the evaluee has previously been under supervision, whether he or she was compliant with expectations, and whether the individual was successfully supervised without re-offending.

The details of any treatment obtained by the offender for mental illness, sexual offending, substance abuse, and anger management problems should be considered. In addition, it is important to discuss who provided the treatment, what specifically the treatment involved, any benefits of the treatment, and the offender's willingness to pursue further treatment. This information can be very important for assessing the offender's risk and making recommendations about what strategies may assist in safely managing the person in the community. For example, if the offender has never received an evidence-based treatment, it is very difficult to argue that the person's risk could not be reduced to a manageable level for the community.

Another primary goal of the assessment is to evaluate for the presence or absence of mental illness and explore how this might affect the evaluee's risk to the community or management needs. Although often overlooked, rates of severe mental illness among sexual offenders are significant (Table 14–1). For example, Dunsieth and colleagues (2004) reported that among 113 sexual offenders, 85% had a substance use disorder; 74% had a paraphilia; 58% had a mood disorder; 38% had an impulse control disorder; 23% had an anxiety disorder; 9% had an eating disorder; and 56% had antisocial personality disorder. In another study of paraphiles, which included many sexual offenders, Kafka described high rates of mood disorders (71.6%), anxiety disorders (38.3%), and alcohol/substance abuse (40.8%) (Kafka and Hennen 2002).

Within our mental health treatment unit for provincially sentenced offenders, the rates of serious mental illness are high among sexual offenders, with 43% diagnosed with depressive disorders, 13% bipolar disorder, 28% anxiety disorders, 16% psychotic disorders, 10% dementia, 31% mental retardation/developmental delay, 42% alcohol dependence, 38% substance dependence, 20% attention-deficit/hyperactivity disorder (ADHD), and 47% personality disorder (Booth 2010). This study has a selection bias but does demonstrate nonetheless that there is significant comorbidity of Axis I disorders with sexual offending behavior. Further study of the comorbidity of the paraphilias and other psychiatric disorders is necessary.

TABLE 14–1. Rates of severe mental illness among sexual offenders

Disorder	Dunsieth et al. (2004)	Kafka and Hennen (2002)	Booth (2010)
Mood disorder	58%	72%	56%
Anxiety disorder	23%	38%	28%
Alcohol or substance abuse issues	85%	41%	55%
Personality disorder	56%	—	47%
Psychotic disorder	—	4%	16%
Paraphilia	74%	100%	65%
Impulse control disorder or ADHD	38%	36%	20%
Mental retardation or developmental delay	—	—	31%
Dementia	—	—	10%

Note. ADHD=attention-deficit/hyperactivity disorder.

Finally, it is important to review a complete sexual history with the evaluee. This should include discussion of erectile dysfunction, ejaculatory difficulties (premature ejaculation or delayed ejaculation), sexual outlets and frequency of sexual outlets, evidence of "hypersexuality" (Bradford 2001; Kafka 2001; Langstrom and Hanson 2006), and an exploration of any paraphilic interests.

Specific Issues in the Forensic Assessment of Sex Offenders

Standardized Testing

Sexual Preference Testing

"Deviant" sexual arousal has been noted as an important factor in sexual offender risk assessment. In a meta-analysis of more than 20,000 offenders, Hanson and Bussiere (1998) noted that pedophilic preference on phallometric testing was one of the most important factors in predicting recidivism

($r = 0.32$). This result was confirmed in another meta-analysis of nearly 30,000 offenders (Hanson and Morton-Bourgon 2005). The Sex Offender Risk Appraisal Guide includes deviant arousal as a predictor of future recidivism (Quinsey et al. 2005). These results also have face validity. If a person is aroused by children, his risk of offending against a child is higher than if he is not aroused by children. Similar results have been obtained with regard to sexual arousal by violence (Hanson and Morton-Bourgon 2005).

Measuring sexual preference is primarily accomplished by one of two methods. The first is *penile plethysmography* (PPG), also known as penile tumescence testing or phallometric testing. The procedure involves measuring arousal by either volume or circumferential changes in the penis while the evaluee is exposed to visual or auditory stimuli of children or nonconsensual sexual situations. First developed by Kurt Freund (Freund 1957), the method has been adapted to assist in the diagnosis of pedophilia (Blanchard et al. 2001; Freund and Blanchard 1989; Freund et al. 1979; Looman and Marshall 2001) with some success. Similarly, the method has been used to assist in the evaluation of rapists.

The literature on PPG is extensive, with several controversies. Clinicians using this technique must be aware of this literature in order to assist the court appropriately. One of the most important concerns is that some nonoffenders and some nonparaphilic men will have significant arousal to rape and pedophilic stimuli. Similarly, nonresponse is not uncommon and may incorrectly suggest the individual does not experience deviant arousal. Thus, great caution should be used when administering testing prior to a conviction, because PPG may inappropriately bias the criminal proceedings.

Marshall and Fernandez summarized much of the literature on PPG (2003). They noted that there are potentially troubling issues with cost, availability, faking, instrumentation differences, nonstandard stimuli, use of low-level arousal, and psychometric properties. Seto (2008) and Lalumière and Harris (1998) have responded to these criticisms (Lalumière et al. 2005; Seto et al. 2008). Despite these limitations, PPG does allow for objective assessment of arousal and is recommended, when available, for evaluating risk.

Although PPG testing, if available, is preferable, many clinicians will not have access to PPG testing or will not be able to use visual stimuli depicting children in sexual situations as a result of federal or state child pornography laws. Another method of measuring sexual interest is *visual reaction time* (Abel et al. 1998). The basic principle of this technique is that individuals will look at stimuli they find arousing for a much shorter or longer time than nonarousing stimuli. In the test, individuals look at a series of clothed individuals of various ages, genders, and ethnicity. They also self-rate their interest in these images and complete a set of questionnaires. The test must be administered and interpreted by trained evaluators.

Abel and colleagues (1998) noted that results have reliability similar to that of PPG, but the method does not use nude photos of children, making it preferable in some circumstances. Visual reaction time measures are also faster and easier to administer, but evaluators cannot score the results themselves. When PPG is not available, visual reaction time may provide valuable information regarding risk. However, published data are not yet available to confirm that viewing time measures of sexual interest predict recidivism in the same way that phallometrically assessed sexual arousal does. It has also not been demonstrated that viewing time can reliably and validly measure sexual interest in violence or nonconsenting sex.

Other Testing to Consider

In an evaluation of sexual offenders, sexual preference testing is always recommended. However, test results do not provide the evaluator with sufficient information to understand the individual's offending and risk to the community. As such, the clinician may access additional testing, as clinically indicated. For example, IQ testing may be appropriate for individuals with developmental delay. Neuropsychological testing may be helpful for individuals with a history of stroke or traumatic brain injury. Tests for malingering or personality disorder may be administered. Scales and continuous performance testing may identify ADHD. Standardized scales are sometimes preferred by the court and can also provide useful information for future research.

Case Vignette 2

Mr. M, a 40-year-old man, was convicted of sexually offending against two children, his 12-year-old niece and her 10-year-old friend. He was married with no children of his own. The offenses consisted of touching and digital penetration of their vaginas. Mr. M had prior convictions for drug and property offenses but no prior convictions for sexual offenses. Mr. M denied having pedophilia, but penile plethysmography testing indicated that he was more sexually aroused by descriptions of sex with children and descriptions of sex with adults, with a pedophile index of 1.3.

Case Vignette 2 demonstrates that despite their sexual arousal by children, individuals with offenses against children may show a pedophilic preference or significant pedophilic arousal on objective testing. This is relevant for diagnosis, risk assessment, and treatment.

Paraphilias and Sexual Offending

There is an intuitive and empirical link between paraphilias and sexual offending (Laws 2008). Paraphilias predispose some individuals to committing

certain sexual offenses. However, paraphilias are not necessary or sufficient factors, because nonparaphilic individuals sometimes commit sexual offenses—and not all paraphilic individuals commit sexual offenses. Nonetheless, paraphilias represent an important motivation for sexual offending. Pedophilia is linked with child pornography and sexual offending against children, sexual sadism is linked with rape, exhibitionism is associated with indecent exposure, voyeurism is associated with trespassing and related crimes, and so on. In some cases, fetishism is associated with ostensibly nonsexual crimes (e.g., someone with an underwear fetish who breaks into women's residences in order to obtain more underwear).

There is controversy about whether there is a meaningful distinction between sexual sadism, defined in the DSM-IV-TR as a sexual interest in the pain, suffering, and/or humiliation of others, and a sexual interest in nonconsenting sex, sometimes referred to in the clinical literature as rape-proneness, preferential rape, or paraphilic coercive disorder (American Psychiatric Association 2000; Lalumière 2005). A sexual interest in nonconsenting sex is not currently recognized in DSM-IV-TR, although some authors have noted that this sexual interest can be diagnosed as a paraphilic disorder not otherwise specified (Doren 2002).

There is a danger of tautology in thinking about the link between paraphilia and sexual offending. Some laypeople (and clinicians) assume that any person who has molested a child must be a pedophile, and they similarly assume that all pedophiles will molest children. Yet some pedophiles have never had any known sexual contact with children, and a substantial proportion of child molesters would not meet diagnostic criteria for pedophilia (Seto 2008; Seto et al. 2008).

It is not uncommon for identified sex offenders to have more than one paraphilia. In fact, having a paraphilia significantly increases the likelihood of having another paraphilia (Abel et al. 1988; Bradford et al. 1992; Freund et al. 1997). This may reflect the idea that there are common vulnerabilities in the etiology of paraphilias, such as prenatal insults and childhood head injury.

Although it was previously thought that sexual offenders tended to only commit the same type of offenses when recidivating, this is now known to be false. Paraphilic interests can "cross over" in terms of sexual offending—in other words, individuals who fit into one category of sexual offending (e.g., hands-off offenses or offenses against children) may commit sexual offenses from another category (e.g., hands-on offenses or offenses against adults). For example, Firestone and colleagues (2006) found that phallometrically assessed sexual arousal by children predicted contact sexual offending in a sample of exhibitionistic sex offenders (Firestone et al. 2006). Some offenders with a history of sexual offenses against children might nonetheless subse-

quently commit a sexual offense against an adult, and vice versa. English and colleagues (2000) also found that one-third of their sample of 180 sex offenders offended against both children and adults; the corresponding value in a study by Heil and colleagues (2003) was 73% (English et al. 2000).

Similarly, an offender with a history of sexual offenses against girls between the ages of 10 and 13 years might nonetheless subsequently offend against younger or older girls or boys. English and colleagues (2000) as well as Heil and colleagues (2003) found that about one-third of their samples of adult male sex offenders offended against both boys and girls. This is an important consideration because there is evidence to suggest that crossover offenders engage in more high-risk behaviors and are more likely to reoffend, and, therefore, risk management cannot be as focused (e.g., a probation or parole officer cannot simply prohibit unsupervised contact with children if the individual has some risk of offending against adults as well) (Abel et al. 1988; Bradford et al. 1992).

Risk Assessment

A critical task for forensic psychiatrists and other professionals in the assessment of sex offenders is to appraise the risk posed for future offenses. Accurate knowledge about an offender's risk informs legal decision making (e.g., dangerous offender hearings in Canada and sex offender civil commitment proceedings in the United States) and assists in decision making about security level, treatment intensity, supervision level when incarcerated, and the identification of potential targets for intervention in various treatment programs.

Contrary to popular belief and public policies that assume most if not all sex offenders will reoffend, large-scale and long-term follow-up research shows that, on average, approximately 13% of sex offenders will incur a new criminal charge for a sexual offense (Hanson and Bussiere 1998). Even after considering that many sexual offenses are not reported to the police and are therefore not officially recognized, this research suggests that there is meaningful variation in the risk posed by sex offenders. Most sexual offenders do not fall into a high-risk category, and those who do can be identified for more intensive intervention and treatment, more secure detention, and enhanced supervision when released.

Current models of sexual offending suggest there are two major dimensions of risk: the first is often labeled *sexual deviance* and encompasses paraphilia, sexual preoccupation, and a preference for impersonal sex; the second is often labeled *antisocial tendencies* and encompasses personality traits, negative attitudes and beliefs, negative associations, and unstable lifestyles that increase the likelihood of antisocial and criminal behavior (Hanson and Morton-Bourgon 2005; Lalumière er al. 2005; Seto et al. 2008). One

can think of sexual deviance as driving sexual offending, whereas antisocial tendencies represent the lack of inhibition or control over the motivation to sexually offend. Examples of variables representing the two major risk dimensions are provided in Table 14–2. Sex offenders whose scores are high on measures of antisocial tendencies are at greater risk of committing either nonsexual or sexual offenses in the future, whereas sex offenders whose scores are high on measures of deviant sexual interests are at greater risk of committing sexual offenses in the future. Offenders whose scores are high in both dimensions are at particularly high risk to reoffend.

How should information about risk to reoffend be combined to make risk-related decisions about sentencing, placement, and intervention? This critical clinical need has driven the development of reliable and valid measures of risk for recidivism, and as a consequence, sex offender risk assessment has advanced a great deal in the past 15 years. Traditionally, decisions about risk were made on the basis of unstructured clinical judgment. However, this approach has been highly criticized as incorrectly overestimating risk (Quinsey et al. 2005).

Instead, current evidence-based practice supports the use of actuarial measures or structured professional guides to assess sex offender risk. Actuarial measures are composed of mathematically identified risk-static (nonchangeable) factors that help uniquely to predict the outcome of interest. Although such measures are helpful, drawbacks include evaluee-specific factors (e.g., disinhibition from dementia causing an offense) and changes in the evaluee (e.g., successful treatment). Structured clinical guides comprise lists of empirically or theoretically identified risk factors and often include dynamic (changeable) factors.

The two main distinctions between actuarial measures and structured professional guides are that structured clinical guides may allow inclusion of additional factors or clinical adjustments of risk scores, and structured clinical guides typically do not provide probabilistic estimates of risk. Professional guidelines and case law support the use of actuarial measures or structured professional guides in sex offender risk assessment. Evaluators must be aware of the benefits and limitations of the methods they choose and be able to explain this to the court. Moreover, evaluators should be aware of whether the method is accepted by the court as valid under *Frye* (*Frye v. United States* 1923) or *Daubert* (*Daubert v. Merrell Dow Pharmaceuticals, Inc.* 1993) (see Chapter 2, "Introduction to the Legal System," this volume).

Many risk assessment measures have been developed, but we will only briefly mention three that have underdone multiple, independent validation studies examining their predictive accuracy with regard to sexual recidivism (Hanson 2009; Hanson and Morton-Bourgon 2005). The Static-99 is an ac-

TABLE 14–2. Variables indicating antisocial tendencies or sexual deviance, the two major risk dimensions identified in sex offender follow-up research

Antisocial tendencies	Sexual deviance
Psychopathy	Phallometrically assessed sexual arousal by children or coercive sex
Antisocial personality disorder	Self-reported interests in paraphilic activities or targets
Childhood behavior problems	Early sexual behavior problems
Criminal history	Sexual offense history
Substance abuse	Sexual victim age and gender
Antisocial attitudes, beliefs, and values	
Associations with criminal peers	

tuarial measure that has undergone many successful cross-validations in both forensic mental health and correctional settings in Canada, the United States, and Europe. The Sexual Violence Risk–20 is a structured professional guide that has also undergone cross-validation, though not to the same extent as the Static-99. The Sex Offender Risk Appraisal Guide, mentioned earlier, has demonstrated good validity for predicting violent recidivism by sexual offenders, an outcome measure that includes both nonsexually violent and contact sexual offenses. Hanson and Morton-Bourgon (2009) reviewed these validation studies and concluded that actuarial measures produced the highest accuracies, followed by structured professional guides, and then unstructured judgments (Hanson 2009).

Special Populations

When performing forensic assessment of sexual offenders, the clinician should be aware of the current literature regarding any special categories of offenders. Although beyond the scope of this textbook, there is a growing literature on these special populations, which include Internet offenders (Seto and Eke 2005; Seto et al. 2006), mentally disordered offenders (Booth 2010), developmentally delayed offenders (Harris and Tough 2004; Riches et al. 2006), and elderly offenders (Fazel et al. 2002; Hanson 2002).

Case Vignette 3

Mr. P, a 32-year-old man with no prior criminal history, was arrested for possession of child pornography after a roommate accidentally discovered images on his personal computer. Subsequent forensic analysis indicated that

> he had several thousand images and videos of child pornography on his hard drive and on CDs found by police during their search of his residence. The images depicted both boys and girls between the ages of 10 and 13 years, but there were some images of older adolescents and some images of very young children. Mr. P also possessed thousands of other pornographic images and videos, including conventional adult content, fetish content, and bestiality. Mr. P denied having pedophilia and claimed that he was "addicted" to online pornography.

In this case, Mr. P is an Internet pornography offender. Internet offenders are increasingly being sent for forensic psychiatric evaluation. The risk assessment for these offenders is quite different from risk assessment for other types of sexual offenders. The evaluating psychiatrist should be aware of this special category, including recent literature on the subject, before embarking on this type of assessment.

Treatment and Recidivism

Completing sexual offender assessments requires a fundamental knowledge of sexual offender recidivism. There is a large body of scientific literature on sexual offender recidivism that is international, covers a variety of types of sexual offending behavior, and currently consists of long-term follow-up recidivism studies (longer than 5 years, and many of 10 years' duration or longer). These recidivism studies provide important information that complements the formal risk assessment, because they provide the background on how the risk assessment instruments have been developed and studied. A helpful concept for the court is the "base-rate"—which denotes, generally, how many sexual offenders will recidivate and whether the evaluee is at a high risk when compared with the base-rate.

There are well-established differences in the base-rates of recidivism among different types of sexual offenders. Sexual offenders against adult females—"rapists," extrafamilial child molesters, and incest perpetrators—are the usual categories of sexual offenders studied, and they have different rates of recidivism (American Psychiatric Association 1999). In general terms, rapists have the highest rates of recidivism, followed by extrafamilial child molesters and, finally, incest perpetrators, who have the lowest rates.

Although there is a considerable scientific body of research on sexual offender recidivism, there is also evidence that the actual rates of recidivism are underreported. Most of the studies include rearrest and conviction rates but do not use self-reported rates. More recent studies use survival analysis as the statistical technique in completing the study. It is generally accepted that a 5-year follow-up is the minimum period required for a recidivism study to have validity. The exception to this would be studies of the dynamic

factors related to sexual offense recidivism, in which the relationship is much more direct and short-term.

Numerous comprehensive reviews of sexual offense recidivism have been conducted. The review by Furby and colleagues (1989) was a turning point in the empirical study of sexual offense recidivism. They were highly critical of the methodology of recidivism studies already in existence, which motivated subsequent researchers to improve the methodological shortcomings of the previous studies. The Hanson and Bussiere (1998) meta-analysis consisted of more than 28,000 sexual offenders, with a follow-up period of approximately 4 years. Included in the meta-analysis were 87 studies from six different countries. The strongest predictors of sexual offense recidivism related to variables associated with sexual deviance and, in particular, deviant sexual arousal, followed by variables associated with antisocial tendencies such as antisocial personality disorder.

Base recidivism rate studies generally focus on untreated individuals. However, most individuals in the field believe that psychological and pharmacological treatment will reduce the recidivism rate. Alexander (1999) completed a meta-analysis of treatment outcome studies of more than 11,000 subjects. Her main findings showed that all treatments have the effect of reducing future sexual offense recidivism when compared with no treatment in adult and adolescent control subjects. In addition, she found that mandatory treatment had a positive treatment outcome compared with voluntary treatment. A more recent and detailed meta-analysis revealed similar findings (Hanson et al. 2002). Nevertheless, some controversy and disagreement continues to exist among experts about the effectiveness of treatment outcome for sexual offenders (Seto et al. 2008). A meta-analysis focused on the effects of age and sexual offense recidivism showed a significant relationship between increasing age and a reduced risk of sexual offense recidivism. The risk of recidivism tended to approach 0% in individuals at age 60 years (Hanson et al. 2002).

Psychological treatment outcomes have been examined in a collaborative research project undertaken by members of the Association for the Treatment of Sexual Abusers (Hanson et al. 2002). In this major analysis, investigators reviewed 43 studies of psychological treatment of sexual offenders, totaling 9,454 offenders in treatment or comparison conditions. The sexual offense recidivism rate averaged across all studies was lower for the treatment groups (12.3%) compared with the comparison groups (16.8% unweighted average from 38 studies). The same trend was found for general recidivism (treatment 27.9%, comparisons 39%, averaged across 30 studies). Most up-to-date sexual offender treatment programs use a cognitive-behavioral approach, although some use a defined systemic approach. In the same meta-analysis, results showed that both treatment program approaches were

associated with reductions in sexual recidivism (17.4% to 9.9%) and general recidivism (51% to 32%)(Hanson et al. 2002). This collaborative study found that all the forms of treatment most commonly being used prior to 1980 did not have significant treatment effects.

Pharmacological treatment consists of the use of agents to reduce sexual drive. The agents' effects center on sexual hormones or neurotransmitters associated with sexual drive (Bradford 2001). The reduction in sexual drive has been shown to be specifically associated with a reduction in sexual fantasies, sexual urges, and behavior that includes deviant sexual behavior. There is also some evidence that deviant sexual arousal can be reduced by pharmacological treatment (Bradford and Pawlak 1993). Pharmacological treatment is also being shown to have effects on recidivism similar to what has been seen in surgical castration studies (American Psychiatric Association 1999).

Pharmacological treatment of sexual offenders commonly involves one of three types of pharmacological agents: selective serotonin reuptake inhibitors (SSRIs), hormonal agents, or antiandrogens. SSRIs have a mode of action through the increase in central serotonin levels. Hormonal agents and antiandrogens have a mode of action through the reduction of available testosterone.

The hormonal agents in common usage are medroxyprogesterone acetate and various luteinizing hormone-releasing hormone agonists such as leuprolide acetate (Bradford 2000). Medroxyprogesterone acetate reduces testosterone levels by interfering with gonadotropin production and also by enhancing the breakdown of plasma testosterone. Luteinizing hormone-releasing hormone agonists overstimulate the hypothalamic pituitary axis and therefore exhaust the supply of luteinizing hormone, which subsequently affects the production of testosterone (Bradford 2000). Luteinizing hormone-releasing hormone agonists produce a pharmacological castration state, with the plasma testosterone levels falling to castration levels (Bradford 2000). Cyproterone acetate is a true antiandrogen, with a mechanism of action that blocks the intracellular androgen receptors throughout the body. It is widely used in Canada and Europe but is not available in the United States.

Bradford (2000, 2001) published an algorithm for the pharmacological treatment of sexual offenders. This algorithm is based on a severity model taken from DSM-III-R (American Psychiatric Association 1987). DSM–III-R categorized paraphilia as mild, moderate, and severe. Bradford added an extra category of catastrophic severity. The latter category was added to accommodate high-risk sexual offenders for whom there was evidence of sexual sadism and the potential concern of extreme sexual violence, such as a sexually motivated homicide. The algorithm advocates the use of psychological treatment as the first level of treatment for all sexual offenders, regardless of

severity of paraphilia. It proceeds through various levels of pharmacological treatment, leading ultimately to pharmacological castration for catastrophic severity and some severe categories of paraphilias.

The algorithm of pharmacological treatment starts with SSRIs; the next level is a combination of SSRIs and oral antiandrogen medication; this is followed by intramuscular antiandrogen medication; the final level is pharmacological castration. This algorithm allows the forensic psychiatrist to logically follow a sequence of pharmacological treatment based on the principle of the least intrusive intervention for the severity of the potential risk of the paraphilia being treated (Bradford 2000, 2001). When considering the algorithm, it is important to acknowledge that not all sexual offenders have a paraphilia. The algorithm is directed toward sexual offenders with a paraphilia and evidence of deviant sexual interest (Bradford 2001).

Ultimately, assessments of risk must include an evaluation of whether the individual has received appropriate trials of evidence-based treatments, including psychotherapy and medications. Evaluators must be aware of the literature regarding the effectiveness of treatments, the relationship to risk, and what treatments might be available or have been tried for the sexual offender.

Conclusion

Ultimately, the role of the forensic psychiatrist is to provide a balanced assessment of risk for the courts. The level of expertise in the assessment and treatment of sexual offenders is becoming more specialized as the empirical basis in this field expands. There is a substantial scientific literature related to the paraphilias (including studies on recidivism, risk assessment, and factors related to treatment effectiveness), sexual offenders, and, increasingly, research on the neurobiological basis of sexual behavior. It is a critical area for forensic psychiatrists, but it is also an area that requires specialized training and expertise. There are certain centers in North America that offer the expertise necessary for training in assessment and treatment of sexual offenders, and it is recommended that forensic psychiatrists should obtain the highest level of training available. Because this is a relatively new area of forensic psychiatric expertise, it is critical that forensic psychiatrists involved in these types of evaluations have the appropriate training and expertise.

Forensic psychiatric experts working in this area need to be able to provide opinions that clearly show they understand the issues of risk assessment, sexual offender recidivism, and the potential for treatment. It is also critical that they understand the strengths and limitations of the assessment

tools that are available. Further, they must also understand their own limitations when giving an opinion and may need to consult with other experts in the area of sexual offender assessment and treatment. The role of forensic psychiatry in the assessment of sexual offenders is typified in sexually violent predator and dangerous offender evaluations. The general approach in this type of evaluation follows a process similar to any forensic assessment. Reliable information must be gathered from collateral sources and reviewed prior to evaluating the offender. Psychiatric diagnoses and the role of paraphilic interests must be considered. Risk assessment should include the Hare Psychopathy Checklist-Revised and actuarial or structured risk assessment, as well as an evaluation of the treatments provided in the past to the offender and a review of any supervision failures that have occurred.

Key Points

- The assessment and treatment of sexual offenders has an empirical basis that is developing rapidly. Expertise in the field requires special training that may not be available in all forensic fellowship training programs but is available in some specialized centers. Assessors must be appropriately trained to provide the important opinions required of them.
- Although there is a significant scientific body of research on recidivism and treatment outcome, the field is still developing and progress in this area needs to be monitored.
- The risk assessment component of evaluating sexual offenders, although reasonably well developed, also has significant limitations.

Practice Guidelines

1. Identify the nature of the forensic psychiatric evaluation of the sexual offender and the limits of the evaluation.
2. Provide risk assessments utilizing a knowledge of both the dynamic and static factors associated with risk assessment and the limitations of the instruments used.
3. Appropriately utilize and interpret objective measures of sexual interest as part of an overall assessment.

References

Abel GG, Becker JV, Cuningham-Rathner J, et al: Multiple paraphilic diagnoses among sex offenders. Bull Am Acad Psychiatry Law 16:153–168, 1988

Abel GG, Huffman J, Warberg B, et al: Visual reaction time and plethysmography as measures of sexual interest in child molesters. Sex Abuse 10:81–95, 1998

Alexander MA: Sexual offender treatment efficacy revisited. Sex Abuse 11:101–116, 1999

Allen v Illinois, 478 U.S. 364 (1986)

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

American Psychiatric Association, Task Force on Sexually Dangerous Offenders: Dangerous Sex Offenders : A Task Force Report of the American Psychiatric Association. Washington, DC, American Psychiatric Association, 1999

Barbaree HE: Psychopathy, treatment behavior, and recidivism: an extended follow-up of Seto and Barbaree. J Interpers Viol 20:1115–1131, 2005

Blanchard R, Klassen P, Dickey R, et al: Sensitivity and specificity of the phallometric test for pedophilia in nonadmitting sex offenders. Psychol Assess 13:118–126, 2001

Booth BD: Special populations: mentally disordered sexual offenders (MDSOs), in Managing High-Risk Sex Offenders in the Community: Risk Management, Treatment and Social Responsibilities. Edited by Harrison K. Cullompton, UK, Willan Publishing, 2010, pp 193–208

Bradford J: The treatment of sexual deviation using a pharmacological approach. J Sex Research 37:248–257, 2000

Bradford JM: The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. Can J Psychiatry 46:26–34, 2001

Bradford JM, Pawlak A: Effects of cyproterone acetate on sexual arousal patterns of pedophiles. Arch Sex Behav 22:629–641, 1993

Bradford J, Boulet MJ, Pawlak A, et al: The paraphilias: a multiplicity of deviant behaviours. Can J Psychiatry 37:104–108, 1992

Bradford J, Firestone P, Ahmed AG: The paraphilias and psychopathy, in International Handbook of Psychopathic Disorders and the Law, Vol 1. Edited by Felthous A, Sass H. Chichester, West Sussex, UK, Wiley, 2008, pp 275–290

Brown SL, Forth AE: Psychopathy and sexual assault: static risk factors, emotional precursors, and rapist subtypes. J Consult Clin Psychol 65:848–857, 1997

Chenier E: The criminal psychopath in Canada: sex, psychiatry, and the law at mid-century. Can Bull Med Hist 20:75–101, 2003

Daubert v Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993)

Doren D: Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond. Thousand Oaks, CA, Sage, 2002

Dunsieth NW Jr, Nelson EB, Brusman-Lovins LA, et al: Psychiatric and legal features of 113 men convicted of sexual offenses. J Clin Psychiatry 65(3):293–300, 2004

English K, Jones L, Pasini-Hill D, et al: The Value of Polygraph Testing in Sex Offender Treatment. Washington, DC, National Institute of Corrections/National Institute of Justice, 2000

Fazel S, Hope T, O'Donnell I, et al: Psychiatric, demographic and personality characteristics of elderly sex offenders. Psychol Med 32:219–226, 2002

Finkelhor D: The international epidemiology of child sexual abuse. Child Abuse Negl 18:409–417, 1994

Firestone P, Kingston DA, Wexlar A, et al: Long-term follow-up of exhibitionists: psychological, phallometric, and offense characteristics. J Am Acad Psychiatry Law 34:349–359, 2006

Freund K: Diagnosis of male homosexuality [in Czech]. Ceskoslovenska Psychiatrie 53:382–934, 1957

Freund K, Blanchard R: Phallometric diagnosis of pedophilia. J Consult Clin Psychol 57:100–105, 1989

Freund K, Chan S, Coulthard R, et al: Phallometric diagnosis with 'nonadmitters.' Behav Res Ther 17:451–457, 1979

Freund, K., Seto, MC, Kuban M: Frotteurism and the theory of courtship disorder, in Sexual Deviance: Theory, Assessment and Treatment. Edited by Laws D, O'Donohue WT. Guildford, New York, 1997, pp 111–130

Frye v United States, 293 F. 1013 (D.C. Cir. 1923)

Furby L, Weinrott MR, Blackshaw L: Sex offender recidivism: a review. Psychol Bull 105:3–30, 1989

Hanson RK: Recidivism and age: follow-up data from 4,673 sexual offenders. J Interpers Violence 17:1046–1062, 2002

Hanson RK, Bussiere MT: Predicting relapse: a meta-analysis of sexual offender recidivism studies. J Consult Clin Psychol 66:348–362, 1998

Hanson RK, Morton-Bourgon KE: The accuracy of recidivism risk assessments for sexual offenders: a meta-analysis of 118 prediction studies. Psychol Assess 21:1–21, 2009

Hanson RK, Gordon A, Harris AJ, et al: First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sex Abuse 14:169–194; discussion 195–197, 2002

Hanson RK, Morton-Bourgon KE:The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. J Consult Clin Psychol 73:1154–1163, 2005

Hare R: Hare Psychopathy Checklist—Revised (PCL-R). Toronto, ON, Multi-Health Systems, 2003

Harris AJ, Tough S: Should actuarial risk assessments be used with sex offenders who are intellectually disabled? Journal of Applied Research in Intellectual Disabilities 17:235–241, 2004

Heil P, Ahlmeyer S, Simons D, et al: Crossover sexual offenses. Sex Abuse 15(4):221–236, 2003

In re Young and Cunningham, 857 P.2d. 989 (1993)

Kafka MP: The paraphilia-related disorders: a proposal for a unified classification of nonparaphilic hypersexuality disorders. Sexual Addiction and Compulsivity 8:227–239, 2001

Kafka MP, Hennen J: A DSM-IV Axis I comorbidity study of males (n = 120) with paraphilias and paraphilia-related disorders. Sexual Abuse 14:349–366, 2002

Kansas v Hendricks, 521 U.S. 346, 138 L.Ed.2d 501, 117 S.Ct. 2072 (1997)

La Fond JQ: The costs of enacting a sexual predator law. Psychol Public Policy Law 4:468–504, 1998

Lalumière ML, Harris GT: Common questions regarding the use of phallometric testing with sexual offenders. Sexual Abuse: A Journal of Research and Treatment 10:227–237, 1998

Lalumière ML, Harris GT, Quinsey VL, et al: The Causes of Rape: Understanding Individual Differences in Male Propensity for Sexual Aggression. Washington, DC, American Psychological Association, 2005

Langstrom N, Hanson RK: High rates of sexual behavior in the general population: correlates and predictors. Arch Sex Behav 35:37–52, 2006

Langton CM, Barbaree HE, Harkins L, et al: Sex offenders' response to treatment and its association with recidivism as a function of psychopathy. Sex Abuse 18:99–120, 2006

Laws D, O'Donohue WT (Eds): Sexual Deviance: Theory, Assessment and Treatment. Guilford, New York, 2008

Looman J, Marshall W: Phallometric assessments designed to detect arousal to children: the responses of rapists and child molesters. Sexual Abuse 13:3–13, 2001

Marshall WL, Fernandez Y: Phallometric Testing With Sexual Offenders. Theory, Research and Practice. Brandon, VT, Safer Society Press, 2003

Quinsey VL, Harris GT, Rice M, et al: Violent Offenders: Appraising and Managing Risk, 2nd Edition. Washington, DC, American Psychological Association, 2005

Rand MR: National Crime Victimization Survey (NCJ 224390). Washington, DC, National Center for Justice, U.S. Department of Justice, 2008

Riches VC, Parmenter TR, Wiese M, et al: Intellectual disability and mental illness in the NSW criminal justice system. Int J Law Psychiatry 29:386–396, 2006

Seling v Young (99-1185), 531 U.S. 250 (2001)

Seto MC: Pedophilia and Sexual Offending Against Children: Theory, Assessment and Intervention. Washington, DC, American Psychological Association, 2008

Seto MC, Eke AW: The clinical histories and later offending of child pornography offenders. Sex Abuse: A Journal of Research and Treatment 17:201–210, 2005

Seto MC, Cantor JM, Blanchard R: Child pornography offenses are a valid diagnostic indicator of pedophilia. J Abnorm Psychol 115:610–615, 2006

Seto MC, Marques JK, Harris GT, et al: Good science and progress in sex offender treatment are intertwined: a response to Marshall and Marshall (2007). Sex Abuse 20:247–255, 2008

Specht v Patterson, 386 U.S. 605 (1967)

Suggested Readings

Booth BD: Special populations: mentally disordered sexual offenders (MDSOs), in Managing High-Risk Sex Offenders in the Community: Risk Management, Treatment and Social Responsibilities. Edited by Harrison K. Cullompton, UK, Willan Publishing, 2010

Bourget D, Bradford JM: Evidential basis for the assessment and treatment of sex offenders. Brief Treatment and Crisis Intervention 8:130–146, 2008

Bradford JM: The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. Can J Psychiatry 46:26–34, 2001

Campbell MA, French S, Gendreau P: The prediction of violence in adult offenders: a meta-analytic comparison of instruments and methods of assessment. Criminal Justice and Behavior 36:567–590, 2009

Hanson RK, Morton-Bourgon KE: The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. J Consult Clin Psychol 73:1154–1163, 2005

Hanson RK, Morton-Bourgon KE: The accuracy of recidivism risk assessments for sexual offenders: a meta-analysis of 118 prediction studies. Psychol Assess 21:1–21, 2009

Saleh F, Grudzinska M, Bradford J, et al (eds): Sex Offenders: Identification, Risk Assessment, Treatment and Legal Issues. New York, Oxford University Press, 2008

Seto MC: Pedophilia and Sexual Offending Against Children: Theory, Assessment, and Intervention. Washington, DC, American Psychological Association, 2008

Chapter 15

Correctional Psychiatry

Jeffrey L. Metzner, M.D.

Joel A. Dvoskin, Ph.D., ABPP

Local jails, which are usually administered by city or county officials, are facilities that hold inmates beyond arraignment, often for 48 hours or less but almost always less than a year. Prisons are state or federally operated correctional facilities in which persons convicted of major crimes or felonies serve sentences that are usually in excess of a year. Six states (Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont) and the District of Columbia have combined jail and prison systems (Metzner 1997).[1]

There were 2,378,897 persons incarcerated in the nation's prisons and jails at year-end 2007. This figure does not include those persons incarcerated in U.S. territories, military facilities, U.S. Immigration and Customs enforcement facilities, jails in Indian country, or juvenile facilities, which together account for approximately 120,000 additional persons. Prisoners in

[1]Despite the clear legal status differences between pretrial detainees in jails and inmates in prisons, the term *inmate* will be used throughout this chapter to refer to both.

the custody of state (1,398,698) and federal prisons (199,618) accounted for two-thirds of the incarcerated population (1,598,316 inmates). The remaining one-third were held in local jails (780,581) (West and Sabol 2008). The total correctional population included about 214,400 female prisoners, who accounted for 9% of all prisoners (Sabol and Minton 2008; West and Sabol 2008). A total of 4,293,163 adult men and women were on probation at year-end 2007, in addition to an adult parole population of 824,365 (Glaze and Bonczar 2008). Recidivism rates are high, as demonstrated by a study of 272,111 state prisoners discharged from prisons in the United States during 1994, which revealed that 67.5% were rearrested for a new offense (almost exclusively a felony or a serious misdemeanor) within three years following their release (Langan and Levin 2002).

Psychiatric hospital populations have dwindled during the past five decades, and the locus of psychiatric treatment has increasingly shifted from long-stay state hospitals to acute general hospitals and community-based treatment. As a result, the frequency of persons with the most serious psychiatric diagnoses interacting with the criminal justice system has dramatically increased. It is not our intention to debate the wisdom of community-based treatment; for many consumers it has resulted in a richer and more fulfilling life, whereas for others it has resulted in frequent incarcerations. It is clear, however, that this change in the mental health treatment system has resulted in a "pooling" of some persons with diagnoses of serious mental illness in correctional settings.

Studies and clinical experience have consistently indicated that 8%–19% of prisoners have psychiatric disorders that result in significant functional impairments and another 15%–20% will require some form of psychiatric intervention during their incarceration (Dvoskin et al. 2003; Metzner 1993; Morrissey et al. 1993). Thus, even if the prevalence of mental illness within correctional populations has remained the same, the 107% increase in correctional populations between 1990 and 2007 (Harrison and Karberg 2003; West and Sabol 2008) has resulted in at least a corresponding increase in the number of mentally ill prisoners.

Psychiatrists and other mental health clinicians should become familiar with these correctional settings and their particular stressors because of the need to provide treatment to people with serious mental illnesses. There are more than 5,000 jails in the United States, and only the larger ones have full-time psychiatrists or mental health staffing. Thus, although correctional psychiatry is an increasingly important and valued specialty, it remains true that the majority of psychiatric care, in local jails especially, will be provided on a part-time or contracted basis, often by general psychiatrists.

Standards of Care in Correctional Mental Health Programs

Numerous sets of standards and guidelines for correctional mental health care programs have been promulgated by national organizations. The most widely recognized are those endorsed by the National Commission on Correctional Health Care (2008) and a task force report by the American Psychiatric Association (2000). The guidelines published by the American Psychiatric Association recommend that the fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice system that *should* be available in the community.

By definition, of course, this standard is generally higher than that provided to people who live in the "free" world. It is appropriate to ask why arrest, and perhaps commission of a crime, would entitle one to better mental health services than one would receive if he or she had obeyed the law and stayed out of trouble. The answer lies in both constitutional and common law. Because inmates are prevented from seeking their own food, clothing, shelter, and medical care by the very fact that they are locked up, those who incarcerate have legally been charged with providing these *necessities* of life to the people they incarcerate. This "necessaries doctrine" and subsequent constitutional law make it illegal for jails and prisons to be "deliberately indifferent" to the serious medical needs of prisoners. State and local governments, perhaps sadly, have no similar constitutional duty to meet the medical needs, however serious, of free citizens (Cohen 1998).

There is, however, a more positive public policy reason to provide a reasonably high "floor" of mental health services to prisoners. Steadman (2005) has spoken of the American jail as a "public health outpost," where those in need of services can be started on a course of physical or mental hygiene that will prevent future, expensive exacerbations of serious illness, including consequences such as crime. Correctional officials have a literally captive population that in many cases has demonstrated an inability to live safely and freely in the community—one that may be more amenable to and in need of psychiatric treatment under the stress of jail. This is not to suggest that jail or prison is the *preferred* method of entry into the mental health system, but, as is the case with illiteracy, jails and prisons have an opportunity to address some of the failures of other social and health systems in our society. To ignore this opportunity would be bad public policy.

Forensic Evaluations in Correctional Settings

In addition to the essential treatment role that a psychiatrist provides in a correctional mental health system, a general psychiatrist and other mental health clinicians will often have the opportunity to participate in various types of forensic evaluations within the correctional setting. In jails, forensic mental health evaluations involving pretrial detainees most commonly address issues related to competency to stand trial, diversion programs (related to sex offender treatment, substance abuse treatment, or mental health treatment), presentencing recommendations, and civil commitment. In the prison setting, forensic mental evaluations are most frequently requested to assess parole board issues (e.g., psychiatric suitability for parole, need for mental health treatment upon parole, risk assessments for violence), consultation for classification purposes (i.e., security-level questions), competency and dispositional issues relevant to disciplinary infraction proceedings, and the so-called Hendricks (*Kansas v. Hendricks* 1997) assessments related to evaluations of sex offenders for commitment following completion of their prison sentences. As correctional systems have become increasingly aware of the legal and ethical obligations to inmates, formal assessments of competency to consent or refuse treatment have become increasingly important and common; these also require forensic expertise.

The vast majority of correctional/forensic psychiatric evaluations have one thing in common: they require the mental health clinician to make an assessment of risk of interpersonal violence. Although a thorough review of violence risk assessment is beyond the scope of this chapter (but see Dvoskin and Heilbrun 2001), we recommend at the very least that mental health clinicians familiarize themselves with the most important types of risk assessment, and actuarial, anamnestic, and guided clinical assessment.

Actuarial prediction or assessment (see, e.g., Harris and Rice 2007; Hart et al. 2007; Monahan et al. 2001; Quincy et al. 1998; Steadman et al. 2000) is a strictly statistical method of assessing risk, which reports a person's risk of violence based on the violent behavior of groups with similar characteristics. Thus far, actuarial instruments have relied predominantly on static, historical variables, and have been criticized as overgeneralizing from the populations on which they were normed (e.g., Canada) to populations with quite different base rates of violence. So far, actuarial instruments have not spoken to the severity or imminence of violence risk, but have demonstrated an impressive ability to assess the likelihood of different forms of interpersonal violence.

Anamnestic assessment (Dvoskin 2002; Dvoskin and Heilbrun 2001) uses the person's own history and patterns of behavior to predict the circumstances under which he or she is likely to offend in the future and guides clinical interventions aimed at reducing the likelihood of their occurrence. Guided clinical assessment (e.g., Douglas et al. 2003; Hart 1998) includes elements of both actuarial and anamnestic assessment. It typically involves a structured set of questions that are investigated, each based on a characteristic that has shown some empirical relationship to violent behavior, either among similar groups of people or in the person's own history.

Whatever method of risk assessment is used, each evaluator should specify the evidentiary and theoretical basis for his or her inferential opinion, especially including limitations such as insufficient data.

As in all forensic assessments, the mental health clinician should inform the inmate, prior to beginning the assessment process, about the purpose of the evaluation and limits of confidentiality. Mental health clinicians who provide treatment to inmates in various correctional settings should be aware of limitations related to confidentiality. Inmates should be informed about these limitations prior to beginning treatment (except in unusual circumstances, such as when the inmate is psychotic and unable to provide informed consent for treatment). These exceptions to confidentiality often vary from one state to another. For example, parole boards by statute often have access to an inmate's health care record, which will include mental health evaluations and treatment notes.

In most settings, correctional staff is usually aware that an inmate is receiving psychotropic medication or is on the mental health caseload, and may often be provided some information by mental health staff about the inmate's mental health status and needs. Mental health clinicians performing forensic evaluations of inmates should attempt to receive informed consent from the inmate to obtain relevant information, both oral and written, from past and current mental health providers. Even if consent is not required by law or regulations, in most cases one should at least inform the inmate of the reason for the evaluation and the inmate's rights and duties to participate or refuse.

The nature of the forensic issue to be addressed will certainly help to structure the interview so that relevant information will be obtained and assessed by the mental health clinician. In general, a standard psychiatric examination, as described in standard textbooks (Nicholi 1999), should be performed. Depending on the specific referral question, the inmate's history relevant to substance abuse, mental health treatment, support systems, employment, plans if granted release, legal history, and adjustment to the correctional setting are often issues that need to be comprehensively assessed. See Chapter 7, "The Forensic Psychiatric Examination and Report," for information relevant to writing the forensic report.

Dual agency issues commonly arise in correctional mental health settings. This potential problem becomes apparent when disclosing to the inmate one of the exceptions to confidentiality that may occur, such as when the inmate has been assessed to be a threat to staff or other inmates. This issue may also become prominent if the health care record is available to the parole board. There are circumstances in which the treating psychiatrist is asked to perform a forensic evaluation concerning his or her patient. Under some circumstances, this is not inappropriate or avoidable, but, generally speaking, dual agency roles should be avoided. In settings with more than one psychiatrist or psychologist, this can best be handled by limiting forensic evaluations to inmates with whom one does not have a treatment relationship. However, as noted, most jails are small and likely to have only one part-time or contracted provider.

Case Vignettes

Vignette 1: Evaluation of an Inmate Suicide

> Dr. W is a forensic psychiatrist who, in the past, has consulted on a part-time basis to local jails. Dr. W receives a call from a plaintiff's attorney concerning the death by suicide of Mr. S at the local jail two weeks following his incarceration. Dr. W is asked whether he will serve as an expert witness for the estate of the deceased, which has initiated a lawsuit against the sheriff and mental health director alleging negligence (in contrast to a Section 1983 constitutional rights violation claim). How should Dr. W proceed?

As in all forensic cases, Dr. W first needs to determine his level of relevant expertise, if any, in the issues being litigated. Dr. W has relevant experience in correctional psychiatry and agrees to review this case. He also checks his own records to ensure that he has not personally treated Mr. S, which might create a real or perceived conflict of interest. Finally, Dr. W should think about any other real or perceived conflicts of interest that would prevent him from providing credible and objective expert testimony.

Because of the increased risk of suicide among incarcerated jail inmates, especially among those with mental illness, correctional institutions are expected to have suicide prevention programs for identifying and responding to each suicidal inmate. In order to provide a competent forensic report, Dr. W will need to be familiar with the standard of care relevant to suicide prevention programs in a correctional facility. His opinion concerning this stan-

dard of care should not be idiosyncratic to Dr. W; rather, it should reflect and be grounded in statements by recognized experts, prior judicial decisions, published literature, empirical studies, and/or, perhaps most importantly, policy statements from relevant professional organizations.

The National Commission on Correctional Health Care (2008) and the American Psychiatric Association (2000) have provided very clear guidelines relevant to the issue of suicide prevention in a correctional facility. Both organizations require policies and procedures designed to identify newly arriving inmates who may require mental health evaluation and/or treatment. The American Psychiatric Association guidelines describe three separate processes that should be in place to identify inmates requiring psychiatric treatment (receiving mental health screening, brief mental health assessment, and comprehensive mental health evaluation). The National Commission on Correctional Health Care provides procedures for identifying inmates requiring psychiatric treatment via receiving screening, comprehensive health assessment, and mental health assessment. All of these processes include assessments relevant to an inmate's potential for suicide and procedures to follow when actions are required as a result of positive findings.

The essential features (American Psychiatric Association 2000; National Commission on Correctional Health Care 2008) of adequate suicide prevention programs in jails include the following components:

1. Training of all staff that have regular contact with inmates concerning recognition of danger signs and procedures to follow when an inmate may be suicidal
2. Procedures for identification, referral, and evaluation of all newly admitted inmates who may be suicidal, as well as evaluation of other inmates who may become suicidal at other times during their confinement
3. Policies and procedures to ensure adequate communication between the arresting/transporting officer and correctional staff, among the jail staff (including correctional, medical, and mental health personnel) and between facility staff and the suicidal inmate
4. Housing options that facilitate adequate monitoring of suicidal inmates by staff
5. Timely provision of mental health interventions to the suicidal inmate
6. Policies and procedures for reporting/notification of suicide attempts or completed suicides
7. Administrative reviews and critical-incident debriefing in the event of a completed suicide.

Awareness of these standards of care issues should result in Dr. W advising the plaintiff's attorney to request via the discovery process the following documents:

1. Policies and procedures relevant to the jail's mental health program, which will include a written description of the suicide prevention program
2. Training records, including the curriculum and the percentage of staff that has received this training, concerning the suicide prevention program
3. The complete health care record of Mr. S
4. A list containing the funded allocated mental health staff positions, which should include vacancies, at the jail during the period of time surrounding Mr. S's suicide
5. The number of suicide attempts and completed suicides during the past 2 to 5 years, which may help to identify systemic issues at the jail
6. A copy of the administrative review and investigations of Mr. S's suicide, including statements of all staff and inmate witnesses, autopsy and toxicology reports, external investigations, and the like

Dr. W will need to closely examine issues related to the screening procedures administered to Mr. S upon admission (e.g., adequacy, timeliness, response to any positive findings), whether the officers with whom he interacted had received the relevant suicide prevention training, adequacy of the policies and procedures relevant to the suicide prevention program, and whether the jail successfully implemented these policies and procedures. As in other forensic evaluations, the initial review of this basic material will generate other questions and discovery requests in order to formulate an opinion relevant to liability issues.

After reviewing all of these materials, Dr. W may also want to obtain information from relevant witnesses, assuming that investigations have been completed. These statements may include information from other inmates who either witnessed the event or knew the deceased, family members of the deceased, and various mental health, medical, or correctional staff. This information may be obtained in a variety of ways, such as interrogatories, depositions, and interviews. The specific method of collecting the relevant information is usually determined by discovery procedures.

Ultimately, Dr. W will render an opinion concerning the presence or absence of negligence in regard to the death of Mr. S, if the suit is a simple tort claim of wrongful death or malpractice. In rendering this opinion, Dr. W must be careful to avoid the retrospective bias that may result from his knowledge that Mr. S is dead. Instead, Dr. W must try to judge whether the appropriate standard of care was met.

Vignette 2: Mental Health Jail Diversion Programs for Adult Offenders

Dr. B consults to a local community mental health center. Recently, the sheriff has entered into an intergovernmental agreement with the community mental health center to provide a jail diversion program in an effort to reduce the unnecessary incarceration of persons with serious mental illness. The first candidate for this program is Mr. H. Dr. B has been asked to provide a mental health evaluation of Mr. H, and to make recommendations for his treatment and management. What are the relevant issues that Dr. B should address in his evaluation?

Mental health jail diversion programs are organized interagency efforts that identify inmates with serious mental illnesses and establish mental health treatment programs that meet their needs in the least restrictive environment that does not appear to endanger the community. These programs negotiate with prosecutors, defense attorneys, courts, and community mental health providers to develop a comprehensive mental health disposition outside of the jail, either instead of prosecution or as a condition of reduction in charges, or at least to transfer defendants into treatment while awaiting trial. These dispositions usually occur when the charge is for a relatively minor crime (Hoff et al. 1999), although many diversion programs also focus on felony defendants.

The first set of questions to be addressed by Dr. B will likely involve the criteria for inclusion into the program. Typically, there will be a requirement that the patient has received a diagnosis of serious mental illness. Further, various types of offenses, especially crimes of violence, may disqualify the person for inclusion in the program. Note, however, that a violent charge does not necessarily signify a high risk of interpersonal violence. For example, police officers in some cases will "overcharge" a person with mental illness for his or her own safety, to ensure that the person remains in jail long enough to receive treatment. The issue of violence risk will be addressed differently by each program, but ideally it should be based on an individualized risk assessment and judged on a case-by-case basis. Dr. B will need to review recent psychiatric records, which will assist in the determination of Mr. H's diagnosis, and relevant legal documents to determine his current charges and criminal history.

If we assume that Mr. H meets the program's minimum criteria, the next set of questions to be addressed will include his appropriateness for release and the conditions under which his release is least likely to result in harm to the community. Both of these questions are best answered by a competent risk assessment for violence. Dvoskin and Heilbrun (2001) have summarized the literature on violence risk assessment, including a description of actuarial, clinical, and anamnestic approaches to the task. Briefly, actuarial instruments, despite many limitations, appear to have value in determining the *likelihood* of violence, which is one important aspect of violence risk assessment. However, it is not the only axis, nor necessarily the most important. *Severity, imminence, and duration* of violence risk are all important determinants of Mr. H's appropriateness for diversion, and must be considered by Dr. B. To do so, Dr. B must conduct either a guided clinical evaluation (Hart 1998) and/or an anamnestic assessment of violence risk (Dvoskin 2002). In anamnestic assessment, Dr. B focuses on the person in context and over time, examining and learning from his or her life story. In a sense, it is an ethnographic way of studying people. There should be little difference between this type of assessment and a good clinical evaluation. Both types of assessments should carefully review prior incidents of violence, including the clinical and situational aspects of Mr. H's life at the time of these incidents. This analysis will result in identification of risk-laden situations, clinical risk factors, skill deficits, and strengths or protective factors (which were likely in evidence at times that Mr. H did *not* commit any acts of violence).

This risk assessment will lead to a set of specific recommendations for services, supports, and monitoring that address the situational and clinical risk factors identified in Dr. B's assessment. These recommendations must include recognition of the role of various social service and criminal justice agencies, in addition to mental health and psychiatric services in the community. Dr. B and the diversion program's staff must take time to familiarize themselves with the practices and resources of local probation, parole, and police agencies, and gain an awareness of various federal and state entitlement programs and how to access them.

Finally, no matter how well crafted a diversion plan may be, it must be accepted by prosecutors and judges. To this end, Dr. B or a program representative must have access to the courts and enjoy a high level of credibility in the eyes of judges and prosecutors. To accomplish this goal, diversion programs must include intensive supports and supervision, especially in the early weeks and months after release. They should also avoid taking marginal cases early in the program's life. Early successes set the stage for later risk taking, but establishing the program as consistent with public safety is essential, so that the inevitable failure will be seen an exception to an otherwise safe and responsible process.

Vignette 3: Juvenile Sex Offenders

> Dr. D, who is the clinical director of a sex-offender-specific treatment program for adolescent males, is asked by the juvenile court to evaluate a 14-year-old boy for treatment as part of a diversion program. What are the likely issues that will need to be addressed concerning confidentiality and double agency?

Dr. D will obviously need to have expertise in the evaluation and treatment of adolescent sex offenders in order to accept the appointment by the juvenile court. It is beyond the scope of this chapter to summarize issues relevant to the sex-offender-specific assessment required, which can be found elsewhere (see Chapter 14, "Forensic Assessment of Sex Offenders," this volume; see also, Colorado Sex Offender Management Board 2008; Metzner and Becker 1999; Metzner et al. 2009). However, this vignette does provide the opportunity to discuss issues of confidentiality and dual agency in the context of a mandated assessment or treatment ordered by a court.

In many states, such as Colorado, the standard of care relevant to mandated treatment concerning confidentiality is as follows:

> Juveniles who have committed sexual offenses must waive confidentiality for purposes of evaluation, treatment, supervision, and case management to obtain the privileges attached to community supervision. This waiver of confidentiality must be based on complete informed consent of the parent/legal guardian and voluntary assent of the juvenile. The juvenile parent/guardian must be fully informed of alternative dispositions that may occur in the absence of consent/assent. (Colorado Sex Offender Management Board 2008, p. 47)

Under such circumstances, the psychiatrist needs to be sure that both the juvenile and his parents/legal guardian fully understand the meaning of this waiver.

These same standards clearly state that "the highest priority of these Standards and Guidelines is community safety. Whenever the needs of juveniles who have committed sexual offenses conflict with community safety, community safety takes precedence" (Colorado Sex Offender Management Board 2008, p. 7). In other words, the evaluating or treating psychiatrist is now in the potentially conflicting role of a double agent. However, this situation may be one of the exceptions to the general rule of avoiding dual agency.

The waiver of confidentiality and dual agency role is often an obstacle to establishing a therapeutic alliance with the juvenile offender. However, this difficulty can be decreased by including the juvenile, when possible, in the process that involves sharing of information with others. For example, information-sharing occurs during treatment planning/review meetings that

often includes the juvenile's probation officer, social worker, residential treatment staff, and mental health clinicians. The adolescent should attend part of this meeting. Discussing issues relevant to the staffing with the adolescent, prior to the actual staffing, can be very helpful in establishing a therapeutic alliance. Including his or her parents/legal guardian in this process is also helpful. Providing the adolescent with a draft copy of reports sent to the court or probation officer prior to actually sending them is consistent with this straightforward approach.

Vignette 4: Evaluation for Disciplinary Board

> Inmate G has been charged with disobeying a direct order from a correctional officer and destroying state property. During the investigation by Lieutenant F, Inmate G appears to be agitated and demonstrates disorganized thinking. Dr. M receives a referral from the disciplinary board hearing officer for a mental health evaluation of Inmate G prior to proceeding with the disciplinary hearing. How should Dr. M proceed?

Dr. M needs to be familiar with the policies and procedures in the correctional institution relevant to such a mental health evaluation. Unfortunately, this area of correctional psychiatry is frequently very unclear, with little guidance being provided in the psychiatric literature (Dvoskin et al. 1995; Krelstein 2002).

In general, these types of evaluations focus on the following three questions:

1. Are there any mental health factors that may cause the inmate to not be able to competently participate in the disciplinary hearing process? This evaluation is analogous to an evaluation of competency to proceed.
2. If the inmate has a mental disorder, did the disorder contribute to the behavior(s) that led to the alleged disciplinary infraction? This evaluation attends to the inmate's blameworthiness or responsibility for the offense, but in most states it is explicitly not equivalent to evaluation for an insanity defense.
3. If the inmate is found guilty of the offense, are there any mitigating mental health factors that should be considered by the hearing officer in determining the punishment? This evaluation is analogous to an aid-to-sentencing examination.

Although somewhat controversial, in some states correctional systems will ask for consultation relevant to a responsibility (i.e., equivalent to a not-

guilty-by-reason-of-insanity plea) examination. Many correctional mental health professionals are not trained to conduct such a forensic assessment, and most systems requesting the specific responsibility evaluations lack adequate standards and definitions for these examinations. It is beyond the scope of this vignette to further discuss issues relevant to responsibility examinations in the correctional setting. However, Dvoskin and colleagues (1995) have argued against formal evaluations of criminal responsibility in prison, preferring an informal process that will divert fewer clinical resources from treatment and will allow the prison mental health professionals to maintain the trust of staff and inmates alike.

Dual agency issues arise if the mental health assessment is provided by the inmate's treating clinician. In general, the treating clinician should be made aware of the alleged infraction because the inmate's actions leading to the alleged rule violation are often clinically significant. However, the actual consultation provided to the disciplinary board should be offered by a clinician who is not treating the inmate, in order to minimize dual agency issues. An exception to this cautionary note occurs when the disciplinary board's questions are factual (e.g., whether or not the inmate is on the mental health caseload).

Conclusion

Historically, jails and prisons were viewed as the least desirable settings in which to practice psychiatry. However, it has been our experience that correctional settings can be financially, intellectually, and clinically rewarding places to work. In many states, it is sadly true that the most mentally disabled citizens are likely to be found in jails and prisons, and these institutions often have more available resources for their treatment than can be found in traditional mental health settings. Medical schools are increasingly looking to contract as service providers, creating exciting opportunities for advancing the field by serving the people who need us most.

Key Points

- Forensic evaluations that are relevant to correctional psychiatric issues generally require either of the following features:
  - Knowledge of specific legal standards (e.g., was the appropriate standard of care followed, did the inmate have the capacity for a specific competency, such as competency to stand trial or competency to refuse treatment, etc.?).
  - Familiarity with relevant treatment resources and their availability, because the forensic question being addressed is related to dispositional issues (e.g., is diversion an option; what psychiatric conditions, if any, should be part of an inmate's parole requirements; are there treatment settings available that will decrease a particular inmate's participation in dangerous activities if released?).

Practice Guidelines

1. Be familiar with standards and guidelines for mental health care services in correctional facilities promulgated by key national organizations such as the National Commission on Correctional Health Care (2008) and the American Psychiatric Association (2000). Your treatment of inmates should be consistent with these standards.
2. Stay current with accepted risk assessment procedures, which are generally important elements of forensic evaluations in a correctional setting and are often relevant to treatment in jails and prisons.
3. Inform inmates of the various exceptions to confidentiality in a correctional setting. As a mental health clinician, you must remain sensitive to treatment issues related to these potential breeches of confidentiality.
4. Dual agency conflicts, similar to issues related to confidentiality, can adversely affect the therapeutic alliance. In general, you should avoid dual agency roles.
5. Be straightforward and respectful in your interactions with inmates and correctional staff.

References

American Psychiatric Association: Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association, 2nd Edition. Washington, DC, American Psychiatric Association, 2000

Cohen F: The Mentally Disordered Inmate and the Law. Kingston, NJ, Civic Research Institute, 1998

Colorado Sex Offender Management Board: Standards and guidelines for the evaluation, assessment, treatment and supervision of juveniles who have committed sexual offenses, Revised 2008. Available at: http://dcj.state.co.us/odvsom. Accessed February 14, 2009.

Douglas KS, Ogloff JRP, Hart SD: Evaluation of a model of violence risk assessment among forensic psychiatric patients. Psychiatr Serv 54:1372–1379, 2003

Dvoskin JA: Knowledge isn't power—knowledge is obligation. J Am Acad Psychiatry Law 30:533–540, 2002

Dvoskin JA, Heilbrun K: Risk assessment and release decision-making: toward resolving the great debate. J Am Acad Psychiatry Law 29:6–10, 2001

Dvoskin JA, Petrila J, Stark-Riemer S: Case Note, Powell v Coughlin and the application of the professional judgment rule to prison mental health. Ment Phys Disabil Law Rep 19:108–114, 1995

Dvoskin JA, Spiers EM, Metzner JL, et al: The structure of correctional mental health services, in Principles and Practice of Forensic Psychiatry, 2nd Edition. Edited by Rosner R. London, Arnold, 2003, pp 489–504

Glaze LE, Bonczar TP: Probation and parole in the United States, 2007. Bureau of Justice Statistics Bulletin (NCJ 224707). Washington, DC, U.S. Department of Justice, Bureau of Justice Statistics, December 2008, pp 1–10

Harris GT, Rice ME: Characterizing the value of actuarial violence risk assessments. Criminal Justice and Behavior 34:1638–1658, 2007

Harrison PM, Karberg JC: Prison and jail inmates at midyear 2002. Bureau of Justice Statistics Bulletin (NCJ 198877). Washington, DC, U.S. Department of Justice, Bureau of Justice Statistics, August 2003, pp 1–14

Hart SD: The role of psychopathy in assessing risk for violence: conceptual and methodological issues. Legal Criminol Psychol 3:123–140, 1998

Hart SD, Michie C, Cooke DJ: Precision of actuarial risk assessment instruments: evaluating the "margins of error" of group vs individual predictions of violence. Br J Psychiatry, 190:60–65, 2007

Hoff RA, Baranosky MV, Buchanan J, et al: The effects of a jail diversion program on incarceration: a retrospective cohort study. J Am Acad Psychiatry Law 27:377–386, 1999

Kansas v Hendricks, 117 S.Ct. 2072 (1997)

Krelstein MS: The role of mental health in the inmate disciplinary process: a national survey. J Am Acad Psychiatry Law 30:488–496, 2002

Langan PA, Levin DJ: Recidivism of prisoners released in 1994. Bureau of Justice Statistics Bulletin (NCJ 193427). Washington, DC, U.S. Department of Justice, Bureau of Justice Statistics, June 2002, pp 1–16

Metzner JL: Guidelines for psychiatric services in prisons. Criminal Behavior and Mental Health 3:252–267, 1993

Metzner JL: An introduction to correctional psychiatry, part I. J Am Acad Psychiatry Law 25:375–381, 1997

Metzner JL, Becker J: Juvenile sex offenders, in Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association, Washington, DC, American Psychiatric Association, 1999, pp 81–101

Metzner JL, Humphreys S, Ryan R: Juveniles who sexually offend: psychosocial intervention and treatment, in Sex Offenders: Identification, Risk Assessment, Treatment and Legal Issues. Edited by Saleh R, Grudzinskas AJ, Bradford JM, et al. Oxford, UK, Oxford University Press, 2009, pp 241–264

Monahan J, Steadman H, Silver E, et al: Rethinking risk assessment: the MacArthur study of mental disorder and violence. New York, Oxford University Press, 2001

Morrissey JP, Swanson JW, Goldstrom I, et al: Overview of mental health services provided by state adult correctional facilities: United States, 1988 (DHHS Publ No SMA 93). Washington, DC, Department of Health and Human Services, 1993, pp 1–13

National Commission on Correctional Health Care: Standards for Mental Health Services in Correctional Facilities. Chicago, Il, National Commission on Correctional Health Care, 2008

Nicholi AM (ed): History and mental status, in The Harvard Guide to Psychiatry. Cambridge, MA, Belknap Press of Harvard University Press, 1999, pp 26–39

Quinsey V, Harris G, Rice M, et al: Violent offenders: appraising and managing risk. Washington, DC, American Psychological Association, 1998

Sabol WJ, Minton TD: Jail inmates at midyear 2007. Bureau of Justice Statistics Bulletin (NCJ 221945). Washington, DC, U.S. Department of Justice, Bureau of Justice Statistics, June 2008, pp 1–11

Steadman HJ: The jail as a public health outpost. Presentation at the 133rd annual meeting and exposition of the American Public Health Association, Philadelphia, PA, December 2005

Steadman HJ, Silver E, Monahan J, et al: Classification tree approach to the development of actuarial violence risk assessment tools. Law Hum Behav 24:83–100, 2000

West HC, Sabol WJ: Prisoners in 2007. Bureau of Justice Statistics Bulletin (NCJ 224280). Washington, DC, U.S. Department of Justice, Bureau of Justice Statistics, December 2008, pp 1–26

Suggested Readings

American Psychiatric Association: Psychiatric Services in Jails and Prisons: A Task Force Report of the American Psychiatric Association, 2nd Edition. Washington, DC, American Psychiatric Association, 2000

Anno J: Prison Health Care: Guidelines for the Management of an Adequate Delivery System Chicago, Il, National Commission on Correctional Health Care, 1991

Cohen F: The Mentally Disordered Inmate and the Law. Kingston, NJ, Civic Research Institute, 1998

Wettstein R (ed): Treatment of Offenders with Mental Disorders. New York, Guilford, 1998

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Chapter 16

Forensic Psychiatry and Law Enforcement

Debra A. Pinals, M.D.

Marilyn Price, M.D.

There has been a growth of interest over the past decade in the ways in which forensic psychiatry and forensic psychiatrists intersect with law enforcement. This relationship has evolved along many fronts in which psychiatrists are called upon for consultation, training, or assessment. First, especially since deinstitutionalization, police are frequently first-responders to community emergencies that involve persons with mental illness. Authors have referred to police as quasi–mental health professionals and have labeled them "streetcorner psychiatrists" (Teplin and Pruett 1992) and "frontline mental health workers" (Green 1997). Given this important social function, law enforcement agents have a heightened need to recognize manifestations of mental illness and appropriately triage individuals who come to their attention. As a result, psychiatrists may be asked to collaborate with police departments and provide mental health training for officers.

Additionally, encounters between police and persons with mental illness have increasingly received public scrutiny, especially when the encounter re-

sults in a lethal outcome (Appelbaum 2000). At times, a review of these encounters points to excessive force on the part of the officer. At other times, however, an individual motivated by suicidal intent provokes the use of lethal force in what has become known as "suicide by cop." Psychiatrists become involved in these issues through a variety of circumstances, including postmortem reviews of suicide by cop in civil litigation, criminal forensic evaluations, and police investigations. Psychiatrists may also work with patients who have a history of attempting suicide by cop or who may be at risk of engaging in this type of behavior. Attempts to reduce negative outcomes in police encounters have also included calling on psychiatrists to assist police with crisis negotiation, at times involving hostage and/or barricade situations.

Finally, as psychiatrists have gained expertise in working more closely with police, there has been a parallel growth in understanding aspects of psychiatric disability specifically related to law enforcement officials. Police departments often seek evaluations of officer fitness for duty. Officers may apply also for disability through private insurance or through state pension funds. Unique job stress, exposure to violence and death, and substance abuse are just some of the factors that play into the potential for psychological sequelae affecting occupational functioning. These types of work-related assessments present distinct challenges to psychiatrists. Given the tight social network among officers, peer relations are important to consider in police fitness for duty assessments. Suicide risk is also important to weigh, given that this group has easy access to firearms. Psychiatrists conducting independent medical examinations of officer fitness for duty or disability must carefully balance risks to the officer and others in light of the social importance of bearing a firearm and the implications for its removal.

These themes reflect focused areas where psychiatry and law enforcement intersect. Many psychiatrists have developed specialized involvement with police along these lines. A more detailed review of each of these areas is discussed later in this chapter in an effort to highlight some of the unique aspects of work with law enforcement and with cases that involve police encounters with persons in crisis.

Mental Health and Law Enforcement: Systems Integration and Training

Systems Integration

Police have long been called to help with crisis situations for persons with mental illness. Although community resources and crisis services have come

a long way, Liberman noted in 1969 that the police would continue to serve a role in the care of individuals with mental illness as long as there were gaps in community treatment. The release of persons from state hospitals in the late 1960s and 1970s has been touted as a primary reason that police encounters with people with mental illness have risen over the years. Studies have shown that arrests of homeless persons and those discharged from psychiatric facilities are quite common (Belcher 1988; Lamb and Lamb 1990). Fisher and colleagues (2006) found that in a cohort of state mental health services consumers tracked over 10 years, 28% experienced at least one arrest. In a survey by the National Alliance on Mental Illness (Hall et al. 2003), 44% of approximately 2600 respondents reported being arrested or detained over their lifetimes.

Data stemming from an examination of police encounters also show that in their careers officers will likely encounter persons with mental illness in crisis. Most officers, in proportions ranging from 60% to 92% in some studies, report responding to one mental health crisis call in a month (Borum et al. 1998; Gillig et al. 1990). Between 42% and 84% said they had responded to more than one such call in the same time period. In a survey of police departments in 194 U.S. cities with a population of 100,000 or more, responses indicated that about 7% of all police contacts involved persons believed to be mentally ill (Deane et al. 1999). In that same study, over one-half of the departments reported having no specialized system in place to handle the issues that arose from these contacts (Deane et al. 1999). Overall, compared with the total types of contacts that law enforcement manage, the relative percentage of call-outs involving someone with a mental illness is small (Reuland et al. 2009). However, from an officer's perspective, these encounters will occur regularly, and the time spent resolving issues, the time spent with repeated calls to the same individuals, and the potential for violent outcomes in rare cases can present a host of unique challenges to police (Reuland et al. 2009).

Considering the steady stream of cases in which police deal with people with mental-health-related disorders and the rate at which persons with mental illness are arrested, systems integration and police awareness of mental health issues become critical. Yet the lack of adequate mental health training for police has been an area of concern (see, e.g., Cotton 2004). Police departments vary in their approaches to training and managing crisis calls involving persons with mental illness. Formal partnerships between police and mental health agencies have become increasingly common as the awareness of these points of intersection has emerged.

Given the recognition that persons with mental illness commonly encounter in the criminal justice system, Munetz and Griffin (2006) described the value of developing interceptions with an augmentation of mental health

services at multiple points along the continuum of criminal justice involvement, from pre-arrest to courts to reentry from correctional settings. They described this approach as the *sequential intercept model.* Through this model, a community may be able to achieve the goal of decreased penetration of persons with mental illness into the criminal justice system. Activities related to this intercept model have also come to be known broadly as *jail diversion,* though assisting people to readjust to the community after incarceration is more specifically referred to as *reentry work.* In this chapter, we focus on the pre-arrest intercept point, describing the role of police mental health linkages and training to see where forensic psychiatrists and police may help each other to improve services.

Several authors have described various organized strategies utilized among some police departments to manage citizens with mental illness who are in crisis (Borum 2000; Deane et al. 1999; Dupont and Cochran 2000). These strategies have been labeled based on the agency responsible (i.e., police- or mental-health-based) and the primary discipline of the responder (i.e., specially trained police officer or mental health professional). For example, a police-based, specialized response is used by a growing number of police departments. In this strategy, a selected group of police officers within a particular department receive specialized training to act as liaisons to the mental health system and manage crisis intervention. These specially trained officers respond to mental health emergencies. A body of research has begun to demonstrate advantages of specialized law enforcement responses as leading to decreased injuries to officers, increasing the chance that a person with mental illness will be brought to a mental health facility or to appropriate crisis services (Reuland et al. 2009). In a second scheme—the police-based, specialized mental health response—mental health consultants work for police departments and are available for on-site and telephone consultations.

Another model involves the use of mental health crisis teams that function as mobile crisis intervention units. Often, these teams represent an arm of local community mental health centers or public agencies whose mission is to be available at all hours to provide evaluations, treatment, and triage decisions. Many of these crisis teams work hard to foster relationships with local police, who may still be called on to assist in emergencies. Lamb and colleagues (2002) cautioned that mental health professionals who are members of mobile crisis teams be mindful of their role and not try to act as police officers. The importance of working within one's expertise during a crisis further highlights the value of collaboration between mental health workers and police and of calling on each discipline as needed.

Mental health professionals should familiarize themselves with the type of mental health crisis response system that exists in their communities. Especially in jurisdictions where there is no formal relationship between police

and mental health, forging a relationship between a psychiatric department or an emergency mental health service provider and a police department can go a long way toward assisting persons with mental illness who are in crisis (Lamb et al. 2002). For example, police mental health training could be used to alert officers on how to access mental health services and avoid incarceration of the individuals. Mental health professionals, through such collaborations, could capitalize on the expertise of the police. Police are often interested in establishing these relationships and at times seek out specialized mental health training. Meetings between mental health providers and police are a forum that can be employed to develop target topics to be included in training and to form approaches to mutual problem solving.

Police Mental Health Training

Setting a mental health training agenda for police can be complex (Vermette et al. 2005), although there is a significant need for it (Price 2005). Law enforcement officers are often called to a scene where a person with mental illness may be at risk of harm to himself or herself or others, or where someone has already tried to commit suicide or harmed another individual (Bower and Petit 2001). In a survey of California law enforcement agencies, it was found that police were called to a robbery as often as they were called to handle a mental health crisis (Husted et al. 1995). Yet, in that same study, most law enforcement officers reported they were given insufficient training to identify, manage, and appropriately refer the mentally ill offenders they encountered. In a study by Vermette and colleagues (2005), police respondents to a survey viewed mental health training as an important area to cover and working with persons with mental illness as an important aspect of their job.

Increased knowledge of mental illness, verbal skills, and crisis intervention strategies related to encounters with persons with mental illness are often at the forefront of desired goals of police officer training. Police may be motivated to receive such training because of their concern for being held liable in the management of encounters with persons with mental illness.

Education alone will not provide solutions to the challenges officers face in managing crises that involve persons with mental illness (Borum 2000; Dupont and Cochran 2000). Watson and colleagues (2004) surveyed police officers on questions regarding whether the knowledge that a person has a mental illness affects police perceptions, attitudes, and responses. Police officers considered individuals identified as having mental illness to be less responsible for their situation, more deserving of pity, and more worthy of help; but, at the same time, these persons were thought to be more dangerous than persons for whom no mental illness information was available. When the police

officers were presented with a vignette in which the story included information that a person had a history of schizophrenia, there was a significantly increased perception of the potential for violence. The study authors hypothesized that an officer's approach to persons with mental illness might become overly aggressive and lead to an escalation in violence, in part related to this exaggerated perception of risk.

Improvement in an officer's knowledge about mental illness can be important and possibly a first step in changing overall attitudes over time. When mental health training is limited or not provided, it may not deliver the emphasis needed to really change attitudes and behavior.

Officers should be trained in a wide variety of issues, both as recruits and during in-service trainings, ranging from education about policies to use of service weapons. Police departments are thus faced with difficult choices to make in determining how many hours of specialized mental health education to provide for officers. In the survey by Vermette and colleagues (2005), topic areas that police ranked as most important among a fixed list presented to them included dangerousness, suicide by cop, decreasing suicide risk, mental health law, and liability management. However, other topic areas may be viewed as important to different stakeholders. Training hours given to individual mental health topics may not receive sufficient time across police departments. In light of potentially competing agendas, the psychiatrist planning mental health training needs to develop a list of educational priorities.

Negative attitudes toward persons with mental illness are likely to be a factor in how police work with them. Prevailing attitudes may be particularly difficult to change (Borum 2000; Fyfe 2000). For example, a study examining the effect of a mental health educational program on police officers indicated that police showed greater knowledge about working with emotionally disturbed persons following training, but their attitudes were not altered (Godschalx 1984). More recent research suggests that crisis intervention training (see discussion later in this chapter) can decrease stigmatizing attitudes of law enforcement personnel toward people with schizophrenia (Compton et al. 2006) and that specialized training of officers can improve understanding of mental illness and its behavioral manifestations (Reuland et al. 2009). Thus, as a start, education should, in part, be aimed to reduce the stigma associated with mental illness. Decreasing stigma may ultimately enhance the communication skills of officers responding to a call involving an emotionally disturbed person.

Training should also help police understand that people are not just "crazy" and that numerous diagnoses can manifest as emotional disturbance. Emphasizing the biological underpinnings of serious mental illness can serve to further diminish stigma. Such emphasis can also highlight the potential need of persons in crisis to receive medical attention to rule out medical causes of

acute symptomatic exacerbations. Factors contributing to behavioral emergency can be explained to include stressors, mental illness, substance use, and medical causes.

As noted, topics of interest among law enforcement personnel may also include the following:

- Suicide and violence risk reduction
- Assessing a person for signs of a psychiatric disorder
- Assessing a scene involving an emotionally disturbed person
- Communication with a suicidal person
- Communication with people manifesting psychotic symptoms
- Written communication regarding observations

Borum (2000) identified the following additional areas worthy of focus in officer training:

- Mediation skills
- Anger control
- Verbal skills to de-escalate conflict
- Education aimed to help shift negative attitudes toward persons with mental illness
- Training to counter popular misconceptions that could negatively affect perceptions or attributions during stressful encounters

One often-touted model of developing specialized technical expertise among police to manage persons in emotional crisis is based on a crisis intervention team (CIT) model that began in 1988 with a program in Memphis, Tennessee, and has gained momentum across the United States (see, e.g., Compton et al. 2008). In this model, as noted above, specific officers are specially trained and designated as CIT officers called to manage crises in order to enhance the safety of all involved, as well as to enhance the effectiveness of the police and mental health system interface. This model continues to show promise in assisting in certain types of encounters. Still, Compton and colleagues (2008) noted the need for further research regarding how changes in knowledge and attitudes can ultimately improve behavior. Others have highlighted that the data regarding CIT may reflect unique systems issues rather than CIT effectiveness alone, again highlighting the need for more research in this area (Geller 2008).

Officers trained in handling criminal behavior are traditionally taught to utilize their authority as a means of control. Police may be trained to identify when force is necessary, at times this very issue becomes the subject of scrutiny. One study showed that in 42% of officer use-of-force situations, suspects were perceived by the officers to be under the influence of alcohol or

drugs (Alpert and Dunham 1999). Although Adams and colleagues (1999) highlighted that use of force is more likely in encounters with individuals under the influence of drugs, alcohol, or mental illness, the same report further described mixed results with regard to whether the presence of substances or impaired mental state was what increased the chance that force would be employed in a police encounter (Adams et al. 1999). Overall, the data support the need for further research on use of force in police encounters with persons with impaired mental states and point toward implications that training might lead to reduced injury to officers and others (Adams et al. 1999).

As Fyfe (2000) commented, it is critical for police to understand that the forceful approach used with rational offenders may, in fact, paradoxically lead to an escalation of behavior in irrational offenders. Patient, one-on-one communication, with minimal distraction from others at the scene, can make a positive difference in a highly charged situation. Yet police are called to manage the heights of psychopathology, often after failed attempts to do so by others. Mental health professionals must recognize the extreme stress inherent in such situations. Psychiatrists conducting trainings should be cautious and avoid going beyond their expertise. Issues such as the use of weapons are best left to police to decide, based on their own policies, training, and practices. In highly dangerous and complex encounters, even in a region with CIT-trained officers, there may still be a need for additional law enforcement response, such as a SWAT (special weapons and tactics) team response (Compton et al. 2009).

Several authors (Husted et al. 1995; Price and Pinals 2006) noted that cross-training between police and mental health professionals is also highly desirable, and may be useful to effect attitude changes through improved communication and interagency satisfaction. Cross-trainings identified as having value include in-service trainings to officers presented by mental health agency representatives and opportunities for mental health personnel to gain exposure to police activities related to crisis calls, such as ride-alongs and briefings.

Numerous studies have examined how officers make decisions related to the management of persons with mental illness at the time of contact. Dispositional decisions often rely on "extrapsychiatric" variables at play in handling encounters with persons in crisis, rather than on symptom presentation alone (Teplin and Pruett 1992). Officer discretion, rather than legal regulation, is commonly the guiding force behind dispositional decisions. Green (1997) noted that police generally attempt to reserve arrest for more violent actions, yet they are faced with difficulties in involuntarily hospitalizing persons with mental illness who have engaged in some type of potentially criminal act.

Use of individual discretion can become problematic when officers exceed their authority through unwarranted arrest. Thus, officer mental health training should include time for case discussions and problem solving on the challenging decision making required in these encounters. Information about available mental health resources can also be of use. Given the inevitable intersection of mental health professionals and police, mental health training should allow a mutual sharing of experiences. In addition, establishing openings to direct communication with mental health professionals and developing collaborative specialized response mechanisms are examples of approaches that can ultimately assist in the management of persons with mental illness who are in crisis.

Suicide by Cop

Case Vignette 1

Mr. S was shot to death by police after a 1-hour confrontation. Mr. S had recently been released from a 1-month hospitalization, precipitated by an attempt to stab himself in the abdomen. Prior to his hospitalization, he had lost his job and his wife had left him. He was treated with a selective serotonin reuptake inhibitor (SSRI) and an atypical antipsychotic medication for his depression and preoccupation with wanting to die. Mr. S had considered himself a failure for having unsuccessfully attempted suicide. He appeared to respond to medications and was discharged home, with a plan for a family member to reside with him.

Several days after discharge, Mr. S began shouting at his neighbors, saying they were part of a conspiracy, that there was no hope, and that he needed to find a way out. The neighbors noted that he was wielding a knife; they became frightened and called the police.

The police arrived on scene and tried to calm Mr. S by speaking with him. His behavior continued to escalate, as manifested when he threatened to kill his neighbors and himself and told the officers he did not care if they shot him because his life was not worth anything. He suddenly raised the knife he was carrying and showed it to the officers. The officers told him to drop the knife, but he did not. Instead, he lunged forward as if to stab one of the officers. An officer fired his service weapon, hitting Mr. S in the chest. Mr. S died within moments.

When an individual engages in behavior intended to provoke police to utilize lethal force, the question may be raised as to whether the individual behaved in such a way because of suicidal ideation. Several terms have been proposed to describe this situation, including the most colloquial and most

commonly utilized term, "suicide by cop." Other names that have been used include "victim-precipitated homicide" (Wolfgang 1959), "law enforcement–forced assisted suicide" (Hutson et al.1998) and "law enforcement officer–assisted suicide" (Homant and Kennedy 2000).

Regardless of the label attached, this phenomenon has gained increasing attention in recent years. Lindsay and Lester (2004) described victim-precipitated homicide behavior that takes place in a wide variety of cultures, such as "crazy-dog-wishing-to-die," a phenomenon among the Plains Indians, such as the Crow, wherein a man tired of living would deliberately seek death in battle and would be accorded special status if he persisted in his plan. According to the authors, rituals before the battle included singing special songs and using a special rattle.

In encounters with police, suicide by cop has been defined as an incident in which a suicidal individual intentionally engages in life-threatening and criminal behavior using a lethal weapon, or what appears to be a lethal weapon, with law enforcement officers or civilians to specifically provoke officers to shoot the individual in self-defense or to protect civilians (Hutson et al. 1998). The police involved may or may not be aware that they are being used to accomplish an individual's suicide. Other definitions have not specifically required the use of a weapon or object appearing as a weapon. For example, Stincelli (2009) offered the definition of suicide by cop as "a colloquial term used to describe a suicidal incident whereby the suicidal subject engages in a consciously life-threatening behavior to the degree that it compels a police officer to respond with deadly force."

In an early, classic paper, Wolfgang (1957) identified 150 cases of victim-precipitated homicides over the course of a 5-year period in Philadelphia and spoke to the notion that a victim's behavior is often an important factor in criminal homicide. Although that study did not address victims who provoke police, his commentary highlighted the intense interpersonal dynamic that may be involved in some homicides. His subsequent paper went on to describe the dynamics involved when suicide is a motivating force in victim-precipitated homicide (Wolfgang 1959).

More recently, the literature has offered expanded examination of incidents involving police who are provoked into shooting a suicidal individual. Categorizing these cases as homicides (based on the police intent in the moment) or suicides (based on the victim intent in the moment) is complicated, and forensic pathologists do not always agree on the best approach to this dilemma (Wilson et al. 1998). Hutson and colleagues (1998) conducted one of the more carefully designed studies of suicide by cop in their review of all files of officer-involved shootings investigated by the Los Angeles County Sheriff's Department from 1987 to 1997. Of note, in the lethal shootings that met the authors' criteria for suicide by cop, all deaths were classified by the coroner as homicides.

Studies have shown that at least 10% of incidents of police deadly force may be attributed to suicide by cop (Homant and Kennedy 2000; Hutson et al. 1998). A recent review of 707 officer-involved shootings indicated that 36% involved suicide by cop and that the incidents were more likely to result in death or injury of the subjects (Mohandie et al. 2009). It has been suggested that the incidence of suicide by cop is on the rise, although this may be related, in part, to better reporting (Mohandie and Meloy 2000; Mohandie et al. 2009). Furthermore, the overall incidence examined in the literature does not speak to additional cases of attempted suicide by cop. Attempted incidents may be harder to study, given that they can include nonfatal police shootings or situations in which attempted lethal force does not end up being used at all. Thus, these incidents can look like routine police contacts, rather than failed attempts at suicide by cop.

Several authors have identified general characteristics of persons who engage in suicide by cop and of the behavior itself by retrospective review of cases purported to be incidents of suicide by cop (Hutson et al. 1998; Mohandie and Meloy 2000; Wilson et al. 1998). In those analyses, suicide by cop was more commonly associated with males. Ages of suicidal persons across studies ranged from late teens to almost 60 years, although average ages tended to be in the 20s and 30s. Most of the suicidal individuals, although not all, had histories of psychiatric problems, most commonly including histories of suicidal ideation and depression.

Histories of substance abuse and prior arrests were also seen in the majority of the suicidal persons. Intoxication with alcohol at the time of the incidents was seen in approximately 40% of cases (Wilson et al. 1998). Use of drugs was less common but was noted in some cases. Use of firearms or facsimile firearms as the provoking weapon was most common, followed by knives and blunt objects. In one study, 10 of 15 victims verbally communicated suicidal threats during the incident, and 8 of 15 had communicated their suicidal intent in writing prior to the incident (Wilson et al. 1998). Interestingly, some of the subjects who had written of their suicidal intent did not verbally communicate it to officers, who may thus have been unaware that the victim was using them to assist in his or her suicide. Although the methodology behind the studies and some of the conclusions to date have been questioned, it does appear that an individual who engages in suicide by cop is likely to have a mental illness, a history of substance use, and recent ingestion of substances at the time (McKenzie 2006; Reuland et al. 2009). In a more recent study by Mohandie and colleagues (2009), which examined cases of officer-involved shootings and classified suicide by cop using multiple raters with good interrater reliability, some of the earlier findings were confirmed, including the likelihood that even in spontaneous situations subjects often showed verbal or behavioral indicators before and during the

police encounter, and weapon use (most likely firearms, but including facsimile firearms) was common.

A typological construct of suicide by cop developed by Mohandie and Meloy (2000) divided the goals of the victim into instrumental and expressive subtypes. In the instrumental subtype, individuals engaged in suicide by cop behaviors in an attempt to

1. Avoid consequences of criminal or shameful acts.
2. Reconcile a failed relationship.
3. Avoid exclusion clauses of life insurance policies.
4. Resolve the spiritual sanction against suicide by allowing oneself to be killed.
5. Seek an effective and lethal means of accomplishing death.

The expressive goal of engaging in suicide by cop was identified as effecting a means of communicating sentiments of

1. Hopelessness, depression, desperation.
2. Ultimate identification as victim.
3. Need to save face by dying rather than surrendering.
4. Intense power needs.
5. Rage and revenge.
6. Need to draw attention to a personal issue.

In order to achieve these goals, varying degrees of physical threat to police may be initiated.

Certain deaths are often difficult to identify as having been motivated by suicide (e.g., motor vehicle accidents). In an effort to categorize reports of police shootings, two police officers with master's degrees in criminal justice cataloged 240 news reports of police shootings into five categories with regard to the motivation of the person who was shot. The categories included 1) probable suicide; 2) possible suicide; 3) uncertain; 4) suicide improbable; and 5) no suicidal evidence (Kennedy et al. 1998). Of the incidents reviewed, 14 (approximately 5%) involved either homeless persons or those with known mental illness.

Kennedy and colleagues (1998) also reported that between 16% and 47% of the cases reviewed were found to involve probable or possible suicidal motivation, although unclear and missing facts made the characterization of these incidents difficult, and the methodology of reviewing news reports had limitations. Nevertheless, the authors commented on the need to maintain an awareness of the possibility that suicide may be a motivation in police shootings. They identified a goal of improving interpersonal communication

skills for officers, who they noted must make reasonable attempts to avoid having to use deadly force, regardless of the victim's determination to die.

In a review of 143 incidents of suicide by police, Homant and Kennedy (2000) proposed dividing suicide by cop behavior into three categories: 1) direct confrontation, 2) disturbed intervention, and 3) criminal intervention. These categories were each further divisible into subcategories. Direct confrontation involved situations in which the subject plans ahead of time to attack law enforcement in order to be killed by them. Subcategories reflected the manner in which subjects interact with police, including sudden attacks on officers; controlled confrontation with demands that police kill the subject; or manipulated confrontation, when the subject sets up a situation so that the police will come and investigate. When police arrive, the subject confronts police with a threat of deadly force. Examples of manipulated confrontation include traffic stops leading to high-speed chases or reporting crimes to police so that they will go to the scene.

Disturbed intervention involved the majority of incidents reviewed by Homant and Kennedy (2000). In these situations, the subject is acting irrationally and is either overtly suicidal prior to police arrival or becomes suicidal upon their arrival. These situations can include police calls for suicide interventions (such as police calls to manage ambivalent suicide attempts or domestic calls to police to help manage a suicidal family member), calls of general domestic disturbances, and disorderly behaviors that result in police calls. In the disturbed intervention category, the disturbed behavior is not specifically designed to bring police to the scene, but behavior leading to suicide by cop comes about after their arrival.

The third major category described by Homant and Kennedy (2000) is one that comes about through routine police work in criminal intervention. In these situations, a person engaged in ordinary criminal activity is under the impression they will avoid detection, such that police involvement is unwelcome and unexpected. The subject, feeling there is no hope for escape, prefers to be killed by police. Suicide by cop behavior may ensue in an effort to avoid incarceration when a major crime is involved or as a matter of principle when the crime was a minor one.

Suicide by cop following criminal intervention was found to occur in only a handful of cases, yet what was noteworthy was that the resistance to police escalated from a seemingly routine incident to a fatal outcome. The authors speculated that unconscious suicidal motivations may be at play in those incidents, even though the suicide by cop is not planned or articulated in advance. The term *unconscious* has different meanings for psychiatrists and law enforcement agents. From a psychiatric perspective, unconscious motivations would be difficult to prove in cases involving litigation. Psychiatrists should thus be cautious about interpreting an individual's actions as uncon-

sciously suicidal without strong collateral data supporting suicidality prior to the incident.

More recently, Lindsay and Lester (2004) described a list of proposed criteria for suicide by cop encounters, which they then applied to specific cases Lindsay had investigated (Lindsay and Lester 2008). The authors noted that more research would be needed to understand the utility of such a list in retrospectively identifying when an encounter with police might be classified as suicide by cop. In their preliminary study, they identified several factors that might distinguish suicide by cop situations, such as when the "subject forces confrontation," "event [is designed] to ensure police response," "[subject] advances toward officer," or there is the "presence of a deadly weapon," as well as a "recent stressor" in the subject's life.

The case of Mr. S reflects an individual who communicated homicidal and suicidal threats, possibly with the goal of instrumentalizing an effective means of accomplishing death. He manipulated either a scenario to bring police to the scene, or he created a disturbance that caused the neighbors to call the police. Mr. S may have previously expressed the idea or plan to die at the hands of the police, given that his own direct attempt at suicide was unsuccessful. The neighbors, family members, witnesses, and other collateral sources should be questioned about this, if possible. A note at the scene, if present, might provide additional information.

Psychiatrists may be called to examine suicide by cop from a number of different perspectives, including post hoc review of an incident related to litigation involving police, questions for life insurance policies, and medical malpractice in which a decedent's cause of death is at issue. Psychiatrists may conduct evaluations of attempted suicide-by-cop survivors related to issues of criminal responsibility (Bresler et al. 2003) and ongoing suicide risk assessment. Officer-involved shootings can be highly traumatic for a variety of reasons and may require specific police and mental health services response protocols after the event to help manage and work with the police officer involved (Miller 2006). Thus, in addition to the variety of aspects of suicide by cop that may involve forensic analysis, psychiatrists may be involved in assessing or even treating a police officer who was involved in the shooting. In this chapter, we highlight issues pertaining more to related forensic roles.

Generally, in cases involving completed suicide by cop, a psychological autopsy is necessary to gather comprehensive information about the manner of death through a variety of collateral sources. These might include examining the coroner's report; contacting family members and friends of the decedent; contacting police; and reviewing police, criminal, and medical records, as available. In conducting this review, psychiatrists should be cognizant of methodological limitations of the retrospective data (Hawton et al.

1998) that may be at issue in the litigation process, and of advances in psychological autopsy techniques (Knoll 2008, 2009).

Psychiatrists evaluating individuals who have had volatile encounters with police should be aware that suicide by cop may have been a motivating factor in the individual's behavior. However, clinicians should consider the possibility that a patient or evaluee is malingering in accounts of suicide by cop. Individuals reporting attempted suicide by cop retrospectively may be trying to present a version of events to exonerate their actions. As with any forensic evaluation, collateral data and a comprehensive review of an individual's premorbid functioning are critical in an analysis of such incidents.

Legal cases have addressed specific questions that are important considerations in a psychiatric evaluation involving suicide by cop. In *Graham v. Connor* (1989), the U. S. Supreme Court held that claims alleging that officers used excessive force in the course of their work should be analyzed using an "objective reasonableness" standard. Such a standard would take into account the facts and circumstances confronting the officer at the time, rather than data learned retrospectively. In *Palmquist v. Selvik* (1997), the Seventh Circuit Court of Appeals held that failure to train officers to adequately handle calls involving emotionally disturbed individuals can be a basis of liability in certain situations. The court noted, however, that officers in the suicide by police case in question had received some training and that the police department had not been deliberately indifferent to the need to train its officers in this area. Exposure to some training, no matter how limited, protected the police from liability in that case.

Suicide by cop involves a complex interplay among people in high-intensity encounters. It has become a relatively common term and is an increasingly recognized occurrence. Thus, police and psychiatrists should continue to learn about the phenomenon of suicide by cop as it gains more attention in the literature and in popular culture.

Crisis Negotiations

Case Vignette 2

Police responded to a call from Mr. and Mrs. H concerning a domestic dispute. The H's reported that the couple living in the apartment next door, Mr. and Mrs. J, had been fighting all night. Mr. and Mrs. H were concerned because they had overheard Mrs. J screaming, "Get away from me. Don't hurt me."

Mr. J had been drinking heavily since losing his job as a computer programmer in a recent company downsizing. The J's were experiencing serious

financial problems and had received an eviction notice. The couple's marital problems had escalated. Mrs. J had confided that she was thinking about asking for a trial separation. Earlier on the day of the dispute, Mr. J had asked Mr. H to recommend an attorney so that Mr. J could get his affairs in order. Mr. J was a Desert Storm veteran and had several guns in the home.

As police were interviewing the neighbors, Mr. J stepped onto his balcony, holding a gun to his wife's head. He threatened to kill his wife if the police officers did not leave immediately. Mr. J insisted that he had the situation in control and this was none of their business.

Police called in a psychiatrist to act as a consultant to the crisis team while they negotiated with Mr. J. The psychiatrist monitored the progress of the negotiations and offered suggestions to the team. The recommendations were helpful in resolving the situation. Mrs. J was released unharmed, and Mr. J later surrendered to police.

The modern era of crisis negotiation began in the 1970s after a series of incidents highlighted the need for specific training and preparation in crisis/hostage negotiations. In 1970, an El Al flight was hijacked, and in 1971 the Attica prison uprising resulted in the deaths of 39 people, including 11 correctional officers. During the 1972 Munich Olympics, 13 Arabs, demanding the release of more than 200 Arab prisoners, killed Israeli athletes who had been taken hostage. In response to this growing threat, New York City Police Commissioner Simon Eisdorfer in 1972 requested that Lieutenant Frank Bolz and Harvey Schlossberg, a police officer and a psychologist, develop a verbal alternative to the use of force in resolving hostage situations. The techniques developed by Bolz and Schlossberg have been credited with creating the discipline of hostage negotiation (Hatcher et al. 1998; Louden 1998). In 1973, building on the experience of the New York City Police Department, the Federal Bureau of Investigation (FBI) began to promote principles of negotiation by instructing police officers nationwide on negotiation skills and practices (Noesner 1999).

Although the field of crisis negotiation has evolved since the 1970s, the goal remains to provide nonviolent resolution options. The technique of crisis negotiation has been applied successfully in the following 10 different situations (McMains and Mullen 2006):

1. Hostage situation
2. Barricaded subject incidents
3. High-risk suicide attempts
4. Domestic incidents
5. Prison and jail riots
6. Mental health warrants
7. Debriefing in crisis incidents
8. Stalking incidents
9. Violence in the workplace
10. School violence

In a hostage situation, verbal strategies are used to secure the safe release of the hostages/victims and, when possible, the arrest of the perpetrator without violence. In barricade situations, the aim is the safe release of the subject. In most cases, the initial approach is focused on de-escalating and defusing an incident by lowering emotions and reducing tensions at the scene. Newer strategies incorporate techniques derived from the field of conflict management and mediation (Fisher and Ury 1991) and are sensitive to cultural differences (Giebels and Taylor 2009). There has been an effort to develop an understanding of terrorist incidents and to develop strategies to effect resolution (Gilmartin 1996; Raven et al. 1999; Wilson 2000).

Classification of Crisis Incidents

The FBI characterizes critical events as either hostage or nonhostage situations and suggests tailoring strategies to effect resolution based on this classification (Noesner 1999; Regini 2004). During true hostage situations, perpetrators take hostages to force their demands upon a third party, usually law enforcement. The FBI's national database of crisis incidents notes that these traditional hostage situations account for only 7% of crisis negotiation incidents (Federal Bureau of Investigation 2001). The perpetrators use their hostages as leverage. They usually make overt or implied threats to harm the hostages unless demands are met. There are clearly recognizable objectives and substantive demands such as money, a means for escape, and political or social change. It is in the interest of the hostage-takers to keep the hostages alive or they risk losing their leverage. The hostage-takers are aware that if their hostages are harmed, police may consider a tactical intervention (Noesner 1999; Noesner and Webster 1997; Price and Kelly 2002).

An example of a classical hostage incident would be when a bank robber is unable to escape because police have arrived on the scene earlier than expected. The robber finds himself trapped inside the bank. He holds employees and customers hostage because he is hoping to negotiate with police for a car and safe passage. The hostages have no special meaning to the bank robber other than as bargaining chips; there has been no previous relationship. Law enforcement strategies include using delay tactics, making subjects work for every concession, and using highly visible containment. This approach serves to lower the perpetrators' expectations and promotes discussion about the benefits of surrender in contrast to the risk of further confrontation. Noesner (1999) suggests that the negotiator offer "safe surrender with dignity." The strategy is based on the premise that the hostage-taker's desire to survive is greater than the need to have his demands satisfied.

In contrast, subjects in a nonhostage situation generally act in an emotional, irrational, purposeless, and often self-destructive manner. If the sub-

ject is holding anyone, the person or persons being held are not being used as bargaining chips. They are really victims at risk of being harmed, possibly in a suicide/homicide scenario. The perpetrator makes no substantive demands or has completely unrealistic ones. Goals are emotionally driven. A barricade is another example of a nonhostage situation that requires crisis intervention and accounts for 59% of crisis incidents. The barricaded subject is often threatening suicide. In the nonhostage situation, the barricaded subject or the subject who is holding someone against his or her will may be expressing anger, frustration, and feelings of being wronged by others or by events (Noesner 1999).

The case vignette of Mr. and Mrs. J is an example of a nonhostage situation: the rejected husband holds his wife against her will. Emotionality is driving the situation. A different strategy is used to resolve such situations, because perpetrators already have what they want, the victim. Noesner (1999) suggests maintaining low-profile containment, using patience and understanding, and giving without requesting something in return. Noesner (1999) recommends using active listening skills to lower emotion, defuse anger, and create rapport. The Behavioral Change Stairway Model (BCSM) uses a five-stage approach that includes 1) active listening, 2) empathy, 3) rapport, 4) influence, and 5) behavioral change (Vecchi 2005). Data from the Hostage Barricade Database System (HOBAS) show that 92% of all law enforcement incidents are emotionally driven, with the subjects having no clear goal (Federal Bureau of Investigation 2001). The FBI is using the HOBAS data to further characterize incidents involving domestic violence (Van Hasselt et al. 2005).

A hostage or barricade incident can be resolved in one of five possible ways (Hatcher et al. 1998):

1. A negotiated surrender
2. SWAT team tactical assault and apprehension of the perpetrator
3. Perpetrator killed
4. Perpetrator suicide
5. Perpetrator escaped

Fortunately, negotiation strategies are highly successful. According to the HOBAS data, 87% of incidents involving victims are resolved through the negotiation process (Federal Bureau of Investigation 2001). In 90% of cases there is no loss of life; 64% of incidents are resolved in 4 hours or less and 91% in 9 hours or less. Certain risk factors related to the perpetrator are associated with a higher risk that the incident will not be resolved by negotiation alone. These factors include multiple stressors, lack of family supports, forcing confrontation with police, notification of others of intent, similar in-

cidents and threats to injure victim in the past, and verbalization of intent to commit suicide (Fuselier et al. 1991).

Role of Psychiatrists

The guidelines of the National Council of Negotiation Associations advise that negotiation teams consider establishing a consultative relationship with a mental health professional. The mental health professional should "serve as a team advisor and not as a negotiator, participate in negotiation team training, respond to team call outs as requested, focus on behavioral assessment of the subject and assist in team debriefing after a critical incident" (National Council of Negotiation Associations 2001, p. 3). The FBI has recommended that because mental health professionals have well-developed active listening skills, they can provide feedback during training of officers engaged in role-playing exercises (Van Hasselt and Romano 2004).

Traditionally, psychiatrists have been less commonly involved in crisis negotiation consultation than other mental health professionals. Psychiatric professional guidelines for this type of work are not available. Psychiatrists who become involved would do well to limit their roles to functions within their area of expertise, acquire appropriate training and mentoring, consult with colleagues on issues that arise, and be mindful of potential pitfalls. Psychiatrists should also consider liability issues that could surface from their work in this arena and protect themselves accordingly.

As indicated by the guidelines issued by the National Council of Negotiation Associations in 2001, crisis/hostage/barricade management is a very specialized area within law enforcement requiring additional focused training. Role-playing tests of crisis negotiation skills illustrate the positive benefits of intensive training (Van Hasselt et al. 2006). If an incident is not managed in an optimal manner, death or serious injury can result (Vecchi 2002). Although a psychiatrist is trained in interactional communication skills (Charle 2007), he or she lacks the training of a police officer. As a result, the mental health professional functions best as a consultant to the team, with clear delineation of responsibilities and expectations.

Some departments, such as the Los Angeles Police Department, have a behavioral science service. One of the many functions of the service is to consult with the crisis negotiation team. Other agencies have consulting relationships with outside providers. Mental health consultants are usually recruited for the crisis negotiation team because of past involvement in providing more traditional services. Credibility is gained over time and may lead to an invitation to consult with the hostage/crisis negotiation team (Hatcher et al. 1998). Only a few police departments offer pre- or postdoctoral training in police psychology to mental health professionals.

National guidelines recommend the use of a mental health consultant (National Council of Negotiation Associations 2001). However, few studies document whether hostage negotiation teams derive any benefit from the use of mental health professionals as consultants. Butler and colleagues (1993) surveyed 300 law enforcement agencies in the United States that used a negotiator in hostage incidents. They found that 39% of the agencies with a negotiator employed a mental health professional as a consultant to the negotiation team and that the teams did demonstrate some benefit from this combined approach. Crisis/hostage negotiation teams with a mental health professional had more hostage incidents ending with negotiated surrender and fewer hostage incidents ending with the use of a tactical team assault and the arrest of the perpetrator. When mental health professionals were used as consultants for the assessment of the perpetrator, fewer hostage incidents resulted in serious injury or death of the hostage. The use of a mental health professional did not result in better outcome in barricade incidents.

Hatcher and colleagues (1998) have estimated that 30%–58% of agencies with a crisis/hostage negotiation team use a mental health professional to provide on-scene or off-scene consultation. Hatcher and colleagues reported that 88% of these mental health professionals are psychologists, as opposed to psychiatrists, social workers, or others. In hostage and barricade situations, non-law enforcement personnel have functioned in one of four roles: 1) consultant/adviser; 2) integrated team player; 3) primary negotiator; 4) and primary controller (Butler et al. 1993; Hatcher et al. 1998).

The most common role assumed by a mental health professional is that of consultant/adviser (Hatcher et al. 1998). Despite the complexity of the task, Butler and colleagues (1993) have estimated that 40%–56% of consultant advisers function without training or field practice in actual negotiation. Off-scene, mental health providers may help in the selection of members of the negotiation or tactical team. They may provide training, especially in understanding the manifestations of mental illness and teaching application of therapeutic communication (Slatkin 1996). Mental health providers can consult on the development of instruments to screen, interview, and debrief witnesses and hostages. Another important function is to foster a collaborative atmosphere among the on-scene commander, the tactical team, and the negotiation team during practice call-outs and during incidents (Bahn and Louden 1999; Vecchi 2002).

Hatcher and colleagues (1998) noted that 40% of the agencies surveyed had used a psychologist as an on-scene advisor during incidents. The on-scene mental health professional may be asked to profile the suspect and hostages and provide a risk assessment (Trompetter and Honig 1999). The mental health professional may evaluate the perpetrators to determine their motivation, agenda, and vulnerabilities. The vulnerability of each hostage and the

importance and value of the hostage to the perpetrator may be assessed (Hatcher et al. 1998).

The field of profiling is quite complex. Any mental health professional embarking on this work should have the requisite training. Additionally, risk assessments in these situations would likely be limited. At times, officers on scene are looking for facts describing symptomatic behavior (e.g., a description that someone with mania could be irritable and/or would not likely need much sleep through the night), which is information a psychiatrist could certainly provide. However, when requests are made for input that goes beyond the psychiatrist's professional expertise, the psychiatrist would need to explain the limits of what he or she can offer.

Monitoring dialogue and suggesting strategies can be of benefit in negotiations, especially when there are impasses (Rogan and Hammer 1995; Taylor 2002a). The mental health professional can aid in the preparation of the negotiation position papers (Dalfonzo and Romano 2003), which are used as a method of written communication that can help brief command, tactical, and negotiation arms regarding the status and assessment of a hostage situation. The mental health professional can provide insight into the dynamics of the interaction and suggest modifications. Taylor (2002b) found that the likelihood of negotiation success was reduced when the dialogue was rated as competitive. Another important function for the mental health professional is to monitor the negotiation team's stress level.

Negotiation teams frequently rely on mental health professionals to interface with relevant mental health providers and family members in order to collect data about the subject or hostages. Mental health professionals may provide advice about the use of a third-party intermediary (Romano 1998). They may also play a role in debriefing hostages as they are released and in interviewing witnesses (Feldman 1998a, 1998b).

Mental health professionals have assumed roles other than that of consultant in the negotiation process, such as primary negotiator, integrated team member, and primary controller (the person directing the operation) (Hatcher et al. 1998). One study estimated that 7% of law enforcement agencies used psychologists in the role of the primary negotiator (Butler et al. 1993).

We strongly advise that the psychiatrist act only as a consultant, because of ethical and procedural concerns (Feldman 1998b; Price and Kelly 2002). By assuming any other role, the psychiatrist would be accepting direct responsibility for the operation. The National Council of Negotiation Associations also recommends limiting the psychiatrist's role to that of consultant (National Council of Negotiation Associations 2001).

Many objections have been raised to psychiatrists acting as primary negotiators. For example, Hatcher and colleagues (1998) noted that hostage-takers may resent any inference that they are mentally ill. In addition, psy-

chiatrists and police officers have very different perspectives, experience, and training related to violence and aggression. Should suspects insist that they would only come out if the negotiator were present, this would create a dilemma for the police on the scene. The police would not wish to place a psychiatrist in potential danger without police training or experience, and yet the failure to do so could negatively affect the outcome. Furthermore, a psychiatrist that does not have police training or experience would not be able to advise the subject about the specific process for surrender, which would demand knowledge of police procedure and safety issues. A controller role requires the assessment of options, which may include a tactical approach, an area clearly outside the expertise of a mental health professional.

Ethical concerns for psychiatrists acting as primary negotiators also militate against psychiatrists taking on this role. Primary negotiators may be asked to distract a hostage-taker while the tactical team enters, possibly leading to the death of the suspect in the interest of saving hostages. Participation leading to the death of the hostage-taker would be at variance with ethical obligations of physicians.

Ethical issues arise in relation to informed consent requirements when psychiatrists act as primary negotiators. Dietz has questioned whether as a primary negotiator the psychiatrist would be acting as a forensic evaluator and thus be required to obtain informed consent from the subject (Burns et al. 2001; American Academy of Psychiatry and the Law 2005). Full disclosure could interfere with the negotiation process. However, psychiatrists could possibly be viewed as forming a doctor-patient relationship with the subject by initiating direct contact in the absence of informed consent (Burns et al. 2001).

In contrast, the police officer faces different obligations to the subject, as defined by case law (Burns et al. 2001). An officer would not be required to provide a warning about the limits of confidentiality (Price and Kelly 2002). The police negotiator may not even be required to give a *Miranda* warning so that statements made to negotiators during the crisis will be admissible (Higginbotham 1994). *Miranda* only applies if the suspect is in custody. Generally, because the perpetrator is not within the complete control of the police during a hostage incident, the perpetrator is not in custody, and, thus, *Miranda* does not apply. According to *People v. Gantz* (1984), the nonviolent resolution of a hostage/crisis situation is not an interrogation. The U.S. Supreme Court has ruled that the *Miranda* rule does not apply when questions are reasonably prompted by concerns for public safety, including questions relating to the safety of persons who have been abducted by the suspect.

The U.S. Supreme Court has also ruled that emergencies relating to life and safety excused the normal warrant requirement (Higginbotham 1994). In *Mincey v. Arizona* (1978) the Court concluded, "The need to protect or

preserve life or avoid serious injury is justifiable for what would be otherwise illegal" (*Mincey v. Arizona* 1978, p. 393). When the negotiator agrees to a subject's demands that seem to have serious legal implications, the government is not bound to enforce them (Higginbotham 1994).

When litigation arises from such cases, a formal accounting of the level of training of negotiators involved in significant events is commonly requested (Becker 1995; Pruessner 2001). The mental health professional acting as a primary negotiator does not have the requisite background and training in law enforcement to perform all the functions of the position. Limiting one's role to that of a consultant and working within one's expertise exposes the mental health professional to fewer ethical dilemmas and decreases liability. Thus, although the literature suggests that the use of mental health professionals as consultants to a hostage team may decrease the risk of hostage injury and death, consultants need to carefully delineate their role in advance.

Fitness for Duty Evaluations of Law Enforcement Officers

Case Vignette 3

Officer L had been with the New City police department since the age of 22. She started as a dispatcher and advanced to the rank of patrol officer. Officer L had a history of being sexually abused as a youth. In addition, she had been involved in a relationship with a man who was physically abusive. She had sought counseling after the termination of this relationship. She was treated briefly with medication for anxiety and depression. These symptoms resolved completely long before she was assigned to patrol duty.

As a patrol officer, Officer L had primarily been involved in minor community incidents, until one day when she was called to the scene of a homicide. She was the first to arrive on scene. While there, she heard family members shouting and yelling and witnessed a woman lying in a pool of blood on the floor. The woman had obviously been beaten and shot. She had bruises all over her body and her clothes were torn and bloody.

Within a month of this incident, Officer L began to have nightmares about the incident. She also became tremulous and hypervigilant at work. She avoided the neighborhood where the homicide took place, despite the fact that it was her "beat." She became irritable, snapping at her coworkers, whom she felt had not handled the homicide scene according to policy. She felt very strongly that she could continue her work. She wanted to keep

working to provide a good role model for her 13-year-old daughter. Her supervisor insisted that she be placed on light duty but noted that even then her concentration was so poor that she could not focus on her work. The supervisor requested an independent medical examination regarding disability and causation.

Law enforcement is commonly viewed as one of the most dangerous, stressful, and health-threatening occupations. Officers are at risk for physical injury, homicide, and accidents, as well as psychological injury (Violanti et al. 1996). They face psychological harm as a result of exposure to death, human misery, inconsistencies in the criminal justice system, and negative public image (Violanti and Paton 2000).

The effects of stress on an officer's physical and emotional health are well documented. Problems include an increased risk of alcohol/drug abuse, ischemic heart disease, marital problems, excessively aggressive conduct, premature retirement, disability, and possibly an elevated suicide risk (Davey et al. 2000; Hem et al. 2001; Neylan et al. 2002; Richmond et al. 1998; Tuchsen et al. 1996), although recent data have raised some questions about suicide risk (Marzuk et al. 2002).

Police are repeatedly exposed to critical incidents. This exposure predisposes them to the development of acute stress disorder and posttraumatic stress disorder (Carlier et al. 1997; Kopel and Friedman 1997; Rivard et al. 2002; Sims and Sims 1998; Stephens and Miller 1998). Given the stressful nature of law enforcement, performance can become impaired as a consequence of any combination of personal, biological, or work-related factors. These factors can include exposure to trauma, ineffective coping strategies, difficulties in interpersonal relationships, marital conflict, or health concerns. Impairment of performance can place officers and others at risk.

A law enforcement officer could become involved in many areas of workplace litigation because of this occupational exposure. The discussion in this section is limited to fitness for duty evaluations for law enforcement officers. (For a general approach to workplace litigation, see Chapter 12, "The Workplace.")

Departments have an interest in promoting the mental well-being of their officers. Departments have been held to have a legal duty to monitor the psychological fitness of officers and take reasonable precautions to avoid hiring and retaining officers who are psychologically disturbed (*Bonsignore v. City of New York* 1982). The courts have also held that administrators have the right to monitor the psychological health of officers by ordering fitness for duty evaluations (McNaught and Schofield 1998).

In *Conte v. Harcher* (1977), a police officer faced allegations of having used excessive force when taking a suspect into custody. The officer refused to undergo a fitness for duty exam as requested by the chief. The U.S. Supreme

Court held that the chief had the authority to order the exam based on the need to protect the public interest and the efficiency of the department and to keep informed about officers' ability to perform their duties. In *Yin v. State of California* (1997), the U.S. Court of Appeals for the Ninth Circuit upheld the department's prerogative to order a fitness for duty evaluation as constitutional and not in violation of the Americans With Disabilities Act. The examination could be compelled to ensure the public safety and guarantee a stable, reliable, and productive workforce.

The International Association of Chiefs of Police (IACP) Police Psychological Services Section has developed guidelines for assessment, which recommend that "referring an employee for an FFDE [fitness for duty evaluation] is indicated whenever there is an objective and reasonable basis for believing that the employee may be unable to safely or effectively perform his or her duties due to psychological factors. An objective basis is one that is not merely speculative but derives from direct observation, credible third party report or other reliable evidence" (International Association of Chiefs of Police 2004, p. 1). Law enforcement agencies have policies that guide referral for fitness for duty evaluations, and these policies may list examples of specific behaviors that could trigger an evaluation (Fischler 2001; Gold et al. 2008). The courts have ruled that some behaviors by an officer, such as domestic violence, excessive absenteeism, tardiness, rapid variation in mood, making threats of physical harm, allegation of sexual misconduct, accusations of excessive force, and concerns regarding emotional stability after a critical incident, such as a shooting, provide sufficient justification to trigger such an evaluation (Fischler 2001).

Even when indicators of possible impairment are present, the supervisor always has discretion in ordering a fitness for duty evaluation. Most law enforcement agencies recognize the need for programs to deal with the stress inherent in police work. The evaluation should not serve as a replacement for a comprehensive policy for providing mental health interventions for at-risk officers and a venue for confidential referral. The supervisor may well suggest that the officer seek treatment on a voluntary basis rather than proceeding with a formal fitness for duty evaluation.

Many departments use an external Employee Assistance Program (EAP), an in-house treatment program, or contract with outside providers to provide a variety of mental health services. These programs usually allow for self-referral and referral by peer counselors (Finn and Esselman-Tomz 1998). They provide for voluntary referral of an officer by a supervisor or an agency chief executive if there is suspicion of psychological problems contributing to poor or erratic work performance.

Some departments have special provisions for officers exposed to a critical incident, including a requirement to see a mental health professional. A

critical incident is any event that has a stressful impact that proves sufficient to overwhelm the usually effective coping skills of an individual (Kureczka 1996). Critical incidents may include line-of-duty shootings; death, suicide or serious injury of coworkers; homicides; and hostage situations (McNally and Solomon 1999).

Exposure to critical incidents can lead to a variety of potential career-threatening reactions, including overreaction to perceived threats or, alternatively, underreaction to clearly dangerous situations. Officers exposed to critical incidents are noted at times to resign or retire prematurely. Additionally, they may have disciplinary problems or develop burnout, stress-related illnesses, posttraumatic stress disorder, or substance abuse disorder (Decker 2002). According to one report, in the 1970s, about 70% of officers who used fatal force left law enforcement within 5 years (McNally and Solomon 1999).

In Case Vignette 3, Ms. L, a patrol officer, had primarily been involved in minor community incidents before being called to the scene of a homicide. Many departments would have referred Officer L to their critical-incident stress management program (Carlier et al. 1997). The FBI's Critical Incident Stress Management Program includes interventions such as defusing and debriefing, peer support, family outreach, manager support, referral for therapy, and post-critical-incident seminars (McNally and Solomon 1999).

When intervention fails and the officer's functioning has deteriorated, the supervisor will meet with the officer. That discussion alone may result in some remediation, or the encounter may result in an agreement for voluntary assessment and treatment. In the case of Officer L, the supervisor arranged for light duty and presumably suggested referral for treatment. When these steps are unsuccessful, a fitness for duty evaluation may be requested.

The IACP Police Psychological Services Section guidelines indicate that the fitness for duty evaluation should be conducted only when these other options have failed or are insufficient, given the seriousness of the specific circumstances. When there is uncertainty about the need for a fitness for duty evaluation, the department should seek input from legal counsel or from the likely evaluator before mandating the exam (International Association of Chiefs of Police 2004). If an officer leaves on disability, the supervisor may request a fitness for duty evaluation upon return if indications of ongoing difficulty are still present (Miller 2007).

A fitness for duty evaluation involving a law enforcement officer requires familiarity with the functions of the officer (Finn and Esselman-Tomz 1996) and the nature of police work (Gold et al. 2008; Miller 2007). Evaluators should also be familiar with conducting independent assessments related to work functioning.

It is helpful for the referring agency to provide documentation of the objective evidence that forms the basis for mandating the fitness for duty ex-

amination (Gold et al. 2008; International Association of Chiefs of Police 2004). The evaluator should request that the department supply information about the officer's history within the department, including commendations, citizen letters of appreciation or complaint, disciplinary history, remediation efforts, involvement in critical incidents, earlier periods of disability, previous referral to EAP, and available treatment records (Anfang and Wall 2006; Gold et al. 2008; International Association of Chiefs of Police 2004). Records of medical and psychological treatment should be gathered. Collateral data, including records and interviews with coworkers, may help distinguish whether the problem is indicative of a longstanding pattern of disruptive behavior or represents a recent change, perhaps in response to a specific stressor as was present in Case Vignette 3 (International Association of Chiefs of Police 2004). Consideration of current relationships with coworkers is important, especially given the need to work closely with colleagues and the tight social network among police.

After obtaining informed consent, the examiner should perform a detailed psychiatric interview. A fitness for duty examination should identify whether the officer is experiencing a psychiatric disorder that is affecting ability to function. The contribution of substance abuse must be explored. The exam should note the level of impairment and offer an opinion about prognosis and the likely response to treatment. The evaluator should assess the officer's amenability to treatment intervention. The evaluating psychiatrist should consider both the effects of the underlying condition and the potential side effects of treatment on the safe use of firearms. The effects on judgment, reaction time, memory, and fine motor skills should be carefully assessed. The clinical interview may need to be supplemented by psychological or neuropsychological testing (Anfang and Wall 2006; Decker 2002; Rostow and Davis 2002, 2004).

The standards for fitness for duty of officers should be higher than the minimum level of functioning for non-law enforcement individuals because police officers must be able to carry firearms and make on-the-spot life-and-death decisions (Decker 2002). The police officer's conduct and mental state may be called into question in court. Officers may need to justify accusations of being either trigger-happy or too scared to carry out their duty. The report will need to address whether or not there are contraindications to the officer continuing to carry a weapon (Decker 2002).

The risk of suicide and homicide must be carefully assessed, given officers' ready access to a firearm. Although there is controversy over whether officers have a higher risk of suicide than the general population (Hem et al. 2001; Marzuk 2002; Stuart 2008), Violanti (2008) reviews literature highlighting that police suicide risk is valid and warrants further research. The study by Janik and Kravitz (1994) illustrates the importance of inquiring about

suicidal ideation. They reviewed the records of 134 police officers at the time of the officers' first fitness for duty evaluation. Surprisingly, 55% of officers admitted to previous suicide attempts. High-risk groups were identified. Officers reporting marital problems were 4.8 times more likely to have attempted suicide. Officers who had been suspended were 6.7 times more likely to have attempted suicide than those who had not been suspended. Another study of 115 police officers revealed that certain types of traumatic work exposures increased the risk for severe symptoms of posttraumatic stress disorder. These symptoms were associated with an increase in alcohol use and suicidal ideation. The presence of both high-level posttraumatic stress disorder symptoms and increased alcohol use was correlated with a tenfold increase in suicidal ideation (Violanti 2004). Stuart (2008) noted that exposure to workplace trauma and organizational stressors have been emphasized as contributing to police suicide risk, though personality factors and coping styles should also be examined for a better understanding of the phenomenon.

Under high-risk circumstances, there would be a need for weapon removal and referral for emergency psychiatric assessment. Mohandie and Hatcher (1999) recommend that in weapon removal situations there be a 30- to 60-day period during which the officer is precluded from carrying a weapon. The premise of this recommendation is to allow time to ensure that the precipitating factors have been successfully managed.

The evaluator should be aware of the agency policy and relevant laws governing the extent of personal information that is revealed in the report (Anfang and Wall 2006; Gold et al. 2008; Rostow and Davis 2002). Depending on departmental policy, the report provided to the department will become part of the confidential personnel record, although there is no real guarantee that it will remain confidential. Even if it remains in that file, the evaluator does not know who in the department (and beyond) may have access to it. Thus, the report should contain only the information necessary to document the presence or absence of job-related personality traits, characteristics, disorders, propensities, or conditions that would interfere with the performance of essential job functions. The amount of feedback given to supervisors should be limited to issues related to referral questions (International Association of Chiefs of Police 2004; Rostow and Davis 2002).

The primary functions of the evaluator are to provide comprehensive evaluation, diagnosis, and opinion on fitness. The officer could be returned without limitation or with optional time-limited accommodations. The officer could be found temporarily fit for duty pending a proposed intervention or unfit with little likelihood of remediation. Departments are not required to create light-duty positions as a form of reasonable accommodation, and the development of a light-duty policy is a function of managerial

discretion. However, most departments consider light duty preferable to having the officer out on sick leave receiving benefits (McNaught and Schofield 1998).

Alternatively, the evaluator could document that the officer is temporarily unfit for duty, pending a proposed intervention, or unfit, with little likelihood of remediation. Under these circumstances, unless prohibited by departmental policy, law, or contractual agreements the evaluator should document the extent of impairment and provide an estimate of the time needed until the evaluee can be returned to full duty (International Association of Chiefs of Police 2004; Miller 2007).

Exceptions to the limited disclosure of the report do exist. Further information derived from the evaluation could be discoverable if the officer has a pending lawsuit, arbitration, grievance, or disability claim or challenge, or if the officer is claiming that his or her impairment is work related. Although many officers are eager to address problems in a fitness for duty evaluation and return to work, others may be litigious or in search of secondary gain through the fitness for duty situation (Anfang and Wall 2006; Decker 2002; Gold et al. 2008).

The evaluator will make recommendations related to the officer's need for further treatment and/or monitoring, if appropriate. By noting in the opinion that specific treatment is warranted, the appropriate representatives or supervisors will be able to initiate a plan, such as referral for treatment, which makes sense for the officer. A timely referral to an appropriate source can keep an otherwise volatile situation from escalating. The evaluating psychiatrist who frequently consults to a police department may wish to consider offering, on an informal or formal level, guidance aimed at decreasing the overall level of organizational stress and ensuring the adequacy of the mental health program offered for officers.

Conclusion

The intersection of mental health and law enforcement is a growing area of interest for many psychiatrists. Mental health training for police, crisis negotiation, reviews of officer-assisted suicides, and police fitness for duty evaluations are aspects of the work that is often undertaken in this arena, and there is an expanding literature exploring those topics. A psychiatrist taking on this work, however, should have a sound understanding of the unique issues at play. Psychiatrists are often seen by others as having easy and ready solutions to some of the complex challenges that arise in police

work, such as suicide and violence risk prediction and assessment of officers and citizens, based on little information. It can be useful to remind police of the importance of having each profession work within its role, and to tolerate the unpredictable nature of some of the issues that surface. Psychiatrists who work with law enforcement should work within their expertise and training and recognize the potential risks, limitations, and benefits involved.

Key Points

Mental Health and Law Enforcement: Systems Integration and Training

- Community models of systematized responses to mental health crises include 1) police-based, specialized mental health response, 2) mental-health-based, specialized mental health response, and 3) police-based, specialized police response.
- Mental health training aimed toward reducing stigma and improving communication skills is an important addition to other types of police education and can improve overall knowledge.
- Officers frequently rely on their own discretion in making dispositional decisions; therefore, education related to mental illness may enhance their understanding of appropriate and available options.

Suicide by Cop

- Suicide by cop refers to an incident in which suicidal individuals intentionally engage in life-threatening and dangerous behavior specifically to provoke officers to kill them.
- Suicide by cop may be planned in advance or may develop in the course of a police-citizen encounter.
- Suicide by cop may be driven by a desire to accomplish certain goals through being killed and/or create an opportunity for self-expression.

Crisis Negotiation

- The goal of crisis/hostage negotiation remains to provide nonviolent resolution options.
- Incidents are classified as hostage and nonhostage situations.
- The recommended role of the mental health professional is that of a consultant to the negotiation team.

Fitness for Duty Evaluations of Law Enforcement Officers

- The evaluator should consider the suitability of officers for continued work in their normal capacity.
- If the person is not fit for duty, then the evaluator should comment on the likelihood of successful return following treatment.
- The need to carry a weapon should be an important factor in the assessment of fitness for duty.

Practice Guidelines

Mental Health and Law Enforcement: Systems Integration and Training

1. When collaborating with police, attempt a focus that provides opportunities for cross-trainings.
2. Develop education around priority topics that can be accomplished in allotted time.
3. Recognize and work within your limits as a psychiatrist in providing advice to officers.

Suicide by Cop

1. When reviewing encounters with police that involve victim provocation, assess intent and planning for suicide by cop.
2. Attempt to gather information about premorbid functioning of the suicidal person in retrospective reviews of suicide by cop and attempted suicide by cop.
3. In evaluating individuals who have engaged in suicide by cop behavior, explore reasons for attempting this means of suicide.

Crisis Negotiation

1. Be clear about the limits of your role as consultant.
2. Obtain the necessary training before acting as a consultant to the negotiation team.
3. Be clear as to the limits of your opinion and expertise.

Fitness for Duty Evaluations of Law Enforcement Officers

1. Be aware of the legal standards in the community and departmental procedures when performing fitness for duty evaluations.
2. Consider the unique job requirements of law enforcement officers and issues related to firearm access.

References

Adams K, Alpert GP, Dunham RG, et al: Use of force by police: overview of national and local data, in National Institute of Justice Research Report, jointly published with the Bureau of Justice Statistics, October 1999. U.S. Department of Justice, Office of Justice Programs. Available at: www.ncjrs.gov/pdffiles1/nij/176330–1.pdf. Accessed June 27, 2009.

Alpert GP, Dunham RG: The force factor: measuring and assessing police use of force and suspect resistance, in Use of Force by Police: Overview of National and Local Data. National Institute of Justice Research Report, jointly published with the Bureau of Justice Statistics, October 1999. U.S. Department of Justice, Office of Justice Programs. Available at: www.ncjrs.gov/pdffiles1/nij/176330–1.pdf. Accessed June 27, 2009.

American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry. Adopted May, 2005. Available at: http://www.aapl.org/ethics.htm. Accessed July 12, 2009.

Anfang SA, Wall BW: Psychiatric fitness-for-duty evaluations. Psychiatr Clin North Am 29:675–693, 2006

Appelbaum KL: Police encounters with persons with mental illness: introduction. J Am Acad Psychiatry Law 28:325, 2000

Bahn C, Louden RJ: Hostage negotiation as a team enterprise. Group 23:77–85, 1999

Becker JB: The first amendment goes tactical: news media negligence and ongoing criminal incidents. Loyola of Los Angeles Entertainment Law Journal 15:625–629, 1995

Belcher JR: Are jails replacing the mental health system for the homeless mentally ill? Community Ment Health J 24:185–195, 1988

Bonsignore v City of New York, 683 F.2d 635, 2d Cir. (1982)

Borum R: Improving high risk encounters between people with mental illness and police. J Am Acad Psychiatry Law 28:332–337, 2000

Borum R, Deane MW, Steadman HJ, et al: Police perspectives on responding to mentally ill people in crisis: perceptions of program effectiveness. Behav Sci Law 16:393–405, 1998

Bower DL, Petit G. The police department's crisis intervention team: a report card. FBI Law Enforcement Bulletin 70:1–6, 2001

Bresler S, Scalora MJ, Elbogen EB, et al: Attempted suicide by cop: a case study of traumatic brain injury and the insanity defense. J Forensic Sci 48:190–194, 2003

Burns B, Phillips R, McGee J, Deitz P, et al: The role of mental health professionals in hostage negotiation. Panel presented at 32nd Annual Meeting of the American Academy of Psychiatry and the Law. Boston, MA, October 2001

Butler WM, Leitenber GH, Fuselier GD: The use of mental health professional consultants to police hostage negotiation teams. Behav Sci Law 11:213–221, 1993

Carlier IV, Lamberts RD, Gersons BP: Risk factors for posttraumatic stress symptomology in police officers: a prospective analysis. J Nervous Ment Dis 195:498–506, 1997

Charle LL: Disarming people with words: strategies of interactional communication that crisis (hostage) negotiators share with systemic clinicians. J Marital Fam Ther 33:51–68, 2007

Compton MT, Esterberg ML, McGee RJ, et al: Crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia. Psychiatr Serv 57:1199–1202, 2006

Compton MT, Bahora M, Watson AC, et al: A comprehensive review of extant research on crisis intervention teams (CIT) programs. J Am Acad Psychiatry Law 36:47–55, 2008

Compton MT, Demir B, Olivera JR, et al: Crisis intervention team training and special weapons and tactics callouts in an urban police department. Psychiatr Serv 60:831–833, 2009

Conte v Harcher, 365 N.E.2d 567 (Ill. App 1977)

Cotton D: The attitudes of Canadian police officers toward the mentally ill. Int J Law and Psychiatry 27:135–146, 2004

Dalfonzo VA, Romano SJ: Negotiation position papers. FBI Law Enforcement Bulletin 72:27–31, 2003

Davey JD, Obst PL, Sheehan MC: Work demographics and officers' perception of the work environment, which add to the prediction of at-risk alcohol consumption within an Australian police sample. Policing: An International Journal of Police Strategies and Management 23:69–81, 2000

Deane MW, Steadman HJ, Borum R, et al: Emerging partnerships between mental health and law enforcement. Psychiatr Serv 50:99–101, 1999

Decker KP: Fitness for duty evaluation in law enforcement personnel: theory and practice. Paper presented at 33rd annual meeting of the American Academy of Psychiatry and the Law, Newport Beach, CA, October 2002

Dupont R, Cochran S: Police response to mental health emergencies–barriers to change. J Am Acad Psychiatry Law 28:338–344, 2000

Federal Bureau of Investigation: FBI Hostage Barricade Study (HOBAS). 2001

Feldman TB: Dealing with large scale hostage and barricade incidents: Implications for negotiation and training, in Collective Violence: Effective Strategies for Assessing and Interviewing in Fatal Group and Institutional Aggression. Edited by Hall HV, Whitaker LC. Boca Raton, FL, CRC Press, 1998a, pp 335–337

Feldman TB: Psychiatric consultation to police hostage negotiation teams. Am J Forensic Psychiatry 19:27, 1998b

Finn P, Esselman-Tomz J: Developing a law enforcement stress program for officers and their families, in Issues and Practices in Criminal Justice. U.S. Department of Justice, Washington, DC, National Institute of Justice, 1996, pp 21–89

Finn P, Esselman-Tomz J: Using peer supporters to help address law enforcement stress. FBI Law Enforcement Bulletin 67:10–18, 1998

Fischler GL: Psychological fitness-for-duty examinations: Practical considerations for public safety departments. Illinois Law Enforcement Executive Forum 1:77–92, 2001

Fisher R, Ury W: Getting to Yes. New York, Penguin Books, 1991

Fisher WH, Roy-Bujnowski KM, Grudzinskas AJ, et al: Patterns and prevalence of arrest in a statewide cohort of mental health care consumers. Psychiatr Serv 57:1623–1628, 2006

Fuselier D, Van Zandt C, Lanceley F: Hostage barricade incidents: high risk factor and the action criteria. FBI Law Enforcement Bulletin 60:6–12, 1991

Fyfe JJ: Policing the emotionally disturbed. J Am Acad Psychiatry Law 28:345–347, 2000

Geller JL: Commentary: is CIT today's lobotomy? J Am Acad Psychiatry Law 36:56–58, 2008

Giebels E, Taylor PJ: Interaction patterns in crisis negotiations: persuasive arguments and cultural differences. J Applied Psychology 94:5–19, 2009

Gillig PM, Dumaine M, Stammer JW, et al: What do police officers really want from the mental health system? Hosp Community Psychiatry 41:663–665, 1990

Gilmartin KM: The lethal triad: understanding the nature of isolated extremist groups. FBI Law Enforcement Bulletin 65(9):1–5, 1996

Godschalx SM: Effect of a mental health educational program upon police officers. Res Nurs Health 7:111–117, 1984

Gold LH, Anfang SA, Drukteinis AM, et al: AAPL practice guidelines for the forensic evaluation of psychiatric disability. J Am Acad Psychiatry Law 36 (suppl 4):S3–51, 2008

Graham v Connor et al. 490 U.S. 386 (1989)

Green TM: Police as frontline mental health workers: the decision to arrest or refer to mental health agencies. Int J Law Psychiatry 20:469–486, 1997

Hall LL, Graf AC, Fitzpatrick M, et al: Shattered Lives: Results of a National Survey of NAMI Members Living With Mental Illnesses and Their Families. Treatment/Recovery Information and Advocacy Database. Arlington, VA, National Alliance on Mental Illness, 2003

Hatcher C, Mohandie K, Turner J, et al: The role of the psychologist in crisis/hostage negotiations. Behav Sci Law 16:455–472, 1998

Hawton K, Appleby L, Platt S, et al: The psychological autopsy approach to studying suicide: a review of methodological issues. J Affect Disord 50:269–276, 1998

Hem E, Berg AM, Ekberg O: Suicide in police—a critical review. Suicide Life Threat Behav 31:224–233, 2001

Higginbotham J: Legal issues in crisis management. FBI Law Enforcement Bulletin 60:27–35, 1994

Homant RJ, Kennedy DB: Suicide by police: a proposed typology of law enforcement officer-assisted suicide. Policing: An International Journal of Police Strategies and Management, 23:339–355, 2000

Husted JR, Charter RA, Perrou B: California law enforcement agencies and the mentally ill offender. Bull Am Acad Psychiatry Law 23:315–329, 1995

Hutson HR, Anglin D, Yarbrough J: Suicide by cop. Ann Emerg Med 32:665–669, 1998

International Association of Chiefs of Police, Psychological Services Section: Psychological Fitness for Duty Evaluation Guidelines, Los Angeles, CA, International Association of Chiefs of Police, 2004

Janik J, Kravitz HM: Linking work and domestic problems with police suicide. Suicide Life Threat Behav 24:267–274, 1994

Kennedy DB, Homant RJ, Hupp RT: Suicide by cop. FBI Law Enforcement Bulletin 67(8):21–27, 1998

Knoll JL 4th:The psychological autopsy, part I: applications and methods. J Psychiatr Pract 14:393–397, 2008

Knoll JL 4th: The psychological autopsy, part II: toward a standardized protocol. J Psychiatr Pract 15:52–59, 2009

Kopel H, Friedman M: Posttraumatic symptoms in South African police exposed to violence. J Traumatic Stress 10:307–317, 1997

Kureczka AW: Critical incident stress in law enforcement. FBI Law Enforcement Bulletin 65(3):1–10, 1996

Lamb HR, Lamb DM: Factors contributing to homelessness among the chronically and severely mentally ill. Hosp Community Psychiatry 41:301–305, 1990

Lamb HR, Weinberger LE, DeCuir WJ: The police and mental health. Psychiatr Serv 53:1266–1271, 2002

Liberman R: Police as a community mental health resource. Community Mental Health J 5:111–120, 1969

Lindsay M, Lester D: Suicide By Cop. Amityville, NY, Baywood, 2004

Lindsay M, Lester D: Criteria for suicide-by-cop incidents. Psychological Reports 102:603–605, 2008

Louden RJ: The development of hostage negotiation by the NYPD, in Crime and Justice. Edited by Karmen A. New York, McGraw-Hill Custom Publishing, 1998, pp 245–250

Marzuk PM, Nock MK, Leon AC, et al: Suicide among New York City police officers, 1977–1996. Am J Psychiatry 159:2069–2071, 2002

McKenzie IK: Forcing police to open fire: a cross-cultural/international examination of police-involved, victim-provoked shootings. Journal of Police Crisis 6:5–25, 2006

McMains MJ, Mullins WC: Crisis Negotiations: Managing Critical Incidents and Hostage Situations in Law Enforcement and Corrections. Cincinnati, OH, Anderson, 2006

McNally VJ, Solomon RM: The FBI's critical incident stress management program. FBI Law Enforcement Bulletin 68(2):20–26, 1999

McNaught MC, Schofield S: Managing sick and injured employees. FBI Law Enforcement Bulletin 67(1):26–31, 1998

Miller L: Officer-involved shooting: reaction patterns, response protocols, and psychological intervention strategies. Int J Emerg Ment Health 8:239–254, 2006

Miller L: The psychological fitness-for-duty evaluation. FBI Law Enforcement Bulletin 76:10–22, 2007

Mincey v Arizona, 437 U.S. 393, 1978

Minnesota v Provost 490 N.W.2d 93 (Minn. 1992), cert. denied, 113 S.Ct. 1306 (1993)

Mohandie K, Hatcher C: Suicide and violence risk in law enforcement: Practical guidelines for risk assessment, prevention and intervention. Behav Sci Law 17:357–376, 1999

Mohandie K, Meloy JR: Clinical and forensic indicators of "suicide by cop." J Forensic Sci 45:384–389, 2000

Mohandie K, Meloy JR, Collins PI: Suicide by cop among officer-involved shooting cases. J Forensic Sci 54:456–462, 2009

Munetz MR, Griffin PA: Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. Psychiatr Serv 57:544–549, 2006

National Council of Negotiation Associations: Recommended Negotiation Guidelines and Principles. Adopted October 4, 2001. National Council of Negotiation Associations, 2001

Neylan TC, Metzler TJ, Best SR, et al: Critical incident exposure and sleep quality in police officers. Psychosom Med 64:345–352, 2002

Noesner G: Negotiation concepts for commanders. FBI Law Enforcement Bulletin 68(1):1–10, 1999

Noesner G, Webster M: Crisis intervention: using active listening skills in negotiation. FBI Law Enforcement Bulletin 66(8):1–7, 1997

Palmquist v Selvik and the Village of Bensenville, 111 F.3d 1332 (1997)

People v Gantz 480 N.Y.S. 2.d 583 (N.Y. S.Ct. 1984)

Price M: Commentary: the challenge of training police officers. J Am Acad Psychiatry Law 33:50–54, 2005

Price M, Kelly B: Crisis/hostage negotiation. American Academy of Psychiatry and the Law Newsletter 27(1):15–17, 2002

Price M, Pinals DA: Law enforcement and mental health professionals: a collaborative approach to training. Law Enforcement Executive Forum 6:61–73, 2006

Pruessner D: The forgotten foundation of state-created danger claims. Rev Litig 20:357–376, 2001

Raven K, Goree W, Miller C: Hostage negotiations after the first shots are fired. The Tactical Edge, Fall 1999, pp 22–29

Regini C: Crisis intervention for law enforcement negotiators. FBI Law Enforcement Bulletin 73(10):1–6, 2004

Reuland M, Schwarzfeld M, Draper L: Law enforcement responses to people with mental illness: a guide to research-informed policy and practice. Council of State Governments Justice Center. Available at: http://www.ojp.usdoj.gov/BJA/pdf/CSG_le-research.pdf. Accessed July 11, 2009.

Richmond RL, Wodak A, Kehoe L, et al: How healthy are police? A survey of life-style factors. Addiction 93:1729–1737, 1998

Rivard JM, Dietz P, Martell D, et al: Acute dissociative responses in law enforcement officers involved in critical shooting incidents: the clinical and forensic implications. J Forensic Sci 47:1093–1100, 2002

Rogan RG, Hammer MR: Assessing message affect in crisis negotiations: an exploratory study. Hum Commun Res 21:553–574, 1995

Romano SJ: Third party intermediaries in crisis negotiation. FBI Law Enforcement Bulletin 67(10):20–25, 1998

Rostow CD, Davis RD: Psychological fitness for duty evaluations in law enforcement. The Police Chief 69(9):58–66, 2002

Rostow CD, Davis RD: A Handbook for Psychological Fitness-for-Duty Evaluations in Law Enforcement. New York, Haworth Clinical Practice Press, 2004

Sims A, Sims D: The phenomenology of posttraumatic stress disorder: a symptomatic study of 70 victims of psychological trauma. Psychopathology 31:96–112, 1998

Slatkin A: Enhancing negotiator training: therapeutic communication. FBI Law Enforcement Bulletin 65(5):1–8, 1996

State v Sands 700 P.2d 1369 (Ariz. App. 1985)

Stephens C, Miller I: Traumatic experiences and posttraumatic stress disorder in the New Zealand police. Policing: An International Journal of Police Strategies and Management 21:178–191, 1998

Stincelli R: Suicide by cop. Available at: http://www.suicidebycop.com/page2.html. Accessed July 12, 2009.

Stuart H: Suicidality among police. Curr Opin Psychiatry 21:505–509, 2008

Taylor PJ: A cylindrical model of communication behavior in crisis negotiation. Hum Commun Res 28:7–48, 2002a

Taylor PJ: A partial order scalogram analysis of communication behavior in crisis negotiation with the prediction of outcome. International Journal of Conflict Management 13:4–37, 2002b

Teplin LA, Pruett NS: Police as streetcorner psychiatrist: managing the mentally ill. Int J Law Psychiatry 15:139–156, 1992

Trompetter PS, Honig AL: Risk assessment in barricade/hostage incidents. The Tactical Edge, Summer 1999, pp 30–38

Tuchsen F, Anderson O, Costa G, et al: Occupational and ischemic heart disease in the European community: a comparative study of occupations at high risk. Am J Ind Med 30:407–414, 1996

Van Hasselt VB, Romano SJ: Role-playing: a vital tool in crisis negotiation skills training. FBI Law Enforcement Bulletin 74(2):12–17, 2004

Van Hasselt VB, Flood JJ, Romano SJ, et al: Hostage-taking in the context of domestic violence: some case examples. J Fam Violence 20:21–27, 2005

Van Hasselt VB, Baker MT, Romano SJ, et al: Crisis negotiation training. Crim Justice Behav 33:56–69, 2006

Vecchi GM: Hostage/barricade management. FBI Law Enforcement Bulletin 71(5):1–14, 2002

Vecchi GM, Van Hasselt VB, Romano SJ: Current strategies and issues in high-risk conflict resolution. Aggress Violent Behav 10:533–551, 2005

Vermette H, Pinals DA, Appelbaum PS: Mental health training for law enforcement professionals. J Am Acad Psychiatry Law 33:42–46, 2005

Violanti JM: Predictors of police suicide ideation. Suicide Life Threat Behav 34:277–283, 2004

Violanti JM: Police suicide research: conflict and consensus. Int J Emerg Ment Health 10:299–307, 2008

Violanti J, Paton D: Police trauma: psychological aftermath of civilian combat. Policing: An International Journal of Police Strategies and Management 23:268–272, 2000

Violanti JM, Vena JE, Marshall JR, et al: Suicides, homicides and accidental deaths: a comparative risk assessment of police officer and municipal workers. Am J Ind Med 30:99–104, 1996

Watson AC, Corrigan PW, Ottati V: Police responses to persons with mental illness: does the label matter? J Am Acad Psychiatry Law 32:378–385, 2004

Wilson EF, Davis JH, Bloom JD, et al: Homicide or suicide: the killing of suicidal persons by law enforcement officers. J Forensic Sci 43:46–52, 1998

Wilson MA: Toward a model of terrorist behavior in hostage-taking incidents. Journal of Conflict Resolution 44:403–425, 2000

Wolfgang ME: Victim-precipitated criminal homicide. Journal of Criminal Law, Criminology, and Police Science 48:1–11, 1957

Wolfgang ME: Suicide by means of victim-precipitated homicide. J Clin Exp Psychopathol 20:335–349, 1959

Yin v State of California, 95F.3d 864 9th Circuit (1996), cert. denied, 117 S.Ct. 955 (1997)

Suggested Readings

Butler WM, Leitenber H, Fuselier GD: The use of mental health professional consultants to police hostage negotiation teams. Behav Sci Law 11:213–221, 1993

Feldman TB: Psychiatric consultation to police hostage negotiation teams. Am J Forensic Psychiatry 19:27, 1998

Hatcher C, Mohandie K, Turner J, Gelles M: The role of the psychologist in crisis/hostage negotiations. Behav Sci Law16:455–472, 1998

Lamb HR, Weinberger LE, DeCuir WJ: The police and mental health. Psychiatr Serv 53:1266–1271, 2002

Mohandie K, Meloy JR: Clinical and forensic indicators of "suicide by cop." J Forensic Sci 45:384–389, 2000

Mohandie K, Meloy JR, Collins PI: Suicide by cop among officer-involved shooting cases. J Forensic Sci 54:456–462, 2009

Reuland M, Schwarzfeld M, Draper L: Law enforcement responses to people with mental illness: a guide to research-informed policy and practice. Council of State Governments Justice Center. Available at: http://www.ojp.usdoj.gov/BJA/pdf/CSG_le-research.pdf. Accessed July 11, 2009.

Rivard JM, Dietz P, Martell D, et al: Acute dissociative responses in law enforcement officers involved in critical shooting incidents: the clinical and forensic implications. J Forensic Sci 47:1093–1100, 2002

PART IV

Special Topics

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Chapter 17

Malingering

H. W. LeBourgeois III, M.D.
John W. Thompson Jr., M.D.
F. William Black, Ph.D.

The assessment of malingering presents a significant challenge for mental health clinicians. The traditional clinician-patient relationship is based on the assumption that a patient is in genuine need of treatment and is invested in accurately reporting symptoms so that accurate diagnoses and effective treatment can be provided; in contrast, individuals who malinger engage in purposeful deception of clinicians to achieve an external incentive other than effective treatment. Even when clinicians suspect malingering, they may feel uneasy about initiating malingering assessment. This uneasiness is understandable, given the potential for escalation of an individual's behavior when presented with the clinician's suspicion of malingering. That being said, clinicians who suspect malingering will best be prepared to evaluate for the condition when equipped with guidelines for malingering assessment.

In this chapter, we review basic knowledge of malingering, provide examples of individuals engaged in malingering, and review methods that have received scientific support in malingering assessment. We also provide information on the potential difficulties clinicians face when interacting with malingering evaluees and guidelines for assessment.

Malingering Overview

Historical Background

Malingering was documented in biblical times. David "feigned insanity and acted like a madman" to avoid a king's wrath (1 Samuel 21). Malingering also appeared in mythological tales, with Odysseus feigning psychological disturbance to avoid combat in the Trojan War, only to be uncovered by the clever Palamedes ("Odysseus" 2009).

In the nineteenth century, the term *malingering* found its way into the English medical literature with Gavin's book *On Feigned and Factitious Diseases Chiefly of Soldiers and Seamen* (1843). Four years later, a French surgeon described the use of ether to distinguish feigned from real disease (Anon 1847). In the late nineteenth century and the early twentieth century, industrial expansion paired with the introduction of workmen's compensation led to increased concerns about the socioeconomic implications of malingering (Turner 1997). Pejorative terms such as "compensation neurosis" and "profit neurosis" began to appear to describe suspected malingered claims of mental injury following traumatic accidents (Resnick 1997, pp. 130–131).

Malingering has been used as a war tactic. During World War II, the British dropped pamphlets over German troops, instructing them on how to malinger in order to obtain military leave (Richards, in press). Currently, a German CD-ROM entitled the "Krankheits-Simulator" (Sickness Simulator) is available for purchase on the Internet; the program instructs employees on how to malinger in order to obtain sick leave ("German Employers Ill Over CD Showing How to Fake for Sick Days" 2001).

Today, malingering is a condition that garners attention in the medical literature as well as the lay press. Popular movies using forensic topics and psychiatric consultants portray malingerers as sly and cunning psychopaths. The film *Primal Fear* (1996), in which Edward Norton's character feigns multiple personality disorder after being arrested for murder, is an example of such a portrayal.

Definitions and Subtypes

DSM-IV (American Psychiatric Association 1994), and its text revision, DSM-IV-TR (American Psychiatric Association 2000, p. 739), define malingering as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoid-

ing military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." DSM-IV-TR (p. 731) also notes that malingering is a condition not attributable to a mental disorder.

Resnick et al. (2008) identified three subcategories of malingering: 1) pure malingering, 2) partial malingering, and 3) false imputation. *Pure malingering* exists when an evaluee completely fabricates a disorder. In contrast, *partial malingering* occurs when an evaluee purposefully exaggerates existing symptoms. *False imputation* occurs when an evaluee purposely attributes actual symptoms to an etiology that he or she knows has little or no relationship to the development of symptoms. Such an example would be an individual in pain management treatment for multiple preexisting injuries to the lower back who then has a minor slip and fall at a shopping center, followed by a lawsuit claiming that all back pain and suffering began after the fall.

Base Rates

Base rates of malingering depend on the evaluation setting and/or the referral issue in question. In a recent study of 33,531 cases seen by members of the American Board of Clinical Neuropsychology over a 1-year period, probable malingering and symptom exaggeration were found in 30% of disability evaluations, 29% of personal injury evaluations, 19% of criminal evaluations, and 8% of medical cases (Mittenberg et al. 2002). More recent studies focusing on Social Security disability claimants (Chafetz 2008) and criminal defendants (Ardolf et al. 2007) undergoing forensic neuropsychological evaluation yielded even higher rates of probable and/or definite malingering. An earlier study of 320 experienced forensic psychologists yielded higher estimates for malingering in the forensic setting (15.7%) as compared to the nonforensic setting (7.4%) (Rogers et al. 1994). Although the aforementioned studies indicate that forensic settings generally harbor higher base rates of malingering when compared to clinical settings, estimates of malingering in particular clinical settings can be significant. From their analysis of Minnesota Multiphasic Personality Inventory–2 (MMPI-2) validity scales, Frueh and colleagues (1997) estimated a 20%–30% base rate of malingering among veterans seeking compensation for posttraumatic stress disorder (PTSD). Greve and colleagues (2009) estimated a 20%–50% base rate of malingering among chronic pain patients evaluated within a medicolegal context. Yates and colleagues (1996) found that resident psychiatrists working in an urban emergency room strongly suspected or definitively diagnosed malingering in 13% of patients evaluated. In another study, a 10%–12% rate of malingering was found among patients who were hospitalized for suicidal ideation (Rissmiller et al. 1999).

Malingered Conditions

Mental health clinicians should bear in mind the malingered conditions that they may encounter in forensic and nonforensic settings. Literature reviews demonstrate that malingered conditions include dissociative identity disorder (McConville and LeBourgeois 2008), psychosis (Greenfield 1987), suicidality (Rissmiller et al. 1999), and PTSD (Frueh et al. 1997). Malingered conditions that cross the spectrum of psychiatry and neurology that have been reported include acute dystonia (Rubinstein 1978), amnesia (Bolan et al. 2002), chronic pain (Greve et al. 2009), cognitive deficits (Iverson and Binder 2000; Sweet 1999), dementia (Gittelman 1998), seizure (DeToledo 2001), and sleep disorder (Mahowald et al. 1992). Additionally, there are now several case reports documenting "malingering by proxy" behaviors, in which caretakers induce or report illness in a dependent in order to reap some external incentive—for example, disability payments or controlled substances for the presumed benefit of the caretaker (Cassar et al. 1996; LeBourgeois et al. 2002; Stutts et al. 2003).

Of the conditions mentioned, forensic mental health clinicians are most likely to encounter malingered psychosis, malingered PTSD, and malingered amnesia/cognitive deficits (see section "Case Vignettes" later in this chapter, where each of these malingered conditions is discussed).

Psychiatric Disorders That May Be Mistaken for Malingering

Factitious disorders and somatoform disorders share common elements with malingering (Cunnien 1997; Eisendrath 1996). Thus, clinicians should be familiar with these conditions when examining suspected cases of malingering. Both malingering and factitious disorders involve the "intentional production of physical or psychological symptoms" (American Psychiatric Association 2000, p. 513). However, the motivation for behavior associated with factitious disorders is a desire to assume the sick role in the absence of obvious external incentives, such as disability payments, shelter, or food. It is presumed that individuals with factitious disorders pursue the sick role to obtain the psychological gains associated with conditions of true illness. Patients with factitious disorders may inflict serious medical problems on themselves, travel widely to health care venues, and have a history of unceasing patienthood (Eisendrath 1996).

Factitious disorders may have primarily physical or psychological manifestations or a combination of both. Individuals with factitious disorders have been reported to induce illness in persons under their care in order to

assume the sick role by proxy. This disorder is known as factitious disorder by proxy. Usually, cases of factitious disorder by proxy involve a mother and her preschool child presenting in pediatric settings (American Psychiatric Association 2000, pp. 781–783).

Individuals with somatoform disorders present with a distinct history as well as physical symptoms suggesting a general medical condition; however, comprehensive medical workups in search of medical illness yield negative results. In contrast to malingering and factitious disorders, individuals with somatoform disorders have no intention to deceive clinicians. Their physical symptoms are not purposefully fabricated. Such patients are unaware of the reason they are experiencing physical symptoms and have no ulterior motive when presenting for medical evaluation and treatment.

The somatoform disorders include hypochondriasis, pain disorder, body dysmorphic disorder, and conversion disorder. Conversion disorder may be the most likely somatoform disorder to be mistaken for feigning. In this disorder, individuals present with pseudoneurological deficits of voluntary motor or sensory function that typically fail to follow known anatomical pathways. Other conversion symptoms include aphonia, urinary retention, blindness, deafness, hallucinations, and seizures. Clinicians should be cautious in diagnosing somatoform disorders during initial evaluation and make reasonable efforts to ensure that medical illness has been ruled out, as sometimes medical illness later surfaces that explains symptoms (American Psychiatric Association 2000).

The distinction among factitious disorders, somatoform disorders, and malingering is not always clear-cut (Table 17–1). The simplified flowchart in Figure 17–1 may be helpful to clinicians when they are attempting to make this distinction. When attempting to distinguish factitious disorder from malingering, the usual method is to examine for external incentives that are presumably absent in factitious disorder. This method is not foolproof, because there may be situations in which external incentives appear present but which clinical judgment indicates factitious disorder as the most likely explanation for feigning. Along those lines, Eisendrath (1996) recommends taking an overall view of the cost-benefit ratio of feigning behaviors when attempting to make this distinction. Where the apparent cost of the behavior to the individual is high, and the tangible benefit (external incentive) is relatively low, one would lean toward diagnosing factitious disorder. Such an example would be a patient who repeatedly injects feces into his joints with a hypodermic needle to cause serious and potentially crippling infections and a risk of fatal sepsis, jeopardizing his own well-being, and who is repeatedly admitted to hospitals for workup in the absence of an identifiable external incentive such as homelessness or a pending disability claim. This is an example of a high-cost behavior with apparently low benefit, except to the

TABLE 17–1. Symptom production and motivation in malingering, factitious disorders, and somatoform disorders

	Symptom production	Motivation
Malingering	Conscious	Conscious
Factitious disorders	Conscious	Unconscious
Somatoform disorders	Unconscious	Unconscious

patient, who highly values the sick role. An opposite example would be an individual on death row feigning psychosis by self-reporting psychotic symptoms to avoid impending execution; in this situation there is very little cost to the individual but a dramatic benefit if he or she is successful, making malingering far more likely than factitious disorder.

Models of Malingering Behavior

Rogers and colleagues (Rogers 1990; Rogers et al. 1994) have outlined the primary motivations implicit in three explanatory models of malingering: 1) pathogenic, 2) criminological, and 3) adaptational. The *pathogenic model* proposes that malingering is motivated by an underlying condition that eventually deteriorates and surfaces as the illness progresses. This model has lost support over the past several decades (Rogers 1997, 2008).

The *criminological model* focuses on multiple aspects of an individual's bad character and bad behavior, "namely, a bad person (antisocial personality disorder), in bad circumstances (legal difficulties), who is performing badly (uncooperative)" (Rogers 1997, p. 7). Rogers (2008, p. 9) indicated that the "DSM classifications (1980, 1987, 1994, 2000) have adopted the criminological model to explain the primary motivation for malingering," but "[w]hen DSM indices are evaluated in a criminal forensic setting, they are wrong four out of five times." According to Rogers (2008, p. 9), "the DSM indicators should not be used even as a screen for potential malingering because they produce an unacceptable error rate." That being said, other studies have examined the relationship between psychopathy and malingering and lend some support to the criminological model. Gacono and colleagues (1995) compared hospitalized insanity acquitees who had successfully malingered mental illness to insanity acquitees who were deemed to be truly insane. This study revealed a significantly higher number of antisocial personality disorder diagnoses among malingerers. A study of 143 college students investigated the relationship between psychopathic personality traits and ma-

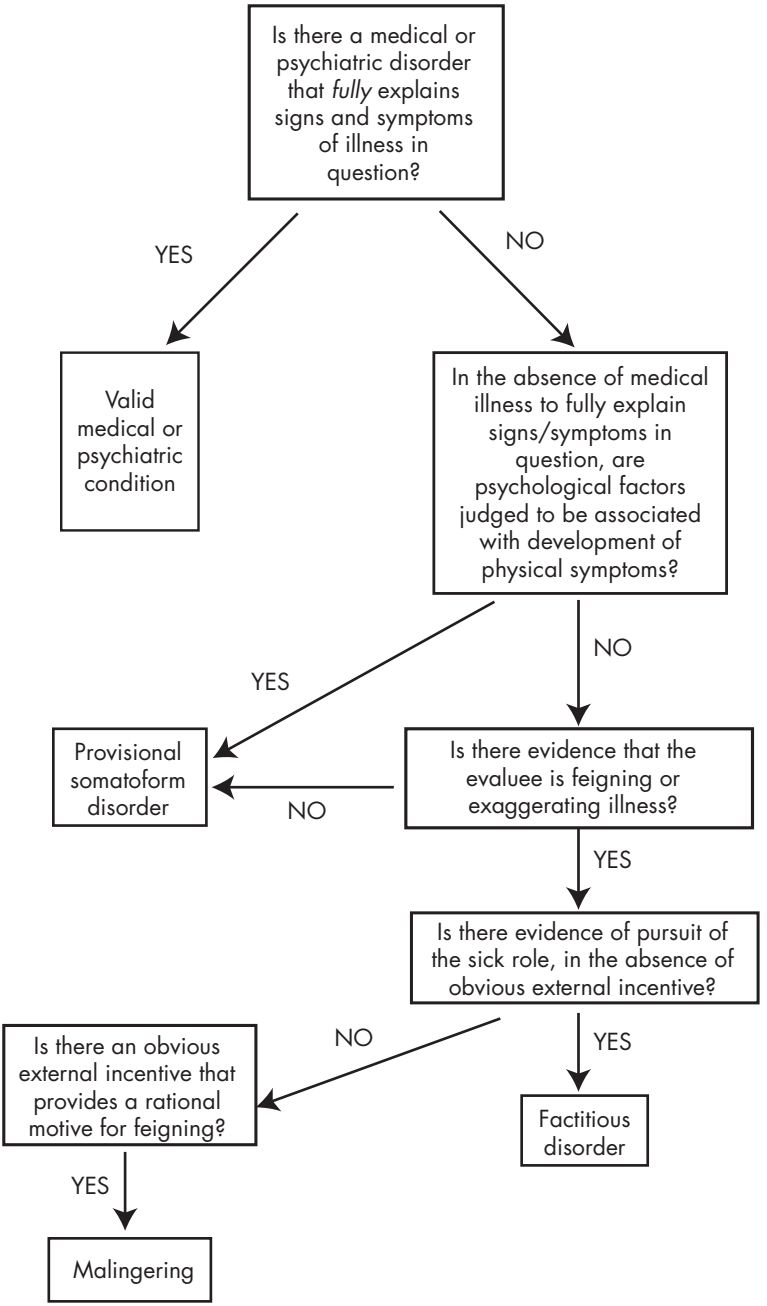

FIGURE 17–1. Differentiation between malingering, factitious disorders, somatoform disorders, and valid medical/psychiatric conditions.

lingering, using the Psychopathic Personality Inventory. The study authors proposed that "psychopathy is somewhat predictive of a willingness to feign mental illness across various forensic/correctional settings" (Edens et al. 2000, p. 290).

The *adaptational model,* delineated by Rogers (1997), proposes that malingerers engage in a "cost-benefit analysis" (p. 8) during clinician assessment. As Rogers (1997) noted, "Malingering is more likely to occur when 1) the context of the evaluation is perceived as adversarial, 2) the personal stakes are very high, and 3) no other alternatives appear to be viable" (p. 8). In this model, individuals malinger on the basis of their estimate of success in obtaining the desired external incentive. Despite criticism of DSM-IV-TR's overreliance on a criminological model (Rogers 2008), DSM-IV-TR is not completely silent on the issue of the adaptational model, noting, "Under some circumstances, malingering may represent adaptive behavior—for example, feigning illness while a captive of the enemy during wartime" (American Psychiatric Association 2000, p. 739).

Personality and Malingering

DSM-IV-TR (American Psychiatric Association 2000, p. 739) notes that malingering should be "strongly suspected if any combination of the following" is noted:

1. Medicolegal context of presentation
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of antisocial personality disorder

Clark (1997) has questioned the utility of singling out evaluees with antisocial personality disorder. He suggests that these individuals are simply more likely to be involved in adversarial situations in which it would benefit them to malinger, for example, if facing criminal charges. Edens and colleagues (2000) endorsed a contrary opinion, stating that results of their study "lend support to the position that the relationship between psychopathic personality features and malingering is not exclusively a function of an increased likelihood that dissimulation will occur in forensic contexts" (p. 293). They concluded that psychopathic traits are associated with attitudes that may be conducive to engaging in malingering in forensic settings.

The psychological research in this area suggests that a wide range of individuals with and without Axis I and Axis II psychiatric disorders engage

in a variety of symptom exaggeration behaviors. Limiting the consideration of malingering only to individuals with diagnosable antisocial personality disorder will result in significant underdetection of individuals who are overendorsing or fabricating emotional and/or cognitive symptoms.

Financial Incentive and Malingering

Individuals who are seeking some form of compensation are commonly believed to be more likely to exaggerate symptoms. Four studies published by different authors in recent times have attempted to evaluate this belief. Frueh and colleagues (1997) found that veterans seeking compensation for PTSD, compared with non-compensation-seeking veterans, endorsed dramatically higher levels of psychopathology across psychometric measures and produced sharply elevated fake-bad validity indices despite controlling for factors such as income and clinician ratings of illness severity. Study authors concluded that their study identified a clear association between symptom overreporting and PTSD compensation-seeking status. Binder and Rohling (1996) evaluated the impact of financial incentives on disability, symptoms, and objective findings after closed-head injury. They found more abnormality and disability in evaluees with financial incentives, despite less severe injuries. Paniak and colleagues (2002) reported that evaluees seeking compensation following mild traumatic brain injury, compared with non-compensation-seeking evaluees, reported symptoms approximately one standard deviation higher at intake, 3 months, and 12 months post-injury. Bianchini and colleagues (2006) proposed a dose-response relationship between the level of financial incentive and the likelihood of malingering or exaggeration based on their study of individuals referred for neuropsychological examination after traumatic brain injury. They found considerably higher rates of diagnosable malingering as the level of financial incentive increased. These studies, taken as a whole, suggest that the effect of financial incentives should be considered during evaluation.

Case Vignettes

Vignette 1: Malingered PTSD

A Vietnam-era veteran was admitted to a PTSD partial hospitalization program upon referral from an outpatient clinician. Shortly after entering the program,

he reported symptoms such as hearing the voice of his dead comrades during group therapy sessions. However, psychologists conducting group therapy sessions began to be concerned about the patient berating other veterans in the program. In group sessions, he chided the other patients as follows: "Y'all aren't here to get help like me because y'all don't have the courage to talk about your problems." He would then exclaim how "serious" he was about treatment and "getting better." The other patients began to complain about their fellow veteran because he insisted on talking about Vietnam all the time, even during downtime. Furthermore, other patients began to question his reports of "chasing dogs through the tunnels when I was a tunnel-rat" and how he reported constantly seeing "the heads of dogs all around me."

In individual sessions with his psychiatrist, the patient tended to report how PTSD had caused all of his problems and declared that the government "should make up for it" by granting him disability payments. He further reported that as a result of PTSD, he "isolated from the rest of society" by purchasing a home in a rural setting and "never leaving the house." In contrast to his reports of isolating from others constantly, he reported seeking out Mardi Gras parades and downtown casinos while on day passes in a heavily urban environment. Other veterans in the program said they "wouldn't go to Mardi Gras if you made me" because of the loud noises that bothered them and the large crowds that would diminish their ability to "survey the area" and perceived ability to stay out of harm's way.

A psychologist on the unit felt the patient might be malingering PTSD and psychotic symptoms and administered the Structured Interview of Reported Symptoms (SIRS) to gain further information. The psychologist shared that the SIRS pointed to probable, but not definite, feigning; however, the psychologist engaged the patient in further questioning after the SIRS to probe for atypical responses (i.e., to see if the patient would "push the envelope" with absurd or preposterous symptom reports when given the chance during an unstructured interview). Among other atypical symptoms, the patient reported having "flashbacks" of his fallen comrades, "Pancho and Ramone," in which they would "play with me like Casper and the Ghost—I punch at them sometimes and they do flips around in the air—we have fun—they are my companions." He reported enjoying such self-reported re-experiencing events; he denied that it aroused uncomfortable feelings. Despite his reports of frequent visual and auditory hallucinations, the patient was never observed to appear distracted or stare around the room as if attending to hallucinations during group or individual sessions.

A call to the referring clinician revealed that the patient was suspected of exaggerating his symptoms in the outpatient setting, and the referring clinician shared that she acquiesced to the patient's insistence to attend the partial hospitalization program, even though he didn't seem entirely appropriate for the program based on the possibility of exaggerated symptoms.

The psychologists who ran the group sessions and observed the patient the most felt strongly that he was malingering; the treating psychiatrist agreed that even if he was not malingering, if he genuinely had psychotic symptoms to the degree he reported, intense trauma work would not be appropriate management because it has been known to lead to exacerbation of psychotic symptoms in vulnerable patients with genuine psychotic disorders.

A treatment team decision was made to discharge the patient from the partial program prematurely to the care of his referring clinician. When the patient was informed he would be discharged, he exclaimed how "honest" he had been and further proclaimed, "All these other patients are just here to get money." He repeatedly referred to the reluctance of other patients to talk about intimate traumatic experiences in group settings and during downtime as evidence of their unwillingness to "get better."

Following the patient's discharge, unsolicited, candid remarks began being issued by other patients. One representative comment was as follows: "We didn't want to say it before, doc, but that guy was full of it."

Discussion

Evaluation of malingering among veterans with potential PTSD is challenging, and one must be cautious not to capriciously assign this diagnosis. However, in this case, results and impressions were shared with the referring clinician for follow-up and consideration. Consistencies with malingered PTSD in this case include the following factors:

1. The patient relished talking about his reported traumatic experiences and chided other patients for not doing the same. (Patients with genuine PTSD tend to avoid such conversations because of the anxiety it can arouse.)
2. There was an observed discrepancy between self-reported avoidance behaviors and behaviors observed during treatment. (The patient reported "isolating from society" by purchasing a rural home and "never leaving the home," but ventured out to Mardi Gras parades and casinos in an urban downtown area on day passes.)
3. The patient reported improbable and absurd symptoms (such as "playing" with his fallen comrades like "Casper and the Ghost").
4. The patient gave a self-report of a rare aspect to his reexperiencing symptoms ("flashbacks"). (He had "fun" when "playing" with visions of his fallen comrades, as opposed to being disturbed by such an experience.)
5. There was collateral contact with the referring clinician who suspected exaggeration of symptoms.
6. Psychological testing pointed to probable feigning of symptoms.
7. Despite frequent self-reported hallucinations, there were never corresponding behaviors (e.g., distraction, staring around as if attending to hallucinations).
8. That the patients came forward after his discharge and shared their belief that the patient was "full of it" was fairly striking and tended to support feigning or gross exaggeration of symptoms.
9. The presence of an obvious external incentive, disability payments, would support malingering as opposed to factitious disorder.

Vignette 2: Malingered Cognitive Deficits

A 38-year-old man presented for neuropsychological evaluation of memory deficits upon referral by his attorney. The evaluee reported that he had been struck on the vertex of the head by a "125-pound piece of metal" 1 year prior to the evaluation while working on an oil rig. Immediately following the trauma, he reported a period of disorientation but no loss of consciousness. He was evacuated to an emergency room, where he was treated for a "4-inch" laceration, given nonnarcotic pain medication, and released to his home.

He failed to return to work—citing increasing problems remembering "anything"—despite the company's attempts to accommodate him by altering his work responsibilities. He retained an attorney and was referred to a number of physicians. Upon neuropsychological evaluation, he tested within the moderate mental retardation range of general cognitive ability and demonstrated markedly impaired language, memory, abstraction ability, and overall performance on other psychological tests. He failed all four tests of symptom validity that were administered, was "unable" to read (despite demonstrating an ability to do so during the weeks after the accident), and produced personality test results reflecting a psychotic state, but he appeared to be not even vaguely psychotic during the evaluation.

The incident report from the oil rig documented that the injury occurred when the patient dove to the floor of the oil rig after a wrench fell approximately 4 feet from him. Curiously, the patient acknowledged that he was wearing a hard hat during the incident, but it was unmarked. Records from the emergency room visit documented that he was treated for a "small laceration." All neuroradiological magnetic resonance imaging (MRI) and positron emission tomography (PET) examinations were read as "normal" by radiologists. Videotapes from various times during the evaluee's period of disability showed entirely normal daily functioning.

Discussion

On the basis of an analysis of the neuropsychological test results and review of collateral information, it was determined that the evaluee was frankly malingering. A marked disparity between the reported and actual history, the discrepancy between test results and demonstrated functional abilities, and the presence of financial incentive were all consistent with a diagnosis of malingering.

Vignette 3: Malingering—To Be or Not to Be?

A 19-year-old jail detainee facing a felony charge of auto theft was evaluated for competence to stand trial by a forensic evaluator in a jail-based setting. The

evaluator noted that the evaluee spoke very little and "did not appear to be taking the evaluation seriously." After spending 15 minutes with the evaluee, the evaluator issued a brief report recommending that the defendant be committed to a forensic psychiatric hospital for further evaluation with "a primary rule-out diagnosis of malingering." The forensic evaluator at the hospital noted that the evaluee was taking moderate doses of a typical antipsychotic and that he presented with what appeared to be prominent negative symptoms of schizophrenia and extrapyramidal side effects (parkinsonian tremor). He had a markedly restricted range of emotional expression and very little spontaneous speech, but when he spoke, he did so in a linear fashion. The evaluee denied current hallucinations, did not speak with any delusional material being evident, and denied any history of psychotic symptoms.

A call to the jail's treating psychiatrist, who had placed the evaluee on antipsychotic medication, confirmed that he had observed the evaluee in a "genuine" psychotic state during his detainment. This included the appearance of "loose associations and neologisms" (symptoms that are difficult to feign) that dissipated following antipsychotic administration. A phone call to family members also brought up a possible history of adolescent-onset psychotic symptoms.

Given the collateral information obtained, the current appearance of difficult-to-feign negative symptoms of schizophrenia, and the observation that the evaluee tended to deny all symptoms of mental illness or a history of such (as opposed to calling attention to psychotic symptoms or grossly exaggerating them), the hospital's forensic evaluator determined that the evaluee was not malingering psychosis.

On the other hand, the evaluee presented with cognitive deficits, such as a poor fund of knowledge, poor short-term memory, and a poor ability to calculate and spell. At times he seemed unmotivated to engage in attempts at competency restoration, such as legal rights education. A decision was made to assess the evaluee for feigned cognitive deficits. School records were obtained. This included intellectual testing conducted at the age of 12 years (prior to any history of criminal conduct) that revealed an IQ in the mild mental retardation range; intellectual testing repeated at the forensic hospital was consistent with the earlier records. The Test of Memory Malingering (TOMM) was administered and did not yield evidence of feigned cognitive (memory) problems. After the hospital's treating psychiatrist changed his medication to an atypical antipsychotic medication, there was a decrease in negative symptoms and extrapyramidal side effects and an increase in spontaneous speech, and the evaluee became more cooperative in efforts at competency restoration.

He was evaluated for competence to stand trial 10 weeks into his hospitalization, and despite valid cognitive deficits consistent with mild mental retardation, he was recommended competent to proceed. The forensic report addressed the question of malingering, stating that malingered psychosis and cognitive deficits had been assessed and ruled out. The defendant was found competent to proceed, pleaded guilty to a lesser charge, and was placed on probation under the supervision of the mental health court.

Discussion

Many cases of malingered mental illness are available for review in the literature. We included this case to demonstrate that by adhering to guidelines for malingering assessment, the evaluator can in fact rule out some cases of suspected malingering.

Vignette 4: Malingered Amnesia

A 48-year-old man was seen in the emergency room after being brought in by his wife 6 hours after a minor vehicle collision. "No physical injury," no loss of consciousness, no alteration in alertness, and no complaints of physical or cognitive problems were recorded in the accident report and EMT notes. However, the evaluee presented with "memory problems," including being "totally unable" to remember "anything" that occurred prior to the instant of the accident. For instance, the patient recognized his wife but reported that he could not recall their wedding, three children, or any event from the 18-year marriage. Similarly, he could not (or would not) provide information regarding his birth and childhood, schooling, work history, or residences.

The patient was admitted to the neurology service for a workup of amnesia. For the first 2 days of hospitalization, the evaluee simply responded to questions with "I can't remember." Several days into admission, the evaluee continued to profess an inability to recall his personal history but appeared to be aware of all events transpiring in the hospital, began to call staff members by name, and watched television avidly—demonstrating enthusiasm for specific players on the local National Football League team. A comprehensive medical workup for amnesia was negative.

A neuropsychologist was consulted to assist with evaluation of the amnesia. On formal memory testing, the evaluee showed an adequate ability to learn, to recall previously presented information, and to remember this information after a short delay period. However, on the binomial choice Test of Memory Malingering (TOMM) and the Word Memory Test, the evaluee performed below random chance. Following observation of the evaluee and his wife discussing "fooling the doctors," the evaluee was confronted about the atypical nature of his memory complaints and the inconsistency of his symptoms with both his personal medical history and the expected memory findings in evaluees with documented brain injury. The evaluee admitted to "faking" the memory disorder (he needed money "because of debts") and rapidly regained a normal memory pattern.

Discussion

This patient was diagnosed with malingering because of the clear financial incentive, the highly atypical nature of his memory complaints, the incon-

sistency between his clinical presentation and collateral data, and the evaluation of his psychological test performance.

Vignette 5: Malingered Psychosis and Cognitive Deficits

A 30-year-old man was admitted to the psychiatric unit of a forensic hospital after being adjudicated incompetent to stand trial. He was charged with armed robbery at a convenience store, along with a codefendant accomplice. The events were captured by video surveillance. He was noted on video to rapidly enter the store with an accomplice, direct the store clerk to the cash register, and exit with great haste, along with his accomplice. Records revealed that he had been convicted of two previous felonies involving robbery with weapons, indicating that if he were convicted once more, he could receive severely enhanced penalties (three-strikes-and-you're-out law in the state where he was arrested).

Upon admission to the hospital, he refused to answer questions, acting as though he were mute, while looking around the room as though he were attending to hallucinations. After the third day of admission, he began to speak with staff and participate in screening evaluations. When questioned about hallucinations, he reported continuous hallucinations ("day and night") of a man's voice telling him, "Rob, rob, rob." He said he had been experiencing the voice talking to him for years and that he had acted on the voice in the commission of this crime and previous crimes. He indicated he had no strategies to diminish the hallucinations, and there were no reports of associated delusions. During administration of the Mini-Mental State Examination (MMSE), he scored extremely poorly, obtaining 5 correct responses out of a total 30 items.

He reported that he had no idea of the roles of the judge, jury, defense attorney, and district attorney and did not know how much time he could receive if convicted of the alleged offense, even after intense education. During staffing with the psychiatrist, he presented as bizarre and disorganized, but staff reported that he flirted with female staff and engaged in goal-directed behavior such as playing cards and writing patient-complaint forms (which were written in a manner that belied decent grammatical abilities) while not directly observed by his psychiatrist. His grammatical abilities were surprising in that he had scored 5 correct out of 30 items on the MMSE on the third day of admission, including being unable to read the phrase "close your eyes" or spell the word "world" forwards or backwards.

He was administered the Structured Interview of Reported Symptoms, and results could be classified as "definite" feigning. Administration of the Test of Memory Malingering (TOMM) further demonstrated evidence of malingered cognitive (memory) deficits. When staff sought clarification about inconsistencies in his performance on psychological testing that supported malingering, he again became mute, angry, and aggressive on the ward.

Discussion

This evaluee was returned to court with a diagnosis of malingering (malingered psychosis and cognitive deficits) and a recommendation of competent to proceed. Malingering in the criminal setting may be pursued by an evaluee to delay or avoid prosecution, to obtain mitigation, or to obviate responsibility for a crime. In this case, a rational, nonpsychotic motive for the robbery (money) and the fact that the robbery fit a pattern established in previous crimes suggested malingering. Having a partner in crime also called into question a psychotic motive for the alleged offense, as it is unlikely that a nonpsychotic individual would collaborate with a psychotic partner (Resnick and Knoll 2008).

Individuals attempting to feign schizophrenia have the most difficulty imitating the form of thinking (derailment, neologisms, incoherence, perseveration) (Sherman et al. 1975) and the negative symptoms characteristic of schizophrenia (Resnick and Knoll 2008). Malingerers of schizophrenia may more easily report positive symptoms of schizophrenia (hallucinations and delusions), but a skilled examiner can ask detailed questions to characterize psychotic symptoms as typical or atypical. Table 17–2 lists features of atypical hallucinations, some of which were displayed by the evaluee in this case vignette.

Malingering Assessment

Resnick (2003) has provided guidelines for the evaluation of malingering in PTSD. These guidelines, although specifically written for the evaluation of PTSD, serve as a framework for designing guidelines for the assessment of malingering in general. In the following discussion, we review useful techniques in the assessment of malingering. We also suggest guidelines derived from Resnick, as well as from our own experience, for the assessment of malingering across the spectrum of psychiatric disorders.

Initial Interview

The initial interview is critical in the assessment of malingering. Estimates of the prevalence of malingering in mental health settings indicate that a screening process for malingering would be useful. Cunnien (1997, p. 45) offers a "threshold model for consideration of malingering." This model is based entirely on clinical history and presentation, which makes it suitable

TABLE 17–2. Characteristics of atypical hallucinations

Auditory hallucinations
Are continuous rather than intermittent (Goodwin et al. 1971).
Are vague or inaudible (Goodwin et al. 1971).
Are spoken in stilted language (Resnick and Knoll 2008).
Evaluee has no strategies to diminish malevolent auditory hallucinations (Resnick and Knoll 2008).
Visual hallucinations are seen in black and white (Goodwin et al. 1971).
Hallucinations are not associated with a delusion (Lewinsohn 1970).

for an initial screening method. Cunnien's threshold model guides clinicians to suspect malingering when an evaluee presents with physical and psychological symptoms accompanied by any of the following features:

1. Suspicion of voluntary control over symptoms as demonstrated by
   - Bizarre or absurd symptomatology
   - Atypical symptomatic fluctuations consistent with external incentives
   - Unusual symptomatic response to treatment
2. Atypical presentation in the presence of environmental incentives or noxious environmental conditions
3. Complaints grossly in excess of clinical findings
4. Substantial noncompliance with treatment

If the initial interaction with an evaluee triggers suspicion of malingering, clinicians should search for further clinical clues that will support or refute this conclusion. Many of these clues can be obtained from the initial, unstructured clinical interview and have been reviewed in the previous section (see "Case Vignettes").

Rogers (1990) stresses the importance of examining an evaluee's self-reports during assessment of malingering, and clinicians may be able to facilitate these reports during the initial interview. Clinicians should rely on their experience and the study of the presentations of true illnesses and their characteristic symptoms in helping them recognize an abnormal pattern of self-reported symptoms. Rogers encourages clinicians to be on watch for endorsement of an unusually high number of symptoms that are rare, blatant, absurd, and preposterous and that are nonselectively endorsed. *Rare symptoms* are those that occur very infrequently among psychiatric evaluees. *Blatant symptoms* are those that are immediately recognized by nonprofessionals as indicative of severe psychopathology. For example, an individual who presents to an emergency room reporting he is "suicidal, homicidal, and

hearing voices telling me to kill myself and other people" is displaying blatant symptoms. Improbable or absurd symptoms are almost never reported or affirmed in even severely disturbed evaluees. An individual who endorses the belief that "honeybees are involved in a plot to kill the president" is demonstrating an improbable and absurd symptom. Nonselective endorsement of symptoms refers to a self-reporting strategy used by malingerers based on the belief that the more symptoms they endorse, the more likely they are to be assessed as ill.

Clinicians should be especially mindful of their interviewing technique if malingering is suspected during the initial interview. Lees-Haley and Dunn (1994) found that a vast majority of untrained subjects were able to endorse symptoms on checklists to meet the DSM-III-R (American Psychiatric Association 1987) self-report criteria for major depression, generalized anxiety disorder, and PTSD. Thus, clinicians should always be cautious in their use of leading questions when interviewing evaluees suspected of malingering (Resnick 1999). Rather, clinicians who suspect malingering should consider relying at first on open-ended questions. After evaluees have been given an adequate chance to report symptoms in their own words, clinicians can ask specific detailed questions that help to characterize symptoms as typical or atypical. For example, in the later stages of the interview, the clinician may ask an individual reporting auditory and visual hallucinations whether he or she has a strategy to diminish voices or whether visual hallucinations only occur in black and white (see Table 17–2).

Clinicians who suspect malingered mental illness during the initial interview and who would like to take a more structured approach to screening may benefit from use of forensic assessment instruments designed as screening measures to provide information regarding the probability that an individual is malingering psychiatric illness. Such an instrument is the Miller Forensic Assessment of Symptoms Test (M-FAST). It was validated among known-groups and in simulation designs and takes approximately 5–10 minutes to administer (Miller 2001); thus, it is feasible to incorporate into the initial interview. Forensic evaluators should also be aware that scales to assist in screening for feigning have been incorporated into a recently developed competence to stand trial assessment instrument, the Evaluation of Competency to Stand Trial—Revised (Rogers et al. 2004). Such scales may assist in the overall process of screening for malingering specific to assessments of competence to proceed.

After the initial interview, some clinicians may feel comfortable having ruled out the diagnosis of malingering. Others may have found clues that heighten their suspicion. The latter clinicians should consider proceeding further, utilizing specific techniques useful in establishing the diagnosis of malingering.

Collateral Data

The review of collateral data is a crucial part of the assessment process. Any information that supports or refutes the evaluee's symptoms may be considered collateral information. Such data may include the following material:

- Depositions, transcripts of court testimony, and sworn affidavits
- School and employment records
- Personnel files
- Hospital and treatment records
- Records of psychological testing and prior forensic reports
- Insurance records (or other information gathered by an insurance agency to investigate a claim) (Crane 2000)
- Military records (Form DD 214 may be especially useful in assessments for malingered military-related PTSD) (Resnick 2003)
- Police reports, witness statements, and video or audio interviews in criminal cases
- Criminal background check
- Surveillance tapes

Clinicians who have access to these data have information with which to compare the evaluee interview and self-report. Information that is inconsistent with the symptoms reported by the individual during the clinical interview may support a diagnosis of malingering. Conversely, collateral data that are consistent with the findings of the interview may help clinicians rule out malingering.

Most evaluators prefer to review collateral data prior to the evaluation so they can address unclear or contradictory issues during the interview. Some evaluators prefer to review collateral data after their clinical interview. Regardless of when collateral data are reviewed, clinicians should be certain to examine this information and look for consistencies or inconsistencies in reported symptoms.

Resnick (2003) has suggested also interviewing a close family member or associate who is familiar with the evaluee's daily habits and symptoms. Such interviews can validate or refute the individual's report of symptoms and would best be conducted separately from the interview of the evaluee.

Once all collateral data have been collected, clinicians may find inconsistencies that tend to support malingering. Some clinicians find they wish to "confront" the evaluee about inconsistencies. A more productive approach involves the clinician seeking *clarification* from the evaluee. The decision to seek clarification about inconsistencies should be handled with care, given that malingerers may respond to such examination by escalating their behavior in an attempt to justify their self-reports. Because of this phenomenon, seeking clarification about inconsistencies from a dangerous individual

or an individual with a history of acting out should be undertaken with adequate mental health staff or security backup. Clinicians should be mindful of their own reactions when interacting with an individual suspected of malingering and take care to avoid accusations of "lying," because such an interaction may only escalate the potential for anger on the part of the evaluee and is unlikely to result in further information being provided for consideration. Clinicians are best served by pointing out inconsistencies in a nonjudgmental manner and then asking the evaluee whether he or she would like to provide commentary on the inconsistencies. Sometimes such a process provides no further information; however, in our experience, there is a minority of cases in which the individual suspected of malingering will directly affirm that he or she has been feigning.

The statement "Remember your ABCs" (LeBourgeois 2007) may be useful to clinicians who decide to seek clarification about inconsistencies from evaluees. This is also a useful mnemonic to provide to trainees conducting malingering assessments:

- Avoid accusations of lying
- Beware of countertransference
- Clarification is being sought, not a "confrontation"
- Security measures

Psychological Assessment and Structured Clinical Interviews

In this section we provide an introduction to and sources for further study of techniques used in the formal psychological assessment of possible exaggeration and/or malingering. The importance of formal assessment is clearly demonstrated by aforementioned data regarding base rates of this condition, particularly in forensic settings. The quantity and sophistication of ongoing published research that focuses on the demographics of malingering and the efficacy and clinical utility of clinical assessment have continued to increase since publication of the first edition of this text in 2004. Excellent comprehensive secondary source references by Boone (2007), Larrabee (2007), Rogers (2008), and Sweet (1999) are recommended.

Traditionally, investigation of malingered cognitive deficits in both civil and criminal venues was the primary area of neuropsychological study (Slick et al. 1999; Sweet et al. 2008), but there is now expanding research related to chronic pain patients (Bianchini et al. 2005), Social Security disability ap-

plicants (Chafetz 2008; Chafetz et al. 2007), in criminal settings (Ardolf et al. 2007; Jelicic et al. 2004) and among medical patients (McDermott and Feldman 2007; McDermott et al. 2008).

In addition to determining the frequency and characteristics of malingered performance, recent research has focused on the formal assessment of abnormal effort, negative response bias, frank malingering and other behavioral factors that interfere with valid test performance. Such efforts typically use the following approaches: 1) clinical observation of test behaviors at different times and while taking various psychometric tests; 2) standard clinical personality measures (e.g., MMPI-2); 3) specifically designed, free-standing, objective measures of inadequate effort, exaggeration and malingering (e.g., Word Memory Test); 4) computation of "embedded symptom validity tests" derived from standard neuropsychometric test data (Larrabee 2003); and 5) methods of analyzing unusual, inconsistent, and discrepant patterns of performance on tests used within a standard psychological assessment test battery (internal inconsistencies, inconsistencies between test performance and observed behavior, inconsistencies between test results and the expected pattern based on the known neurological history).

Psychologists routinely administer the following standard personality measurement tests: typically, the MMPI-2 or Minnesota Multiphasic Personality Inventory–2—Reformed Version (MMPI-2-RF), Millon Clinical Multiaxial Inventory–3 (MCMI-3), and Personality Assessment Inventory (PAI). Each of these objective personality measures includes validity scales that enable the psychologist to assess response patterns that could negatively affect the validity of test results and/or reflect malingering, such as exaggeration, defensiveness, untruthfulness, inconsistency in responding over time, and tendency to respond excessively in either a positive (true) or negative (false) manner. The FBS, or Faking Bad Scale, on the MMPI-2 (Greiffenstein et al. 2007) is controversial but potentially very useful in detecting the overreporting of health and cognitive concerns. Bieliauskas (1999) and Greene (1999) provide comprehensive reviews of the use of the MMPI-2 and other personality measures to assess potential malingering in clinical and forensic practice. There has also been research on the use of a variety of other self-report symptom checklists for health concerns and pain as indicators of exaggeration/malingering (Larrabee 2007).

Observation of behavior during test performance often provides valuable information regarding the evaluee's style of presentation and pattern of attention, involvement, and effort. Among the factors that should be clinically assessed are 1) inadequate and/or variable levels of effort on standard psychological tests, 2) presence of atypical or implausible behavior and test responses, 3) inconsistency in style or quality of behavior and test performance over time and across tests of similar cognitive/emotional functioning, and 4) inconsistencies between test performance and observed behavior and/

or expected patterns of functioning based on the neurological history (Sweet 1999). A comparison of performance on tests of specific emotional and cognitive functions and the evaluee's functioning in real-life situations can provide compelling evidence of malingering. Discrepancies between test results on the MMPI-2 clinical scales suggesting significant emotional distress or on cognitive tests suggesting memory dysfunction, and actual functioning that is inconsistent with test results, suggest exaggeration or malingering rather than a genuine disorder or deficit. In addition, an analysis of test patterns can reveal test performance that is implausible or incompatible with the evaluee's history and/or clinical presentation.

In addition to the standard personality measures, a number of objective structured interviews and assessment procedures are available to improve the clinical evaluation of malingered psychiatric illness. These include the M-FAST, Rogers Criminal Responsibility Assessment Scales (R-CRAS), and Structured Interview of Reported Symptoms (SIRS) (see Iverson and Binder 2000; Vickery et al. 2001).

Lastly, a variety of objective cognitive measures have been specifically designed and validated for the detection of symptom validity. Most such instruments are based on the premise that individuals who tend to malinger or dissimulate in an attempt to magnify symptoms will perform less adequately than normally functioning or genuinely brain-damaged patients on even simple measures of cognitive functioning. Among the more commonly employed and most useful of these tests are the Computerized Assessment of Response Bias (CARB), Test of Memory Malingering (TOMM), Victoria Symptom Validity Test (VSVT), Word Memory Test, Validity Indicator Profile, Portland Digit Recognition Test (PDRT), and Digit Memory Test. A wide range of other procedures are also available. Iverson and Binder (2000), Larrabee (2007), and Boone (2007) have provided comprehensive reviews of the various psychometric measures currently available to aid in the assessment of symptom validity/malingering. For further information regarding the clinical utility of formal symptom validity measures, see the listed reference texts in the "References" section at the end of this chapter.

The assessment of an individual who is suspected of malingering should include the following procedures:

1. Careful evaluation of inadequate effort (or frank malingering) across the battery of tests used.
2. Use of specific, current, and valid tests of symptom validity, including cognitive forced-choice and standard personality measures.
3. Examination of illogical or unique malingering response patterns (e.g., Ganser-like answers [approximate but incorrect answers to questions, for example, 7 + 3 = 11]).

4. Examination of excessive inconsistency in the quality of performance during the course of the evaluation—in particular, differences in the adequacy of performance on tests of similar cognitive or emotional functions (e.g., abnormal memory performance on one test and normal performance on another; significant self-reported depression but minimal symptoms of depression on the MMPI-2).
5. Comparison of the difference between performance on psychological tests and the quality of functioning in real-life situations. Objective collateral data sources are very important.
6. Determination of the logical relationship between the history (medical, psychiatric, and social) and the evaluee's presentation within the context of the formal evaluation. Are the observed behaviors and test performance reasonably consistent with the pattern expected on the basis of the neurological history?

Conclusion

Forensic settings provide multiple and powerful incentives for malingering clinical conditions. Clinicians providing any type of forensic evaluation must consider the possibility of malingering and adopt a low threshold of suspicion for making this assessment. This stance differs from that adopted in purely clinical evaluations, where, in most cases, clinicians reasonably assume that individuals seeking treatment are motivated to be truthful in order to obtain accurate diagnoses and effective treatment. Nevertheless, the conclusion that an evaluee is malingering should not be made without good supporting evidence, given that its implications for the evaluee may be profound. A conclusion that an evaluee is malingering should be based on a variety of evidence, including clinical presentation, review of records, collateral information, and, when necessary, psychological testing.

Key Points

- Clinicians across all specialties may encounter malingering, but clinicians should be particularly aware of the potential for malingering in forensic settings.

- An atypical presentation in the presence of external incentive should trigger suspicion of malingering during assessment of an evaluee.
- Clinicians who suspect malingering may use techniques to establish or rule out the diagnosis of malingering.
- A diagnosis of malingering requires evidence gathered from clinical interviews, review of collateral data, and, often, psychological testing. A diagnosis of malingering should not be made on the basis of any one piece of information, such as personality testing, but rather on the basis of an integrated assessment.
- Clinicians are aware of the potential for stigmatizing of evaluees mistakenly assessed as malingering; therefore, they may avoid making the diagnosis or seeking clarification from evaluees suspected of malingering. Clinicians may feel more confident in their opinions regarding malingering if they follow the guidelines suggested in the section on "Practice Guidelines" for malingering assessment.

Practice Guidelines

1. Consider malingering in the differential diagnosis, especially in forensic settings.
2. During the initial interview, be on the watch for endorsement of an unusually high number of symptoms that are rare, blatant, absurd, and preposterous and that are nonselectively endorsed.
3. Be cautious in the use of leading questions when interviewing evaluees suspected of malingering. Rather, use open-ended questions at the outset of the interview, and later ask detailed questions that help to characterize symptoms as typical or atypical of the mental disorder in question.
4. Review collateral data for consistencies or inconsistencies that support or refute a diagnosis of malingering.
5. Employ psychological testing when clinical interview and review of collateral data result in a suspicion of malingering but it cannot be conclusively determined that malingering is present.
6. "Remember your ABCs" when seeking clarification from evaluees regarding inconsistencies. Avoid accusations of lying; Beware countertransference; seek Clarification, not a "confrontation;" and undertake Security measures. Such a process may better ensure safety and a more productive interview.
7. Make a diagnosis of malingering on the basis of an assessment that integrates many sources of information.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Anon: Des inhalations d'ether comme moyen de reconnaître les maladies simulées. Gaz Méd Paris 2:209, 1847

Ardolf BR, Denney RL, Houston CM: Base rates of negative response bias and malingered neurocognitive dysfunction among criminal defendants referred for neuropsychological evaluation. Clin Neuropsychol 21:899–916, 2007

Bianchini KJ, Greve KW, Glynn G: On the diagnosis of malingered pain related disability: lessons from cognitive malingering research. Spine J 5:404–417, 2005

Bianchini KJ, Curtis KL, Greve KW: Compensation and malingering in traumatic brain injury: a dose-response relationship? Clin Neuropsychol 20:831–847, 2006

Bieliauskas L: The measurement of personality and emotional functioning, in Forensic Neuropsychology. Edited by Sweet JJ. Lisse, The Netherlands, Swets & Zeitlinger, 1999, pp 121–143

Binder LM, Rohling ML: Money matters: a meta-analytic review of the effects of financial incentives on recovery after closed-head injury. Am J Psychiatry 153:7–10, 1996

Bolan B, Foster JK, Schmand B, et al: A comparison of three tests to detect feigned amnesia: the effects of feedback and the measurement of response latency. J Clin Exp Neuropsychol 24:154–167, 2002

Boone KB (ed): Assessment of Feigned Cognitive Deficits. New York, Guilford, 2007

Cassar JR, Hales ES, Longhurst JG, et al: Can disability benefits make children sicker? J Am Acad Child Adolesc Psychiatry 35:700–701, 1996

Chafetz MD: Malingering on the Social Disability consultative exam: predictors and base rates. Clin Neuropsychol 22:529–546, 2008

Chafetz MD, Abrahams JP, Kohlmaier J: Malingering on the Social Security Disability consultative exam: a new rating scale. Arch Clin Neuropsychol 22:1–14, 2007

Clark RC: Sociopathy, malingering, and defensiveness, in Clinical Assessment of Malingering and Deception, 2nd Edition. Edited by Rogers R. New York, Guilford, 1997, pp 68–84

Crane M: How high-tech private eyes catch malingering plaintiffs. Medical Economics 77(14):122–124, 130–132, 137, 2000

Cunnien AJ: Psychiatric and medical syndromes associated with deception, in Clinical Assessment of Malingering and Deception, 2nd Edition. Edited by Rogers R. New York, Guilford, 1997, pp 23–46

DeToledo JC: The epilepsy of Fyodor Dostoyevsky: insights from Smerdyakov Karamazov's use of a malingered seizure as an alibi. Arch Neurol 58:1305–1306, 2001

Edens JF, Buffington JK, Tomicic TL: An investigation of the relationship between psychopathic traits and malingering on the psychopathic personality inventory. Assessment 7:281–296, 2000

Eisendrath SJ: When Munchausen becomes malingering: factitious disorders that penetrate the legal system. Bull Am Acad Psychiatry Law 24:471–481, 1996

Frueh BC, Gold PB, de Arellano MA: Symptom overreporting in combat veterans evaluated for PTSD: differentiation on the basis of compensation seeking status. J Pers Assess 68:369–384, 1997

Gacono CB, Meloy JR, Sheppard K, et al: A clinical investigation of malingering and psychopathy in hospitalized insanity acquittees. Bull Am Acad Psychiatry Law 23:387–397, 1995

Gavin H: On Feigned and Factitious Diseases Chiefly of Soldiers and Seamen. London, J Churchill, 1843

German employers ill over CD showing how to fake for sick days. Knight Ridder/Tribune News Service, February 09, 2001. Available at: http://www.accessmylibrary.com/coms2/summary_0286-5836580_ITM. Accessed January 12, 2010.

Gittelman DK: Malingered dementia associated with battered women's syndrome. Psychosomatics 39:449–452, 1998

Goodwin DW, Alderson P, Rosenthal R: Clinical significance of hallucinations in psychiatric disorders: a study of 116 hallucinatory patients. Arch Gen Psychiatry 24:756–780, 1971

Greene RL: The MMPI-2/MMPI: An Interpretative Manual, 2nd Edition. Boston, MA, Allyn & Bacon, 1999

Greenfield D: Feigned psychosis in a 14-year-old-girl. Hosp Community Psychiatry 38:73–77, 1987

Greiffenstein MF, Fox D, Lees-Haley PR: The MMPI-2 Fake Bad Scale in detection of noncredible brain injury claims, in Assessment of Feigned Cognitive Impairment. Edited by Boone KB, New York, Guilford, 2007

Greve KW, Ord JS, Bianchini KJ, et al: prevalence of malingering in chronic pain patients referred for psychological evaluation in a medico-legal context. Arch Phys Med Rehabil 90:1117–1126, 2009

Iverson GL, Binder LM: Detecting exaggeration and malingering in neuropsychological assessment. J Head Trauma Rehabil 15:829–858, 2000

Jelicic M, Merckelbach H, van Bergen S: Symptom validity testing of feigned amnesia for mock crime. Arch Clin Neuropsychol 19:525–531, 2004

Larrabee G: Detection of malingering using atypical performance patterns on standard neuropsychological tests. Clin Neuropsychol 17:410–425, 2003

Larrabee G (ed): Assessment of Malingered Neuropsychological Deficits. New York, Oxford University Press, 2007

LeBourgeois HW III: Malingering: key points in assessment. Psychiatric Times, Vol 24, 2007. Available at: http://www.psychiatrictimes.com/display/article/10168/54091. Accessed March 7, 2009.

LeBourgeois HW III, Foreman TA, Thompson JW Jr: Novel cases: malingering by animal proxy. J Am Acad Psychiatry Law 30:520–524, 2002

Lees-Haley PR, Dunn JT: The ability of naive subjects to report symptoms of mild brain injury, post-traumatic stress disorder, major depression, and generalized anxiety disorder. J Clin Psychol 50:252–256, 1994

Lewinsohn PM: An empirical test of several popular notions about hallucinations in schizophrenic patients, in Origin and Mechanisms of Hallucinations. Edited by Keup W. New York, Plenum, 1970, pp 401–403

Mahowald MW, Schenck CH, Rosen GM, et al: The role of a sleep disorder center in evaluating sleep violence. Arch Neurol 49:604–607, 1992

McConville JB Jr, LeBourgeois HW III: A case of feigned dissociative identity disorder? You be the judge. Paper presented at The Annual Tulane Forensic Symposium, New Orleans, LA, April 2008

McDermott BF, Feldman MD: Malingering in the medical setting. Psychiatr Clin North Am 30:645–662, 2007

McDermott BF, Leamon MH, Feldman MD, et al: Factitious disorder and malingering, in The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition. Edited by Hales RE, Yudofsky SC, Gabbard GO. Washington, DC, American Psychiatric Publishing, 2008, pp 643–664

Miller HA: Miller Forensic Assessment of Symptoms Test Professional Manual. Lutz, FL, Psychological Assessment Resources, 2001

Mittenberg W, Patton C, Canyock E, et al: Base rates of malingering and symptom exaggeration. J Clin Exp Neuropsychol 24:1094–1102, 2002

Odysseus. Wikipedia, the free encyclopedia. Available at: http://en.wikipedia.org/wiki/Odysseus. Accessed March 7, 2009.

Paniak C, Reynolds S, Toller-Lobe G, et al: A longitudinal study of the relationship between financial compensation and symptoms after treated mild traumatic brain injury. J Clin Exp Neuropsychol 24:187–193, 2002

Resnick PJ: Malingering of posttraumatic stress disorders, in Clinical Assessment of Malingering and Deception, 2nd Edition. Edited by Rogers R. New York, Guilford, 1997, pp 130–152

Resnick PJ: The detection of malingered psychosis. Psychiatr Clin North Am 22:159–172, 1999

Resnick PJ: Guidelines for evaluation of malingering in PTSD, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Edited by Simon RI. Washington, DC, American Psychiatric Publishing, 2003, pp 187–205

Resnick PJ, Knoll JL IV: Malingered psychosis, in Clinical Assessment of Malingering and Deception, 3rd Edition. Edited by Rogers R. New York, Guilford, 2008, pp 51–68

Resnick PJ, West S, Payne JW: Malingering of posttraumatic stress disorders, in Clinical Assessment of Malingering and Deception, 3rd Edition. Edited by Rogers R. New York, Guilford, 2008, pp 111–112

Richards L: Malingering and desertion campaigns, in Black Art: British Covert Psychological Warfare Against the Third Reich (in press). Excerpted chapter available at http://www.psywar.org/malingering.php. Accessed March 7, 2009.

Rissmiller DA, Steer RA, Friedman M, et al: Prevalence of malingering in suicidal psychiatric inpatients: a replication. Psychol Rep 84:726–730, 1999

Rogers R: Development of a new classificatory model of malingering. Bull Am Acad Psychiatry Law 18:323–333, 1990

Rogers R: Introduction, in Clinical Assessment of Malingering and Deception, 2nd Edition. Edited by Rogers R. New York, Guilford, 1997, pp 1–19

Rogers R (ed): An introduction to response styles, in Clinical Assessment of Malingering and Deception, 3rd Edition. New York, Guilford, 2008, pp 1–13

Rogers R, Sewell KW, Goldstein A: Explanatory models of malingering: a prototypical analysis. Law Hum Behav 18:543–552, 1994

Rogers R, Tillbrook CE, Sewell KW: Evaluation of Competency to Stand Trial—Revised Professional Manual. Lutz, FL, Psychological Assessment Resources, 2004

Rubinstein JS: Abuse of antiparkinsonism drugs: feigning of extrapyramidal symptoms to obtain trihexyphenidyl. JAMA 239:2365–2366, 1978

Sherman M, Trief P, Strafkin R: Impression management in the psychiatric interview. J Consult Clin Psychol 43:867–871, 1975

Slick DJ, Sherman EM, Iverson GL: Diagnostic criteria for malingered neurocognitive dysfunction: proposed standards for clinical practice and research. Clin Neuropsychol 13:545–561, 1999

Stutts JT, Hickey SE, Kasdan ML: Malingering by proxy: a form of pediatric condition falsification. J Dev Behav Pediatr 24:276–278, 2003

Sweet JJ (ed): Malingering: differential diagnosis, in Forensic Neuropsychology. Lisse, the Netherlands, Swets & Zeitlinger, 1999, pp 255–312

Sweet JJ, Condit DC, Nelson NW: Feigned amnesia and memory loss, in Clinical Assessment of Malingering and Deception, 3rd Edition. Edited by Rogers R. New York, Guilford, 2008, pp 218–236

Turner M: Malingering. Br J Psychiatry 171:409–411, 1997

Vickery CD, Berry DTR, Inman TH, et al: Detection of inadequate effort on neuropsychological testing: a meta-analytic review of selected procedures. Arch Clin Neuropsychol 16:45–73, 2001

Yates BD, Nordquist CR, Schultz-Ross RA: Feigned psychiatric symptoms in the emergency room. Psychiatr Serv 47:998–1000, 1996

Suggested Readings

Bianchini KJ, Curtis KL, Greve KW: Compensation and malingering in traumatic brain injury: a dose-response relationship? Clin Neuropsychol 20:831–847, 2006

Edens JF, Guy LS, Otto RK, et al: Factors differentiating successful versus unsuccessful malingerers. J Pers Assess 77:333–338, 2001

Eisendrath SJ: When Munchausen becomes malingering: factitious disorders that penetrate the legal system. Bull Am Acad Psychiatry Law 24:471–481, 1996

Larrabee, GJ: Assessment of Malingered Neuropsychological Deficits. New York, Oxford University Press, 2007

Resnick PJ: The detection of malingered psychosis. Psychiatr Clin North Am 22:159–172, 1999

Rogers R (ed): Clinical Assessment of Malingering and Deception, 3rd Edition. New York, Guilford, 2008

Simon RI (ed): Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd Edition. Washington, DC, American Psychiatric Publishing, 2003

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Chapter 18

Children and Adolescents

Peter Ash, M.D.

Forensic work in child and adolescent psychiatry tends to have a different thrust from forensic work with adults. In a case involving adults, the psychiatric expert is typically retained by a party to the case (although some evaluations are court-ordered and the expert is an expert for the court). This places the expert on one side or the other of an adversarial process. Moreover, the well-being of the evaluee is not the court's prime consideration. In contrast, regardless of which adult or agency is paying the bill, the expert in both civil and criminal matters involving juveniles is often expected to evaluate and advocate for the well-being of the child. In cases involving child placement, the child is often not even formally a party to the case. Such a role allows the expert to occupy a position somewhat above the fray, because the expert is not beholden to any of the parties in the case.

The most common civil forensic questions psychiatrists are called on to answer regarding children involve cases of divorce and child abuse or neglect. In divorce cases, the issues involve child custody and the parents are the named parties. In abuse/neglect cases, issues pertain to child placement, and the parties are the state and the parent(s). In most criminal cases involving minors, the minor is before a juvenile court. The mission of juvenile courts includes rehabilitation of the juvenile, which also leads the court to a consideration of the minor's best interest. This emphasis on the child's inter-

ests gives child forensic work a more therapeutic focus and is more familiar to clinicians who view themselves primarily as therapists.

A second key difference in forensic work with children and adolescents is that interviewing young persons requires different techniques from evaluating adults. The accreditation guidelines for forensic psychiatry training programs specifically require that those fellows who have not completed a fellowship in child and adolescent psychiatry do not independently conduct forensic evaluations of children under the age of 14 years (Accreditation Council for Graduate Medical Education 1996). There is, however, a national shortage of child and adolescent psychiatrists. Thus, in underserved, nonurban areas, some general psychiatrists who lack formal fellowship training but who nevertheless have considerable experience working with youth do conduct forensic evaluations involving children. Forensic work with preadolescents, which requires specialized techniques and training, is beyond the scope of this chapter. The interested reader or child and adolescent psychiatrist is referred to standard works on forensic child and adolescent psychiatry (Benedek et al. 2009; Haller 2002) and the Suggested Readings section at the end of this chapter.

Adolescents are a different matter. Many general psychiatrists who lack child psychiatry fellowship training nevertheless have had some training and experience working with adolescents, and so also conduct forensic evaluations on this population. A general psychiatrist who undertakes a forensic evaluation of an adolescent should expect that his or her expertise in working with this age group will be the subject of cross-examination, and thus should think through carefully how he or she will justify his or her expertise to the court.

Even for a clinician who does not see children, adult patients, in their role as parents, may become involved in litigation concerning their children. Thus, the range of issues in child and adolescent forensic psychiatry that may affect the work of a general psychiatrist is very wide. This chapter discusses general principles in child and adolescent forensic psychiatry. It emphasizes examples of child and adolescent forensic work in which the general psychiatrist is most likely to become involved—primarily cases that involve evaluating a parent of a younger child and cases dealing with adolescents.

Comparing Child and Adolescent Cases With Adult Cases

Some child and adolescent forensic cases follow the same formal legal structure as similar cases involving adults. For example, the statutory test for civil commitment of a minor is the same as the statutory test for the commitment

of an adult. Nevertheless, a commitment case involving a minor is somewhat different in the way the case actually evolves. A minor can be admitted involuntarily when a physician recommends admission and a parent consents (*Parham v. J.R. and J.L.* 1979). Commitment of a minor only becomes necessary when parents refuse voluntary admission or actively oppose admission and the youth meets commitment criteria.

Many differences in cases involving minors follow from two legal presumptions: 1) minors are less responsible for their actions than are adults, and 2) minors are less legally competent than adults. Salient differences in child and adolescent cases in which the forensic tests are formally the same as in adult cases are listed in Table 18–1.

However, cases concerning minors in which there are no clear adult parallels are frequently referred for evaluation. This group of cases arises from the different standing of adults and children under the law. The law generally presumes that children are incompetent to make decisions, and their parents or guardian legally speaks for them. Forensic cases involving minors in which there are no clear adult analogues arise in situations in which the parents are not in a position to speak appropriately for the child. These can include circumstances such as when the parents themselves disagree (custody in divorce), have interests opposed to the child (abuse and neglect), or when the child acts outside the parent's control (delinquency, certain medical care issues).

Forensic evaluations focus on whether or not the individual's condition meets a forensic test specific to the matter at issue. Forensic tests in similar cases vary from state to state and in federal jurisdictions. Nevertheless, certain general principles cut across jurisdictions. Typical forensic tests in cases involving minors that have no clear counterpart in adult forensic work are shown in Table 18–2.

Beginning a Forensic Evaluation

Clarifying Role

Clinicians who do not have a great deal of forensic experience may find that some consultations go awry and result in considerable hair-pulling. Generally, this occurs when the consultant's role is not clearly defined at the beginning of his or her involvement in the case. Before beginning the evaluation, the forensic consultant should have a clear understanding of the pertinent issues, which can be clarified by asking the following questions:

TABLE 18–1. Key differences in cases involving minors in which the forensic test is the same as for adults

Issue	Difference from adult cases
Civil cases	
Malpractice	Since minors are less responsible than adults, clinicians have a greater duty to protect from other patients, from committing suicide, etc.
Personal injury	Minors are more sympathetic plaintiffs. Minors are held to a lesser degree of responsibility, which tends to shift responsibility to defendants.
Civil commitment	Less common because in most states only required if parents refuse to voluntarily admit minor.
Civil competency	Presumed legally incompetent except in specific situations authorized by state law.
Disability	Social Security disability criteria for children worded slightly differently. School-related issues mostly governed by education legislation.
Special education services	Is child "seriously emotionally disturbed"? If so, what special educational services are appropriate?
School threat assessment	Different techniques from workplace violence assessment.
Criminal cases	
Competency to stand trial	Only about half the states require competency to stand trial in juvenile court. Incompetence in some states may be due to developmental immaturity.
Criminal responsibility	Not usually a defense in juvenile court. Rare in adolescents waived to adult court.
Competency to waive a constitutional right (such as competency to confess, waive right to counsel, or plead guilty)	Developmental considerations affect whether waiver is knowing, intelligent, and voluntary.
Sex offenders	More treatable than adults.

TABLE 18–2. Forensic child and adolescent cases without clear adult analogues

Issue	Typical forensic test
Custody in the context of divorce	Best interests of the child.
Abuse/neglect proceedings	Varies according to the stage of the proceeding: Was the child abused or neglected? Are the parents fit to raise the child? Should protective services pursue reunification? Is termination of parental rights in the best interests of the child?
Adoption	Is termination of parental rights in the best interests of the child? If mother is a minor, is she competent to give up child for adoption?
Medical care	
Can minor provide consent?	Varies according to state law. Although general rule is that minors cannot provide consent, state law may give some minors authority to provide consent in certain situations (such as outpatient therapy, treatment of sexually transmitted diseases, contraception) or a right to object (such as to psychiatric hospitalization). Some states allow a "mature minor" to provide consent.
Consent to an abortion without parental consent	Is girl a "mature minor"?
Participation in research that will not benefit minor	Assent required if minor can understand general nature of participation, in addition to parental consent.
Consent for organ donation	For donations that pose more than minimal health risk to minor, assent of minor plus judicial review.
Delinquency	
Study and report	What mental health issues are relevant in rehabilitating and planning a disposition for the delinquent?
Waiver to adult court	Risk of future dangerousness and amenability to rehabilitation.

1. What is the forensic question that needs to be answered?
2. Who is requesting the evaluation: the minor, a parent, a guardian *ad litem,* an attorney, the court?
3. Who is to be interviewed?
4. If a minor is being interviewed, who will give informed consent for the evaluation?
5. What are the limits on confidentiality in the evaluation?
6. To whom will the report be sent (including to what extent a parent will control whether the report is sent at all)?
7. What are the arrangements for paying the fees?

These issues are frequently more complex in cases involving minors than in cases involving adults. First, minors have limited formal decision-making authority, and so, although the minor may be the subject of a case, others will often be speaking for the minor in court. Second, in child placement cases, both in divorce/custody and in abuse/neglect proceedings, the child is typically not a formal party to the case at all. In such cases, the consultant should consider in advance how (or if) the report will be brought to the attention of the court in the event a parent does not like the outcome. If the child is not a party to the case, the court may appoint a guardian *ad litem* to speak for the child's interests. Some particulars of defining this role will be discussed in the case vignettes that follow.

Fees should generally be paid prior to conducting the work and, in any event, prior to completing the evaluation, unless the retaining agent is a corporate defendant or state agency. A parent who is disappointed in an evaluation is easily tempted to withhold payment, either to save money or to prevent distribution of the report. An evaluator who is concerned that he or she might not be paid the full fees may be subject to a subtle source of bias, which may be brought out on cross-examination ("Now doctor, do you really think you'll be paid for your testimony today if it's not favorable to Mr. X?").

Forensic Evaluations of One's Own Patients

Not uncommonly, a minor or a parent in treatment will become the subject of a legal proceeding. The attorney for either the child or a parent may wish to use the treating clinician as the expert on the grounds that the clinician knows the child or parent best. However, a treating clinician is best advised to avoid becoming the expert in such cases. By conducting a forensic evaluation, the clinician takes on a duty toward the court, in addition to continuing his or her duty to the patient. This dual role conflict is known as the *double-agent problem* (being the

agent of the child, as therapist, and being an agent of the court or parent, as forensic evaluator). Conflicting duties give rise to a host of difficulties (see Chapter 5, "Ethics in Forensic Psychiatry," this volume). Even if the psychiatrist believes the double-agent problem can be surmounted, the court is likely to see the treating psychiatrist as biased toward his or her patient and partially discount the weight it gives to the expert's opinions. It is almost always preferable to refer one's patient to another clinician for forensic evaluation.

Such a referral is also advisable because the expert role is usually quite disruptive of treatment. Conducting a forensic assessment will generally require going outside the established treatment relationship. Once the child (or parent) knows that the therapist is a route to the judge, confidentiality goes out the window, the patient has a motive to distort what he or she tells the therapist, and the parameters of the treatment change. Furthermore, the treating clinician may not have a well-formed opinion on the particular forensic issue. For example, if a divorcing parent wishes the clinician to give an opinion on post-divorce custody arrangements, the clinician may well not have assessed the parents' parenting capacity or compared their relationships with the child.

An attorney for a parent may nevertheless subpoena the treating psychiatrist out of a sense of efficiency or for other reasons. Such actions can sometimes be discouraged. For example, in a child custody case in which a mother's attorney threatens to subpoena the child's treating psychiatrist, the therapist may point out that such an action will disrupt the child's treatment, and thus may serve as evidence that the mother is not acting in the best interest of the child.

Consent for Evaluation

If a forensic evaluation of a minor is court-ordered, parental consent is not required. If an evaluation is requested by a parent, the evaluator should obtain the informed consent of the parent, which should include a signed release to send the report to designated recipients. In limited situations, an adolescent can provide consent for the evaluation. Such situations arise if the adolescent is emancipated (because he or she is married, in the military, or is self-supporting and living independently), waived to adult criminal jurisdiction, or can consent to treatment (as when a girl is seeking to obtain an abortion without her parents' knowledge). In any event, the evaluator should explain to the child or adolescent, in developmentally appropriate terms, the nature of the evaluation and with whom information will be shared.

Exceptions to Confidentiality

As a general rule, confidentiality is controlled by the person or agency that provides legal consent for the evaluation. In some instances, most often in

order to protect a child, legal and ethical obligations compel a treating clinician to disclose forensically relevant information to outside agencies without a release from the consenting party. All psychiatrists in all states have a duty to report reasonable suspicions of child abuse to the state child protective agency, even if the information that gave rise to the concern was obtained in a confidential communication. State laws vary in some respects as to what behaviors constitute abuse and whether abuse by noncaretakers needs to be reported. All clinicians should be familiar with the reporting statute in their jurisdiction. However, they should also be aware that the duty to breach confidentiality ends with the report and the basis for it. Courts have generally held that only that information which gave rise to the report is discoverable (*People v. Stritzinger* 1983; *State v. Andring* 1984). The clinician does not generally have a duty to further investigate the abuse (although the abuse may well become a clinical issue needing attention).

Clinicians confronting the unenviable necessity of reporting their own patient as a suspected child abuser face the challenge of conforming to their duty to report and attempting to maintain the therapeutic alliance. Under such circumstances, it is almost always best to discuss with the patient that one is making the report and why. Many therapists fear that such a patient will become angry and either quit therapy or mistrust the therapist in the future. An open acknowledgment of the difficulty and an offer to help the parent resolve the difficulties that gave rise to the reported behaviors often allow the patient to continue to see the therapist as an ally. A clinician who does not tell his or her patient about the report runs the risk that the patient will think the therapist is complicit with the abuse (many patients know about reporting duties) or that the patient will later find out about the report (the anonymity of reports is not all it might be) and feel betrayed.

Child Custody Related to Divorce

Case Vignette 1

Mr. J came to treatment for help with his depressed feelings arising out of an impending divorce. While in treatment, he asks his psychiatrist to write a letter to the court recommending that he have custody of his 8-year-old son. He offers to bring his son in "because he'll tell you he wants to live with me."

Child custody issues often arise when a parent who is in treatment is going through a divorce and contesting custody of his or her child, as in Case

Vignette 1. There are a number of reasons for the clinician not to accede to Mr. J's request for a letter to the court supporting his arguments regarding custody. First, the clinician may lack training for these specialized evaluations. Second, as discussed earlier, performing forensic evaluations on one's own patients is generally not advisable. Finally, current standards for conducting custody evaluations strongly recommend that all parties to a custody case (including both parents and all children) be interviewed before rendering an opinion on child custody matters (see, e.g., guidelines of the American Academy of Child and Adolescent Psychiatry [Herman 1997] and the American Psychological Association [1994]).

In Case Vignette 1, the psychiatrist recommended that Mr. J obtain a full custody evaluation by an independent clinician. The central issue before the court in a custody dispute is a comparison of custody options and a determination of which of these is in the best interest of the child. The clinician presenting an opinion based on the assessment of only one parent is not likely to have a basis for comparing the custody options or making a well-informed recommendation regarding the child's best interest. An evaluation of the parent and parent-child relationship by an independent evaluator is usually much more helpful to the court. Parents sometimes want a letter that is essentially a clean bill of mental health. Such letters are unlikely to be of much use to the court except in rare cases, such as when one parent asserts visitation should be terminated solely on the grounds that the other parent is mentally ill, and an attorney fears the judge will focus on the parent's diagnosis and not understand the importance of looking into the nature of the child-parent relationship.

In the event a patient does obtain an independent evaluation, the treating psychiatrist will need to consider carefully his or her role as a collateral source of information. Custody evaluators commonly request releases from parties to a custody case in order to talk to the parties' therapists. The patient may feel some pressure to provide the release, if for no other reason than to appear cooperative with the evaluation. The therapist should bear in mind that all such conversations are discoverable, and that releasing information to the evaluator may have effects on the treatment.

In these circumstances, clinicians should consider the option of having a telephone discussion with the evaluator but not providing written records. Many custody evaluators are interested in talking to therapists as a means of identifying some of the patient's salient issues. However, evaluators then utilize that information in their own interviews of the parent to hone in more quickly on important issues relevant to custody. By doing so, evaluators can base their recommendations on their own findings, rather than having to rely on the conclusions of the therapist. This provides a stronger basis for the evaluator's opinions and protects the confidentiality of the treatment.

Most custody disputes reflect marital disputes that compromise one or both parents' abilities to reason about their children's best interests. Few divorces stem from disagreements about how to raise children. A psychiatrist working with a patient who is going through a divorce and contemplating obtaining a child custody evaluation can provide assistance by helping the parent understand why he or she is having difficulty negotiating with the spouse regarding the post-divorce arrangements for their children. There are many types of interferences in parents' ability to reach their own resolution (Johnston et al. 1985), and understanding the impasse is important in helping parents resolve their difficulties without resorting to the aggravation and expense of a trial. Parents may be helped to settle the case themselves, to settle through mediation (Benjamin and Irving 1995; Emery 1994), or even to settle after a custody evaluation (Ash and Guyer 1986).

Parenting Evaluations in Abuse/Neglect Cases

Case Vignette 2

Ms. G, who suffers from chronic bipolar disorder, had her infant removed at birth because of neglect. The baby tested positive for cocaine. Ms. G had not been taking her mood-stabilizing medication for many months prior to delivery and was thought to be psychotic while in the hospital. Child protective services had set out a plan for the mother, which included going into psychiatric treatment and substance abuse treatment, and remaining abstinent from street drugs. After 6 months, the juvenile court ordered the mother to obtain a psychiatric evaluation regarding her capacity to parent her infant.

Assessments of parenting capacity may be requested by courts in a wide variety of circumstances and at any stage of an abuse or neglect proceeding. Such requests most often come to general psychiatrists after a child has been removed for abuse or neglect and some practical or therapeutic intervention has occurred intended to increase the child's safety. The psychiatrist is then asked to assess whether the parent can now safely resume custody of the child. A request for such an evaluation may be initiated by a child protection agency, by a judge, or by a parent who has been instructed by the court to obtain such an evaluation and present it to the court. Evaluation may also be requested when the child protection agency has given up on reunification and is petitioning for termination of parental rights. In order to terminate

parental rights, the state must show that termination is necessary by clear and convincing evidence (*Santosky v. Kramer* 1982).

Precise legal standards describing fitness to raise one's child after a finding of abuse or neglect vary among the states. Typically, such standards require a determination that the child will be safe from further abuse and neglect and that the parent or parents are fit to raise the child. However, clear definitions of these terms are not available. Indeed, a clear professional consensus on the specifics of what parenting functions render a person a "fit parent" does not exist, and there is even less agreement on how to measure those functions.

Assessing parenting capacity after an adjudication of neglect or abuse typically involves addressing the following questions:

1. Are there specific legal tests that must be addressed in this jurisdiction or this case, and if so, what are they?
2. What were the mental health issues and other factors that gave rise to the abuse or neglect?
3. To what extent have those difficulties been treated?
4. What is the likelihood of relapse?
5. What is the likelihood of recurring abuse or neglect?
6. What are the parenting needs of this particular child?
7. Can the parent meet this child's needs? How will the parent carry out essential parenting functions, such as providing for the child's safety, basic needs, medical care, discipline, education, and emotional needs?
8. What is the nature of the relationship between the parent and child?
9. What treatment or other interventions are needed to improve or maintain the parent's functioning?

Psychiatric evaluations are commonly obtained in cases in which a parent has a severe mental illness, and the court is particularly interested in the course, treatment efficacy, and prognosis of the parent. Such assessment should focus on parenting functions. Although the evaluator will conduct a standard psychiatric assessment as one component of the evaluation, a parent's mental illness is important to the extent that it interferes with parenting. A "standard" psychiatric evaluation that does not make the link between mental disorder and parenting function is of very little use to the court.

If the psychiatrist evaluates only the parent(s), but not the child or the parent-child relationship, only some of these questions can be answered, and the lack of data and opinions about the child should be made explicit in the report. The general psychiatrist's report will be only one piece of information. The court will take this report into consideration with other information from other sources. A more comprehensive evaluation in such cases may in-

clude the parent as well as the child and the parent-child relationship. Such an evaluation may allow the psychiatrist to reach an opinion on the ultimate question of whether the child should be returned. In either event, however, the link between mental disorder and parenting function should be made explicit.

Delinquents in Juvenile Court

Working with juvenile court cases differs from working with adult criminal cases. These differences arise from both procedural differences and from the juvenile courts' explicit mandate to provide rehabilitation for youth who come before them. The 1967 Supreme Court decision *In re Gault* and subsequent court decisions brought most adult criminal due process requirements to juvenile procedures (except for trial by jury), but rehabilitation remains a primary mission.

When minors are arrested on criminal charges, they are typically placed under the jurisdiction of the juvenile court. In some instances, the minor may be waived to adult court. State law governs which of three types of such waivers will apply to an individual case. Waiver statutes typically take the form of "Youth over the age of X, who are charged with one of the following offenses…, may [or shall] be waived to adult court if…" *Judicial waivers* are those in which there is a hearing before a juvenile court judge, who will typically consider the nature of the crime, likelihood of future dangerousness, and the youth's amenability to rehabilitation in deciding whether to move the case to adult court. *Direct file* or *prosecutorial waivers* allow the prosecutor to decide in certain cases (such as murder committed by a youth over a certain age) to move the case to adult court. *Mandatory* or *legislative waivers* derive from statutes which, based on the defendant's age and the charge, automatically waive the youth to adult court. Practically all states have some form of judicial waiver. The U.S. Supreme Court has held that a judge cannot waive a youth without a hearing (*Kent v. United States* 1966). In response to the upsurge in juvenile crime in the early 1990s, many states adopted direct file or mandatory waivers, so that by the end of 2004, a majority of states had such provisions (Snyder and Sickmund 2006). There are no federal juvenile courts: minors arrested on a federal charge have a hearing before a federal district court judge on whether they should be prosecuted in federal court or remanded to a state juvenile court.

Waiver hearings commonly make use of mental health evaluations to assist them in making a determination. Judges have considerable discretion in

what factors they consider and how they weigh each factor. The statutory criteria for waiver to federal court (18 U.S.C. § 5032) are typical and include the age and social background of the juvenile, the nature of the alleged offense, the extent and nature of the juvenile's prior delinquency record, the juvenile's present intellectual development and psychological maturity, the nature of past treatment efforts and the juvenile's response to such efforts, and the availability of programs designed to treat the juvenile's behavior problems.

If a youth is waived to adult court, the full panoply of adult criminal process comes into play, including issues of competency to stand trial and insanity or other diminished capacity defenses. Insanity defenses are very rare in waived youths because the incidence of psychosis is considerably lower in adolescents than in adults, and because severe mental illness is a strong reason not to waive a youth to adult jurisdiction.

If a youth remains under juvenile court jurisdiction and emotional disturbance is thought to play a role in the youth's behavior, the juvenile court judge will often order a mental health evaluation. This is often referred to as a "study and report," and is intended to assist in formulating a disposition. A study and report is a general psychological evaluation that often includes psychological testing and concludes with recommendations for mental health interventions. If the defendant youth was in treatment prior to arrest, the treating clinician may be contacted to provide collateral information.

Assessments Around the Time of Arrest

Case Vignette 3

George K, age 14 years, was brought by his father for an urgent consultation after a neighbor said that the neighbor's 4 year-old daughter alleged that George had asked her to take off her pants and "touched my privates." George had no previous history of such problems or of any other mental health problems. The father wanted to know, "Did I miss something?" and was very worried George might be arrested.

A parent may bring a youth to a psychiatrist because the parent anticipates an arrest and wishes to receive guidance on how to proceed. In the example of Case Vignette 3, the clinician at this point owes a duty to George as his patient, not to the police. However, the possible impending arrest makes this evaluation different from other clinical encounters. First, although the evaluation is confidential, the psychiatrist has an obligation to notify child protective services if he or she has a reasonable suspicion that child abuse took place. Thus, the clinician should inform both the father and patient of this duty prior to asking about material which may lead to such a report.

Second, if the parent has not obtained the services of an attorney for his son, the psychiatrist should recommend strongly that the parent do so. The psychiatrist should seriously consider deferring the evaluation until an attorney has been retained or appointed. In most cases, the psychiatrist should not ask about the circumstances of the alleged abuse (or other crimes) at all until he or she has a clear sense of what questions the attorney will ask. Following this course of action will help the psychiatrist avoid the possibility that the psychiatric evaluation will be used to incriminate the patient.

In addition, if no attorney has been obtained or appointed, the psychiatrist should discuss with the father what to do if the youth is questioned by the police. Without giving legal advice, the psychiatrist should help the father and adolescent understand their options and some of the possible consequences of cooperating with the police. As is the case for any criminal suspect, talking to the police without first consulting with an attorney is seldom in the youth's best interest. If arrested, the youth will be given a *Miranda* warning. Younger adolescents may cognitively understand what a *Miranda* warning is, but are nevertheless more likely to waive their rights and confess than are older adolescents or adults (Grisso 1981). In most states, police are not allowed to question a suspect who is a minor without a parent's permission. However, parents who have raised their child to be honest and admit mistakes may advise their children to confess to the police.

Once a youth has an attorney, the psychiatrist can be helpful to his patient by working with the attorney. The authorities have wide discretion in juvenile cases on questions of what charge to bring (for example, manslaughter rather than murder) and disposition (probation with conditions rather than incarceration). This discretion includes whether to arrest the youth at all. Rapid institution of treatment may decrease the likelihood of arrest. A skilled attorney can have considerable impact on the course of a case by negotiating with the authorities without resorting to formal criminal procedures. A youth's attorney can often make effective use of mental health information and treatment plans in such negotiations.

The cautions about obtaining incriminating information discussed above become even more imperative in situations when the youth is unaccompanied by a parent. For example, a general psychiatrist providing coverage to an emergency room may become involved in a case when the police bring a distressed, just-arrested youth to an emergency room. The psychiatrist should provide limited treatment for acute distress (assuming appropriate informed consent can be obtained). However, he or she should be acutely aware that any information obtained during evaluation and treatment may not remain confidential. A clinician unfamiliar with juvenile criminal processes, in the mistaken belief that he or she is helping, all too often will begin an interview in the emergency room by asking, "What happened?" He or she then continues to

obtain highly incriminating information that may get passed along, formally or informally, to law enforcement. Even if the information obtained remains confidential, legal consequences may follow from the fact that the youth has told his or her story without having a clear understanding of the implications of doing so. One of these may be the youth's own belief that he or she has already "confessed" and so be ready to repeat the story before obtaining the advice of counsel ("After all, I already told the doctor what happened…").

Treatment Following Adjudication

Case Vignette 4

Johnny Y, age 15 years, has been adjudicated as a delinquent on a charge of aggravated assault stemming from his hitting a classmate in the head with a book bag. The court has mandated treatment, and Johnny was referred to a general psychiatrist who also treats adolescents. The youth's probation officer wants regular progress reports.

A general psychiatrist who accepts a patient for whom psychiatric treatment is made a condition of probation may be required to share certain information that would normally be confidential. He or she should be certain to have a clear understanding with both the probation officer and the patient regarding the nature of the information that will be provided to the probation officer. Clinicians vary in how they structure such understandings. As a general rule, the clinician treating adult patients can attempt to maintain the confidentiality by making clear that he or she will only advise the probation officer whether the patient is coming and whether the psychiatrist believes treatment is completed. The patient should also be advised that if the sessions are not paid for, the patient will not be seen and this will be reported to the probation officer as nonattendance. With adolescent patients, the psychiatrist may need to broaden this stance to some degree. A juvenile probation officer can assist the clinician in obtaining court and community services and thus can be a very useful ally. The psychiatrist will likely want to have the option of being able to release to the probation officer information that will justify additional services.

School Threat Assessments

Case Vignette 5

A teacher in a small, rural town has been told by a student that her friend, 16-year-old Carey W, told her that she "might want to stay home from school

next Tuesday because 'not everybody will be going home that day.'" The school is referring Carey W to the only psychiatrist in town for an emergency assessment of his dangerousness.

Mass school shootings generate enormous amounts of media coverage and grave concerns about school safety. The shootings in Littleton, Colorado, have come to exemplify such acts of violence. From 1992 through March 2001, there were 19 incidents, including two instances in which two students participated in shooting at classmates (for descriptions, see Verlinden et al. 2000). As a result, schools have become highly sensitized to possible threats, such as those presented by Case Vignette 5. Statistics reassuringly demonstrate that schools are safer than media coverage may imply. A youth is far more likely to be shot away from school than at school (Dinkes et al. 2009). Nevertheless, students who are thought to pose some threat are frequently sent for psychiatric evaluation.

Detailed psychiatric information about school shooters is difficult to obtain. Some of the killers committed suicide immediately after the shootings. Others have been protected by the confidentiality of the juvenile court. Therefore, most information about individuals who commit such acts has been limited to publicly available data. Verlinden and colleagues (2000) identified a number of characteristics common to these offenders. These include prior threats of violence, having a detailed plan, blaming others for problems, having a history of regression, uncontrolled anger, depression, troubled family relationships, poor coping and social skills, alienation from peers, fascination with weapons and explosives, preoccupation with violent media and music, and attack-related behavior such as an interest in targeted violence, and social-environmental factors such as access to firearms. Meloy and colleagues (2001) identified consistent findings in a study of juvenile mass murderers. In all cases, peers failed to report threats of serious violence to others and to consider the threats seriously. This fact has led to prevention efforts that emphasize assessing all threats of school violence, even those seemingly made in jest.

In Case Vignette 5, the school sent Carey W for emergency evaluation immediately upon being advised by his friend of his statements. The disclosure of a threat is usually the trigger to an evaluation. Most threats are not carried out, but all need to be considered seriously. However, not all threats are equal. More severe threats should prompt more intensive evaluation. Threats that are vague, implausible, or made in a context that suggests they will not be carried out call for less intensive workup than threats that are specific or indicate active planning.

Threat evaluation research has grown largely out of law enforcement work focused on adults, but similar principles are likely to apply to adolescents.

Many psychiatrists tend to think about the assessment of potential violence as similar to the assessment of suicidal thinking, with its emphasis on identifying risk factors, violent ideation, and plan. However, such evaluations have been recognized to be fairly ineffective in predicting planned, predatory violence. Threat evaluation has moved away from profiling the subject and toward evaluating pathways that lead to violent action. Such evaluations look less at the characteristics of the subject, and more at recent behavior that suggests the subject is moving on a path toward violence (Borum et al. 1999).

The Federal Bureau of Investigation recommends assessment in four domains: 1) personality characteristics, 2) family dynamics, 3) school dynamics, and 4) social dynamics (O'Toole 1999). Because individuals frequently deny planning predatory violence, other indicators of violent thinking are important. A key concept in these evaluations is "leakage": fantasies of thinking and planning violence may spill out in identifiable ways. These can include talking about a fascination with weapons and assassinations with peers, diaries or other written communications, drawings, Internet chatting on violence-related themes, and veiled threats expressed to peers.

Utilizing these principles, threat assessment procedures for schools have been developed by federal law enforcement agencies (O'Toole 1999; Vossekuil et al. 2002). These approaches emphasize that attack is the consequence of an understandable and discernible process of thinking and behavior. In evaluating a pathway toward violence, actions that indicate planning, such as practice with a weapon or surveillance of a victim, are especially worrisome. A youth will frequently deny planning violence in interviews. Therefore, collateral information, particularly from peers, is vital.

The best way to obtain a comprehensive picture of recent actions involves working as part of a team with school personnel and law enforcement. A clinician should be very cautious, once a serious threat has been made, in concluding that the risk of violence is low, based solely on findings from an individual interview. It is a mistake to think that an individual interview is likely to get at the most significant data. Nevertheless, an individual interview can identify many factors that may be significant in the overall and comprehensive assessment of risk of violence. The following appear to be the most important domains to assess in an individual interview:

- Mental illness and/or substance abuse
- Fascination and increasing interest in weapons, attacks, and attack-related behaviors
- Leakage and fantasy material of a violent nature
- Talk or writings about committing violent acts
- Alienation and narcissism

- Specificity of details: plan, target, etc.
- Recent loss and/or prior history of suicidal thinking

Findings from a psychiatric evaluation then need to be integrated with information from other sources to develop an assessment of the level of risk and a prevention plan.

Case Vignette 5 *(continued)*

Carey W admitted to the evaluating psychiatrist that he had been feeling depressed and quite resentful of the "popular crowd." School personnel learned from several of Carey's peers that he had been making threats. With the parents' permission, the police searched Carey's bedroom and found directions for building a bomb and several drawings of schoolrooms with what looked like computations of blast effect. Carey was deemed to be at high risk, and was admitted to an inpatient psychiatric facility.

Key Points

- Forensic evaluations of preadolescents usually require specialized training in child and adolescent psychiatry.
- Forensic evaluations of adolescents may be done by general psychiatrists who additionally can demonstrate special training and experience with adolescent populations.
- Opinions on parenting functions should be limited if parent-child interaction is not directly assessed.
- The rehabilitative mission of the juvenile court broadens the usefulness of mental health input when compared to adult criminal procedures.
- Assessments of threats of predatory violence should focus on ascertaining whether the youth is on a behavioral path toward violence.

Practice Guidelines

1. Clarify role at outset of evaluation.
   a. Be clear on the forensic question being asked.
   b. Clarify who is requesting an evaluation, to whom a report will be sent, and issues of consent.
   c. Avoid forensic evaluations of your own patients.
2. Evaluations of parents involved in litigation with their children
   a. Do not opine on the best interests of a child in a custody arrangement without evaluation of both parents, the children, and the interaction of parents and children except under unusual circumstances.
   b. In evaluations of parenting capacity, make a clear link between mental disorder and parenting.
3. Evaluations of youth facing criminal charges
   a. Conduct only very limited evaluation before a youth obtains an attorney.
   b. In evaluations of whether to waive to adult jurisdiction, focus on assessment of dangerousness and amenability to rehabilitation.
4. Evaluations of threats of predatory violence
   a. Focus on whether youth is moving along a path toward violence rather than on static risk factors.
   b. Obtain collateral information, especially from peers.
   c. Utilize a team approach that includes school personnel, law enforcement, and mental health evaluation to obtain a comprehensive assessment of moderate to serious threats.

References

Accreditation Council for Graduate Medical Education: Program Requirements for Residency Education in Forensic Psychiatry. Chicago, IL, Accreditation Council for Graduate Medical Education, 1996

American Psychological Association Committee on Professional Practice and Standards (COPPS): Guidelines for child custody evaluations in divorce proceedings. Am Psychol 49:677–680, 1994

Ash P, Guyer M: The functions of psychiatric evaluations in contested child custody and visitation cases. J Am Acad Child Psychiatry 25:554–561, 1986

Benedek EP, Ash, P, Scott, CL (eds): Principles and Practice of Child and Adolescent Forensic Mental Health. Washington, DC, American Psychiatric Publishing, 2009

Benjamin M, Irving HH: Research in family mediation: review and implications. Mediation Quarterly 13:53–82, 1995

Borum R, Fein R, Vossekuil B, et al: Threat assessment: defining an approach for evaluating risk of targeted violence. Behav Sci Law 17:323–337, 1999

Dinkes R, Kemp J, Baum K: Indicators of School Crime and Safety: 2008 (NCES 2009–022/NCJ 226343). Washington, DC, National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2009

Emery RE: Renegotiating Family Relationships: Divorce, Child Custody, and Mediation. New York, Guilford, 1994

Grisso T: Juveniles' Waiver of Rights. New York, Plenum, 1981

Haller LH (ed): Forensic psychiatry. Child Adolesc Psychiatr Clin N Am 11: entire issue, 2002

Herman SP: Practice parameters for child custody evaluation. American Academy of Child and Adolescent Psychiatry. J Am Acad Child Adolesc Psychiatry 36:57S–68S, 1997

In re Gault, 387 U.S. 1 (1967)

Johnston JR, Campbell LE, Tall MC: Impasses to the resolution of custody and visitation disputes. Am J Orthopsychiatry 55:112–129, 1985

Kent v United States, 383 U.S. 541 (1966)

Meloy JR, Hempel AG, Mohandie K, et al: Offender and offense characteristics of a nonrandom sample of adolescent mass murderers. J Am Acad Child Adolesc Psychiatry 40:719–728, 2001

O'Toole ME: The School Shooter: A Threat Assessment Perspective. Washington, DC, U.S. Department of Justice, 1999

Parham v J.R. and J.L., 442 U.S. 584 (1979)

People v Stritzinger, 668 P.2d 738 (Cal. 1983)

Santosky v Kramer, 455 U.S. 745 (1982)

Snyder HN, Sickmund M: Juvenile Offenders and Victims: 2006 National Report. Washington, DC, Office of Juvenile Justice and Delinquency Prevention, 2006

State v Andring, 342 N.W. 2d 128 (Minn. 1984)

Verlinden S, Hersen M, Thomas J: Risk factors in school shootings. Clin Psychol Rev 20:3–56, 2000

Vossekuil B, Fein R, Reddy M, et al: The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States. Washington, DC, U.S. Department of Education, Office of Elementary and Secondary Education, Safe and Drug-Free Schools Program and U.S. Secret Service, National Threat Assessment Center, 2002

Suggested Readings

Benedek EP, Ash P, Scott CL (eds): Principles and Practice of Child and Adolescent Forensic Mental Health. Washington, DC, American Psychiatric Publishing, 2009

Bernet W: Practice parameters for the forensic evaluation of children and adolescents who may have been physically or sexually abused. American Academy of Child and Adolescent Psychiatry. AACAP Official Action. J Am Acad Child Adolesc Psychiatry 36:423–442, 1997

Ceci SJ, Bruck M: Jeopardy in the Courtroom: A Scientific Analysis of Children's Testimony. Washington, DC, American Psychological Association, 1995

Elliott DS: Serious violent offenders: onset, developmental course, and termination. American Society of Criminology 1993 Presidential Address. Criminology 32:1–21, 1994

Grisso T: Forensic Evaluation of Juveniles. Sarasota, FL, Professional Resource Press, 1998

Haller LH (Ed): Forensic psychiatry. Child Adolesc Psychiatr Clin N Am 11: entire issue, 2002

Herman SP: Practice parameters for child custody evaluation. American Academy of Child and Adolescent Psychiatry. J Am Acad Child Adolesc Psychiatry 36:57S–68S, 1997

U.S. Department of Health and Human Services: Youth Violence: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, 2001. Available at: http://www.surgeongeneral.gov/library/youthviolence/. Accessed May 23, 2009.

Vossekuil B, Fein R, Reddy M, et al: The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States. Washington, DC, U.S. Department of Education, Office of Elementary and Secondary Education, Safe and Drug-Free Schools Program and U.S. Secret Service, National Threat Assessment Center, 2002

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Chapter 19

Forensic Geriatric Psychiatry

Stephen L. Read, M.D.

Robert Weinstock, M.D.

The forensic psychiatrist can expect to encounter issues related to aging in the coming decades with greatly increased frequency because of several factors. First is simple demographics: the *geriatric imperative* refers to the transition from a "pyramidal" to a "columnar" age distribution, a process that continues in "developed" as well as "developing" countries. Populations worldwide have increasing numbers of elderly and proportionately fewer children and younger adults. Between 2008 and 2040 in the United States, the proportion of the population age 65 and over is projected to increase by 107%. An analysis by the AARP (Towner 2009) of 2000 U.S. census data also describes the increased diversity of ethnic background to be anticipated in the over-50 age group in the coming half century: White/nonwhite percentage ratios are expected to decrease dramatically, from 77/23 to 55/45.

When one considers the percentage of property and wealth that will be held by older persons and the complexities associated with aging, one appreciates the likelihood of increased recourse to the legal system. Individuals continue to differentiate with passing years in relation to experience and chance. Nonetheless, there are commonalities among the biomedical, neu-

ropsychiatric, and psychosocial changes that will be encountered by aging persons in our society. Familiarity with these aspects will facilitate the forensic geriatric psychiatrist's appreciation of the context in which consultation is requested. Some of these factors and situations are described below.

In the past 30 years, Alzheimer's disease has been transformed from a rare "presenile" illness into an international epidemic. In addition, entire new categories of degenerative brain disorders have been recognized and defined, and this remains an active area of neurobiological research. Expertise in this area is of central importance to forensic psychiatric evaluations in older persons for these reasons:

- Higher prevalence of serious medical illnesses, including cardiac disease and malignancies, can lead to complex disputes about capacity and influence concerning medical decision making, application of advance directives, and end-of-life care.
- Chronic "degenerative" disorders (e.g., arthritis, osteoporosis, neurologic disorders, pulmonary and metabolic conditions, hearing and visual loss) impact decision making in terms of quality-of-life valuation, dependence for care that can lead to opportunities for influence, and issues of control.
- Long-term care issues, either at home or in the differently regulated types of institutions that have emerged, can lead to conflicts based on differing goals and values, mediated by stress and economic factors.
- Challenges to the continuity of social position and related networks for elderly persons can contribute to isolation, precisely at a time when these persons may in fact need increased support, thereby potentially increasing their vulnerability.

In this chapter we address competence and capacity as the core issues in forensic geriatric psychiatry and discuss specific topics such as the evaluation of "undue" influence. Some topics relevant to geriatric forensic psychiatry, such as competence to testify or to stand trial in a criminal proceeding, not guilty by reason of insanity, child custody issues, labor and disability law issues, and needs of aging prisoners, are beyond the scope of this chapter. However, we postulate that the issues addressed here will assist the practicing forensic geriatric psychiatrist in those other areas as well.

Competence and Capacity

Competence and capacity are the central issues for the geriatric forensic psychiatrist, because the high prevalence of cognitive impairment in the elderly

commonly results in a presumption of impaired decision-making capacity. Competence is assessed as regards to specific tasks or functions; lack of competence (or competency) is ultimately the prerogative of the court. A clinician or forensic evaluator uses the terms *capacity* and *incapacity* for decision making. Testamentary capacity and the need for guardianship (or conservatorship) are the most common matters brought before the court, but an opinion may be sought about competence for other actions—for example, to drive, to sign a contract, to testify, or to marry. Medical decision making can be complex; balancing differing views of autonomy with a need for oversight or the valuation of different alternatives can be challenging. When interested parties (e.g., family members) have strongly different views, the disputes can become very heated; financial aspects of decisions may be more or less prominent in different cases. The statutory components for a judicial determination of competence vary among different jurisdictions. If retained in a case in a new venue, therefore, the psychiatrist should request the retaining attorney to provide relevant guidelines.

Case Vignette 1

Mrs. A's children filed a petition for conservatorship and the court-ordered psychiatric evaluation. Their 80-year-old long-widowed mother had taken in a boarder from her church 6 months prior—"for protection." Shortly thereafter, the children were no longer welcome at Mrs. A's home, nor could they reach her by phone. They learned that Mrs. A had assigned power of attorney to her boarder, who had also taken Mrs. A to consult with a "friend," who happened to be an estate planning attorney; Mrs. A told the attorney she was considering transfer of title to the house to the boarder because "my children want to put me in a home."

Mrs. A's account of the events omitted many specifics, especially names and dates, but she "knew" her children were "after my money." Mrs. A said she intended to put the house in the boarder's name to "protect" it from the children; she was *so* relieved the boarder had "helped" her. Mrs. A was well dressed and groomed, and she spoke clearly and fluently. Despite her uncritical acceptance of the representations of her boarder and the psychiatrist's diagnosis of mild dementia, it was not clear that Mrs. A would be deemed incompetent to execute her plans by a judge who favored maximum autonomy for elderly persons. Mrs. A's view lot alone was worth $2 million; however, Mrs. A estimated the value of her home at $10,000—since prices had inflated so much since she and her husband had bought it 60 years previously. This underestimate illustrated the significance of Mrs. A's "mild" dementia to the court, and conservatorship was awarded. No police department took any interest in the fraud apparently perpetrated by the boarder, but Mrs. A's property was thereby saved, as was her sense of well-being.

Principles of the Assessment of Competence and Capacity

As discussed in two recent articles (Buchanan 2009; Simon 2009), albeit on different areas than geriatrics, authorities tend to favor one of two approaches to analyzing a decision. One approach to the assessment of competence and capacity is to rely on a standardized instrument—a subject who "passes" is deemed to retain capacity, independent of the details of the matter at issue. However, a study of decision making in dementia produced different results depending on the referent standard, the severity of dementia, and the complexity of the treatment decision under consideration (Marson et al. 1995). We therefore strongly favor the alternative approach: a flexible individual assessment of the subject's ability to understand the options and the alternative consequences of the specific decision at hand and the subject's ability to formulate and to carry out a decision.

Collateral information is an important component of the evaluation of dementia (Jorm 2003), due in large part to the major potential for memory impairment compromising accuracy. It is even more important in a forensic psychiatric evaluation of a subject's understanding and appreciation of a particular issue (e.g., Mrs. A's misevaluation of her property's worth). For example, if a patient is refusing a recommended course of treatment, the consultant can only assess the patient's understanding in comparison to relevant information about the risks and benefits of the alternatives available. Clearly, information about a financial decision, a testamentary option, or choice of a surrogate decision-maker is necessary if that is what is to be assessed. In addition to information about the options, knowledge of the subject's personal history, family makeup and history, and financial and legal status will allow comparison to the subject's own report and will assist the consultant in evaluting the subject's rationale for expressing a preference. Knowledge (or lack thereof) of current medications is directly relevant to the person's medical decision-making capacity and also may reveal agents whose effects on cognition should be addressed or suggest the presence of a relevant medical condition not otherwise mentioned. Medical care data may alert the evaluator to an illness that should be explored for potential effects on brain function or for consequences for function, dependence, or prognosis. Since collateral sources are at least potentially biased, the forensic psychiatrist should seek information from multiple sources, including the claims or allegations from "both sides," and specify the sources of information used and requests made for other information and whether that information was forthcoming.

Assessment of Mental Functions

In the interview to evaluate capacity, the psychiatrist will explore the subject's understanding of the matter at issue and the context in which the decision is experienced. Beliefs (including culturally relevant and specific matters), mood and affect, and the degree to which the subject reflects on a question or answers impulsively may bear on the consultant's eventual opinion. Values and goals are relevant to the subject's sense of purpose. In addition, the examiner will gain preliminary impressions of any difficulties with cognitive domains such as language and memory, pending more formal, objective review, and be able to comment on the implications for capacity and competence.

A comprehensive cognitive examination informed by the expert's knowledge of cognitive and other neuropsychiatric disorders forms the bedrock for expert opinion, report, and testimony. Necessarily, the reader is referred elsewhere for a detailed review of a comprehensive geriatric psychiatry assessment (Devanand 2005; Silver and Herrmann 2004; Strub and Black 2000), but aspects related to competence and capacity should include the elements in Table 19–1. The forensic examiner may find more detailed neuropsychological testing to be of value when the clinical findings are ambiguous or borderline or when difficulties are based on a particular area of mental function that warrants more detailed characterization. A particular area of concern is the possibility of malingering. While it may be difficult for a malingering individual successfully to make errors that will deceive an experienced examiner, specialist neuropsychological evaluation may be very helpful to ensure an accurate assessment (Boone 2007).

In addition to assessing and recording relevant responses on these domains of mental activity, it can be very helpful for explanation to score the subject's performance on a standard cognitive rating scale. While not diagnostically specific or free of technical issues (Cummings 1993), the Mini-Mental State Examination (MMSE), first introduced in 1975 by Folstein et al., has been the most widely used tool potentially describing the subject's overall level of impairment and characterizing the course of the subject's cognitive function over time, especially in dementia due to Alzheimer's disease (Tombaugh and McIntyre 1992). Alternatively, the consultant may need to explain why the MMSE score can be misleading when used to compare patients with other pathological conditions, for example, depression, nonfluent aphasia after left frontal stroke, Parkinson's disease, or frontotemporal dementia.

TABLE 19–1. Mental status domains for the forensic geriatric subject

Alertness and attention
Level of arousal
Orientation
Cognitive functions
Memory: immediate recall, short-term recall, long-term memory
Language: fluency, comprehension, repetition, reading and writing for comprehension
Visual: figure copying, ability to recognize faces and emotional expressions
Numerical skill: arithmetic, valuation
Reasoning: level of abstraction, logical conclusions
Executive functions: working memory, ability to focus, distractibility, shift set
Perception and thought
Affect and mood, response and modulation

Undue Influence

Undue influence constitutes grounds for a court to overturn an action. Definitions of undue influence lack precision but refer to a decision made as the result not of the *decider's* will but when that will is "overcome" by, and to the benefit of, another person (e.g., the boarder in Case Vignette 1). Although "overcoming" suggests a struggle, undue influence is distinguished from "duress," because the former results from persuasion rather than force or the implied use of force. Similarly, although trickery and deception are commonly involved, outright falsity is fraud. The core allegation involves a claim that there is disproportional benefit to one party, who has taken advantage of the alleged victim of undue influence. The beneficiary must have a position of trust that can be exploited. Included are those with a *fiduciary* responsibility, such as close advisors, family, caregivers, or close friends—or physicians. The psychiatric expert's opinion may bear on this issue of trust. The beneficiary will have used the opportunity created by the relationship to obtain the will or contract or other benefit. The expert can be expected to consider information related to the allegations of opportunity, control, and the subject's ability to resist influence.

If one considers psychotherapy to be a form of influence—that is, with the goal of changing a person's behavior—one would expect that psychiatrists would be experts in analyzing persuasion, but this is rarely the case.

TABLE 19–2. "Weapons" of influence

Reciprocity
Consistency and commitment
Social validation and proof
Liking
Authority
Scarcity

Source. Cialdini 2001.

Techniques relevant to undue influence involve less ethical means of persuasion than psychotherapy—for example, flattery, inducing of false fears, exhortation, and/or insinuation—and these techniques gain power in relationship to, for example, the type and degree of mental impairment in the victim and the degree of lost independence. Different disciplines (e.g., business and advertising) have explored some related topics. For example, Cialdini (2001) has identified six "weapons" of influence that may be useful in analyzing the exercise of influence (Table 19–2).

The forensic psychiatrist's opinion is most relevant to the *susceptibility* to influence of the alleged victim. Although in rare cases there may be direct evidence of the exertion of influence, analysis and testimony on this subject rarely permit an unequivocal opinion that influence was exerted. It is part of the human condition to be influenced; one may even say it makes life interesting. Response to influence is mediated particularly by brain functions that depend on the integrity of frontal lobe function. The insensitivity of the MMSE, both in the diagnosis of frontotemporal disorders and in the domain of decision making, mandates including other items sensitive to the executive functions that are particularly relevant in considering the vulnerability to "undue" influence.

Tests of working memory, the ability to focus and shift attention appropriately, switch and return to set, and maintain consistency in effort on a complex task, are considered frontal lobe executive functions (Strub and Black 2000). Donald Royall and colleagues have stressed the special importance of executive functions as directly relevant to the assessment of decision-making capacity (e.g., Royall et al. 1992) in comparison to other cognitive functions, and they are of especial relevance in the assessment of the vulnerability to influence. Since evidence is accumulating that these functions show the earliest decline in many disorders, including many cases of Alzheimer's disease, the forensic psychiatrist can expect more often to see such cases. As the field now christened *neuroeconomics* continues to develop, with the tools of functional neuroimaging, the science of decision making can be

expected to advance rapidly and to impact the work of the geriatric forensic psychiatrist (Glimcher 2003).

Case Vignette 2

Mr. B was a 95-year-old lifelong bachelor. His nephew, his agent under durable powers of attorney, learned the 32-year-old caregiver had taken Mr. B to Las Vegas and had arranged to marry him. Upon returning to California, she made an appointment for Mr. B with an estate planning attorney. Mr. B reportedly said he wanted to "leave everything" to his new wife. The nephew took action because the estate, derived from the entrepreneurship of Mr. B's father, had long been intended to go to community philanthropy (not, as it happens, to the nephew).

At examination, Mr. B proved to be the affable, gentle, mild-mannered man described by the nephew. He was starstruck describing his "wifey" and rhapsodized extensively on her name alone. He had mild memory impairments and essentially intact language and reasoning consistent with treated normal-pressure hydrocephalus, a diagnosis made several years earlier. Mr. B scored 25 (out of 30) on the Mini-Mental State Examination but had major deficits in executive functions, including working memory and the ability to sustain attention or to shift attention to a new task or to cope with a problem involving several steps. Mr. B did not, however, fail outright at the elements of testamentary capacity; he knew the value of his estate, identified his living relatives, and understood the purpose of a testamentary document.

The rights that accrued to the caregiver from marriage proved to be a formidable obstacle to the petitioning nephew's case. However, the "caregiver" had made multiple videotapes of Mr. B over several months, clearly intended to demonstrate Mr. B's competence. These tapes in fact provided material by which the psychiatric expert was able to illustrate the impact of Mr. B's major deficits in executive functions and how these rendered him exquisitely sensitive to influence. Sadly, with further prosecution of the case, Mr. B's performance (at deposition and in public court testimony) confirmed many of these features in prolonged—and expensive—legal proceedings. The court determined that while Mr. B's capacity per se was only mildly compromised, he had acted as a result of deliberate and undue influence by the caregiver; the marriage was dissolved and the subsequent estate planning changes abrogated. No further legal action, criminal or civil, was taken against the caregiver.

Relevance and Irrelevance of Diagnosis

The expert can expect to be asked about the presence of dementia. Pending the completion and release of DSM-V, the current criteria for a diagnosis of dementia (DSM-IV-TR) fundamentally require that impairment in memory and at least one other cognitive deficit (such as language or executive function) be present AND that each of these deficits "cause significant impairment in social or occupational functioning and represent a significant decline

from a previous level of functioning" (American Psychiatric Association 2000, p. 157). Characterization of persons with cognitive deficits but who do not meet the full criteria for dementia is currently an area of uncertainty and controversy, without even a consensus about terminology, much less criteria (Schneider 2005). This leads to several areas of difficulty:

1. Many brain disorders cause grievous deficits in mental functions without affecting memory—for example, the frequently long premonitory phases of frontotemporal degenerations or many poststroke syndromes (Read 2004).
2. Persons who are eventually diagnosable with many degenerative brain disorders (prominently, Alzheimer's disease) manifest the "insidious onset" of deficits in memory and other mental functions prior to meeting criteria for *dementia.* This may be precisely the time frame that applies to the matter in dispute. While this matter is (appropriately) the target of very active research investigation, there is currently a ferment of terminology and criteria. At this time, the physician has no official recourse except a diagnosis of "cognitive disorder not otherwise specified" for such persons.
3. Since the subject's capacity or vulnerability to influence, or the lack thereof, is precisely the focus of the judicial matter, characterizing the subject's actions that are at issue as representing "a significant decline from a previous level of functioning" may be tantamount to testifying to the "ultimate question" of the matter, which the court may regard as its prerogative.

In summary, therefore, although accurate diagnosis is the cornerstone of clinical medical and psychiatric practice, diagnosis per se is not sufficient for an analysis of competence and capacity and has been statutorily designated as irrelevant—for example, in the Due Process in Competence Determination Act (C.P.C. § 810–813), the California law governing determinations of conservatorship. Given the vagaries of current clinical diagnostic accuracy (Brunnstrom and Englund 2009), this is a fortunate and prudent approach in our view. Instead of diagnosis, the forensic psychiatry opinion grounded in an analysis of the subject's mental functions and specific circumstances in relationship to decision-making capacity will provide the most effective assistance to the court. Diagnosis is not irrelevant, as regards expectable areas of difficulty or reasonable expectations for future constraints on the subject's life, but it is not, in and of itself, determinative of competence or capacity or vulnerability to influence except as it may inform the expert of expectable areas of impairment based on his or her medical and psychiatric knowledge.

Specific Topics in Competence and Capacity

Testamentary Capacity

The financial impact of inheritance is enormous: the value of assets to be transferred by inheritance in the United States by 2050 has been estimated to be more than $40 trillion. Demographics, the many persons surviving for many years with impaired cognition, and social factors such as the frequency of divorce and remarriage would all be expected to increase the frequency of will contests, with challenges to testamentary capacity and allegations of the exertion of influence in testamentary decisions, as illustrated in Case Vignette 2.

The conservative stance of courts in terms of overturning a testamentary document reflects the long tradition of respect paid by society to carrying out a person's "will" (Hall et al. 2009b). The testamentary act appears early in human culture (e.g., an Egyptian papyrus is clearly a will). Cautions about the validity of a will in Solon's code for Athens sound almost modern: there are admonitions about senility, "phrenzy" (i.e., delirium or dementia or psychosis), and the pernicious influence of women—who did not have property rights in Athens 2,500 years ago (Harris 1911). Prior to widespread literacy, witnesses were the repository of a testator's intentions, and "making a will" was a substantially public act (e.g., Cervantes 2003; Rogers 1993), with emphasis on witnesses to attest to the veracity and intentions of the testator's statements. However, since the mid-nineteenth century, the written will has become standard; even a handwritten ("holographic") document may be accepted for probate. The circumstances of production of a will or a trust, including the testator's "mental state," then become directly relevant to any challenge to the validity of such a document representing the "true" wishes of a testator.

Forensic psychiatry expertise is therefore central to a will contest, with an analysis conducted in terms of statutory requirements. Although specific wording varies by jurisdiction, to have testamentary capacity, a testator must generally demonstrate adequate performance with regard to three factors 1) knowledge of the composition and value of one's estate, 2) knowledge of the "natural objects of one's bounty" (i.e., close relatives and others who may reasonably expect to be included), and 3) knowing the nature of the testamentary act (i.e., that the purpose is to distribute assets after one's death). Although dementia and other disorders of cognition come to compromise capacity, persons with mild and often moderate dementia will commonly be found to retain testamentary capacity, even when decision-making competence has deteriorated for more complex matters such as contracting.

Marriage

The forensic psychiatrist will realize that while a spouse is accorded automatic status in many areas of authority and entitlements, a marriage "contract" in modern times is not generally subjected to close scrutiny of the parties' capacity and competence. Marriage has been characterized by the U.S. Supreme Court as one of the "basic civil rights of man (*sic*)," and in many jurisdictions a conservatee (or person under guardianship) is presumed to retain the right to marry (Hankin and Read 1994). As in the case of Mr. B in Case Vignette 2, dissolution of a marriage on the basis of impaired capacity or undue influence is often difficult, even when there is abundant evidence of exploitation of an impaired elder.

Health Care Proxies, Advance Directives, and End-of-Life Decisions

Health care is an arena directly affected by the "aging of the population" and especially as regards the epidemic of dementia. A person may be faced with complex major health care decisions as the result of a sudden change in condition, a difficult situation for a cognitively intact person. For the ill person who is also impaired, transiently or not, and who has not completed an advance health care directive (AHCD), disagreements are common. Even when appropriate documents have been completed with clear language, the designated "health care agent" (differently named in different jurisdictions) may face other interested parties—family members, friends, health care workers—who advocate sharply conflicting choices. In addition, questions may be raised about the now impaired person's understanding and appreciation, at the time the document was executed, of the issues addressed in the AHCD. The conflict about life-sustaining treatment in the matter of Mrs. Terri Schiavo is a very public example of the potential bitterness and intransigence that can arise in such situations. The forensic geriatric psychiatrist may become involved in several ways:

1. Evaluation of the subject's capacity to designate an agent or to make a meaningful AHCD may be requested, particularly in relation to conflicted family circumstances.
2. Retrospective evaluation of the subject's competence at such time the AHCD was signed may be requested out of concern that the designated agent obtained authority as a result of influence—to gain power against other family members or for financial benefit (potentially applicable to Case Vignette 1).
3. Clarification of the current state of mental function of the subject may be sought as regards *application* of AHCD guidelines, as in Case Vignette 3 below.

4. Disputes may arise from the assertion of control by the agent over the subject's living situation and access to other family or friends, with allegations that these are inappropriate extensions of the "health care" authority, as in Case Vignette 4 below.
5. Consultation with a geriatric psychiatrist may be sought regarding interpreting AHCD statements that may underlie a dispute about health care.

If asked to consult in this area, the psychiatrist is cautioned to consider ethical issues with special care; opinions may border on medical "advice," and to the extent opinions may favor one or another party, accusations of bias are possible.

Case Vignette 3

A nephew of Mrs. C sought evaluation by a forensic psychiatrist regarding her possible capacity to change her wishes concerning discontinuing life support in the face of futility. Mrs. C had "end-stage" dementia; attempts to wean her from a respirator with tracheostomy for 8 months had failed. The nephew was the second successor designated on Mrs. C's AHCD, which specified that she did not want her life sustained "on machines." Mrs. C's nephew felt this statement directly applied in the current circumstance, but Mrs. C had designated her only son as the first agent, and he was unable to authorize withdrawing treatment. The son recognized his mother could not talk, but he believed she "recognized" him—she turns to look at him, "smiled," and "squeezed my hand." His friends reportedly supported his observations, so he (and they) felt she was "still there." Nonetheless, Mrs. C's son agreed to evaluation of his mother's mental functions regarding her ability to communicate meaningfully.

Mrs. C was bed-bound, with some apparently random movement of her limbs; she was on a "turning schedule" to prevent decubitus ulcers. She could not vocalize, and she was incapable of following any command. She was at times able to track with her eyes, and she sometimes turned toward a sound, including a voice; she indeed managed a "social smile" once when the psychiatrist spoke and made eye contact. Mrs. C manifested a strong reflexive grasp response (and other primitive reflexes). Facility staff confirmed that she had been essentially unchanged since admission (months); her physician unequivocally opined that she would not be able to survive without the respirator support.

Conveying to the son that the "responses" he detected were automatic features of end-stage dementia was discouraging but accepted by him. After an ensuing family conference, he decided to resign as his mother's agent to allow his cousin to make the decision that he recognized as being consistent with his mother's directives but that he could not himself make.

Case Vignette 4

Mr. D was a 92-year-old man who developed severe vascular dementia with very erratic behavior. His AHCD specified his two sons were to *share* powers, but they continued to disagree bitterly, attempted to restrict each other's access to Mr. D (only, of course, for his own good), and retained attorneys to press their cases, including a petition for conservatorship.

In the meantime, Mr. D had collapsed and been taken to the hospital, where the sons' disagreements (and threats of legal retaliation) confounded the treating physicians. Mr. D's AHCD stated he wanted "everything done," but another clause specified that pain was to be treated even at the risk of medical complications. The sons disagreed on the priority of these statements, and hospital staff were faced with difficult decisions that resulted in delay or forgoing pain medication that many felt was clearly indicated. Psychiatric opinion was required for behavioral management, as well as to inform the court of Mr. D's current mental functions in relationship to decision-making powers. A neutral professional was appointed conservator. With this clarification, when Mr. D's medical condition stabilized, he was returned to his home with round-the-clock care.

Elder Abuse

Elder abuse affects people of all ages, either directly by involving family or friends or indirectly by adding to the fears and stresses that accompany our own aging and the aging of family members. Tens of thousands of cases of presumed elder abuse are reported to Adult Protective Services (APS) agencies annually (National Center on Elder Abuse 1998). One study determined that more than 3 per 100 persons age 65 and over had been victims of elder abuse—*not* including *financial* elder abuse (Pillemer and Finkelhor 1988). These numbers almost certainly underestimate the current dimensions of the problem and can be expected to mushroom in coming years.

The American Medical Association's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect define elder abuse and/or neglect as "an act of commission or omission that results in harm or threatened harm to the health or welfare of an older adult" (American Medical Association 1994) and delineates subtypes, as summarized:

1. *Physical abuse* results from the use of force that can result in injury, pain, or impairment and can be documented by the resulting injuries. Inappropriate use of drugs, restraints, or punishment and the imposition of medical procedures without consent are also considered physical abuse.

2. *Sexual abuse* is any type of nonconsensual sexual contact, including rape, other types of assault, exposure, and nudity. Sexual abuse of elders is an especially grave concern in settings where unrelated caregivers attend patients without supervision (Weinberg 2002).
3. *Emotional or psychological abuse* refers to any verbal or nonverbal acts resulting in anguish, pain, or other distress (e.g., insults, threats, humiliation, or harassment); actions may include
   - "Brow-beating" an elder whose responses may be constrained by immobility and/or cognitive limitations.
   - Isolation from contact with friends, family, and/or community, which further allows an abuser unfettered access for influence—as well as reducing the risk of discovery. Controlling mail, phone, transportation, and other access facilitates this effort.
   - "No one else cares about you except me" reinforces isolation and control of access, as in previous point, and provides "evidence" that family, friends, or neighbors are not involved (as in Case Vignette 1); an analog of the "Stockholm syndrome" may result from such isolation.
   - Romance, often with overt sexual contact, can be a powerful weapon of manipulation. An elder may accept professions of love and lust at face value, as in Case Vignette 5, and maintain these poor judgments in the face of overwhelming evidence of the mendacity and duplicity of the abuser. When the abuser is able to "sanctify" the relationship by marriage, further rights and privileges accrue, as in Case Vignette 2.
   - "Care"—eating, toileting, cleaning up, thirst, medications—can easily be "managed" to reinforce the abuser's commitment or overtly to suppress will and cognition. Manipulation of prescription medicines, especially for pain, or access to alcohol or cigarettes also can be very effective means of control that do not leave an identifiable trace.

Case Vignette 5

Mr. E was an 89-year-old bachelor carpenter who "fell in love" with a 42-year-old female real estate agent who was making a "cold call" at his house. Within 18 months of answering the door, she had acquired a new house and a new car, and Mr. E had designated her as his heir. Neighbors reported the situation to APS (Adult Protective Services), resulting in a petition for conservatorship.

At evaluation with the psychiatrist, conducted in a care facility, Mr. E was very friendly and sociable—and flirtatious with the female staff—but he avowed that he "loved" the agent and that she "wanted to marry" him—and he reciprocated; when the phone rang, he almost panted in anticipation that she might be calling. Mr. E confirmed he had "bought" her house and was happy to have done so. He spoke of his home with pride, but he believed the

value was less than one-third of the amount that had been obligated (to buy the house and car for his beloved), and he flatly denied that so much could have been borrowed—or that his lover would have exploited him in that way. Examination documented deficits in memory, executive functions, visual skills, and verbal fluency characteristic of mild to moderate dementia due to Alzheimer's disease.

Mr. E was in fact bankrupt. Civil action was brought against the real estate agent and her firm by the court-appointed conservator; she also faced criminal proceedings for elder abuse. Given the low prospects of regaining his wealth, it was fortunate that Mr. E belonged to a professional organization that provided long-term care benefits.

Financial elder abuse and exploitation is often the primary motivation of the abuser and therefore may accompany psychological or other forms of abuse. Financial irregularities are pleomorphic and are more likely to be identified by friends and neighbors, family members, financial professionals, or attorneys than by a physician. As in Case Vignette 5, the "victim" may not experience "abuse" and in fact may feel demeaned by the suggestion that he or she was exploited. Instead the victim may have strong feelings of appreciation for the abuser's "caring" and may actively collaborate in concealing the abuser's role (and deny overt dependence). In particular, the victim may excuse other actions undertaken by the abuser even when it is clear they were for the abuser's benefit.

The role of the forensic psychiatrist can be crucial in assisting the court to distinguish actions taken by a competent elder, however foolish, from those that result from influence exerted by a calculating person to exploit weaknesses of an elder. In a case of elder abuse, the details of the analysis should focus on correlating specific deficits in mental function demonstrated by a careful and thorough examination with those actions taken as a result of the subject's vulnerabilities. When it is available (as with the videotapes of Mr. B in Case Vignette 2 and with Mr. E's unbridled lust), direct evidence for the actions of the abuser that take advantage of the victim's weakness or situation can be very helpful in confirming a presumption of exploitation based on circumstantial evidence.

Other examples of elder financial abuse are noted below (note that this list cannot be considered exhaustive, given the creativity of the unscrupulous):

a. Cheating dependent elderly on expenses and/or wages by caregivers (not excluding family members) and workers. As dependent elders become more impaired (vision, memory, ability to write), they will often need "help" paying bills, managing household maintenance, and getting cars repaired—and will come to trust the caregivers, thereby providing many opportunities for "padding" bills or creating fictitious "expenses."

b. Providing unneeded or misjudged financial "services"—for example, selling a 25-year annuity to a 97-year-old with cancer.
c. Making property transfers disadvantageous to the victim, often attributable to the victim's poor awareness of true property values, as in Case Vignette 1.
d. Inducing a change in beneficiaries in testamentary documents.
e. Exploiting a contract for home repairs or other services or persuading an elderly person to undertake unneeded repairs.
f. Exploiting elders via the computer. Computers, surprisingly enough, have become a new means of access to vulnerable elders for exploitation. "Dating" services may obviate the need to actually knock on doors to make contact. Fraudulent notice of winning a "lottery" can lead to financial ruin, as the victim sends money to pay "fees" or "deposits" or to fund the fraudulent agent's efforts.
g. Obtaining authority to receive and/or cash Social Security or other pension checks, sign on bank accounts, and so forth.

Violence

Elderly persons do commit violent crimes, although less frequently and in different circumstances than persons at younger ages (Wilbanks and Murphy 1984). In many cases, motivations for violent acts differ in the elderly, with the acts occurring in the context of aging issues (e.g., fatigue and hopelessness of a dementia caregiver). Forensic assessment of an elderly person accused of a violent crime should be undertaken in view of these issues and with awareness of the potential influence of dementia, delirium, or other cognitive disorder on mental function, as discussed earlier. If no cognitive disorder is present, the legal system may appropriately respond as it would to a crime by a younger person. Here we briefly review particular aspects of the analysis and management of violence in older persons; the reader may wish to consult more complete treatments (Weinstock et al. 2008).

Violence in a hospital setting is very likely to precipitate urgent psychiatric consultation. It may be necessary to administer sedation or otherwise ensure safety before completing what will be a complex assessment. Performing and documenting as complete an evaluation as possible is important not only for caregivers to determine appropriate treatment and management but also for subsequent evaluators to use if legal action ensues. A difficulty of eliciting a history of the event is that witnesses are likely to emphasize the violent act itself, and its consequences and their reaction, rather

than retaining observations about what preceded the act, which is critical if one is to understand cause. The problem is compounded if no direct witnesses are available; one must take care in accepting a retrospective formulation (e.g., by a supervisor) as a statement of fact. The patient's awareness of and statements regarding the event are also important both for management and for subsequent legal implications, but reliability is always an issue: delirium is common in hospitalized elderly patients, especially in those with preexisting dementia, in addition to potent emotionality and the possibility of lying and/or malingering.

Violence is an important issue in the context of long-term care—either at home or in a facility (Hall et al. 2009a). Incidents may involve altercations between residents; violent actions on an elderly resident by caregivers; or violent actions by an elderly person against family, other residents or patients, caregivers, or facility staff. In such settings, there is greater likelihood of a gap between the incident and the consultant's involvement. Obtaining a history is challenging: there may be no witnesses if there is only an injury recognized after the fact; residents (and identified victims and perpetrators) are more likely to have some degree of dementia; the staff present during the incident may be off-duty, or the consultant may only be able to communicate with a person of authority such as an owner or an administrator; and charting may be nonexistent (e.g., in home care), and when it does exist, one may encounter the uncertain training of caregivers regarding behavioral issues. In addition, awareness of the potential for allegations of elder abuse, or for compensation issues if staff are injured, can inhibit or distort the account given.

It has long been recognized that violence is a precipitant of placement for patients with dementia (Rabins et al. 1982), but violent actions threaten the stability of any living situation, whether at home or in a skilled nursing facility or another facility at a less intensive level of care. If the victim is elderly, investigation for elder abuse may be mandated, and the victim may be removed for safety and/or assessment. In addition to clinical psychiatric assessment, issues of responsibility, capacity, and competence may well be raised, explicitly or implicitly—that is, referral for psychiatric hospitalization or to a "higher level of care."

Ethics

All the ethical issues that arise in younger patients are also seen in the elderly. The American Academy of Psychiatry and the Law (AAPL) ethical guidelines

(www.aapl.org/ethics) apply in all these contexts. Many ethical issues in the care of the elderly (Read 2005) also apply to the forensic psychiatrist. Issues of elder abuse and exploitation have been discussed earlier in this chapter. Determining the capacity for informed consent, either at present or at the time of designating a surrogate decision-maker or completing an AHCD, is often central to resolving the more complex ethical dilemmas that happen in serious illnesses or at the end of life (Spielman 1986; Weinstock 1987). AHCDs are intended to assist family and clinicians, but they can be subject to different interpretations. If they include a provision that the burdens of an intervention should not outweigh the benefits, disputes can arise due to differing interpretations. As in Case Vignettes 3, 5, and 6, a forensic psychiatrist may be asked to consult about the competence of a patient to make these decisions.

Physicians' own feelings about these issues can affect their objectivity if they do not watch out for their own biases in complex decision making. Traditionally, doctors have wanted to prolong life and might still be tempted to disregard the documented wishes of patients or their proxy substitute decision-makers. Although not strictly geriatric, Case Vignette 6 below illustrates the more recent ethical problem of patients or surrogate decision-makers who may feel pressured to forgo or to stop life-sustaining treatments or who may be loathe to continue aggressive treatment when they evaluate "quality of life" as negligible. Financial pressures on hospitals to get patients out of expensive ICUs may be involved. A physician may invoke the concept of "futility" when he or she does not feel that intensive care is appropriate because there is no credible hope of functional recovery. It may be appropriate to stop treatment if there is a very trivial chance of recovery, but where is the cutoff: 5%? 10%? And how sure can one be about those statistics?

Age discrimination can be a factor in regard to views about what kind of life is worth living. The physician or medical team may judge the burdens and benefits of treatment differently from patients or surrogates. For example, patients and family might view certain types of recovery as meaningful even if the doctors do not. People might want to stay alive for an event like a child's marriage, graduation, or birth of a grandchild. Similarly, a physician must also be aware of being overly dogmatic in judgments about safety versus other life issues. Evaluating the significance of a lack of insight in an elderly individual with early dementia is a common issue in a forensic geriatric psychiatry consultation. Sometimes it is necessary to seek a conservatorship or guardianship to protect an elderly person because of self-neglect, but sometimes elderly people might legitimately prefer to take some chances and remain in their own homes. Total safety should not always trump the desire of a person to live independently. Our main point is that many of these

issues are complex, lead to ethical dilemmas, and need careful individual assessment, including awareness of the potential pitfalls on both sides of the proposed decision.

Case Vignette 6

Mr. F was a 43-year-old man who lapsed into coma after a cholecystectomy. After 3 months in ICU, the medical team proposed to discontinue life support. At admission, Mr. F had designated his longtime girlfriend as his surrogate, but she voluntarily abdicated when his parents became passionately involved. The parents' religious faith reinforced their pride in their son's having been the first member of his immigrant family ever to graduate from university. They were convinced that he would return to consciousness and life. They firmly disputed the opinion of the neurology team that the patient was completely unable to communicate and that his condition was permanent with no hope for recovery.

A court ordered a forensic psychiatric evaluation. The psychiatrist was unable to achieve any meaningful communication with the patient but did observe him respond to touch and verbal contact, especially from the patient's mother. It was noted that the patient had had severe seizures post-op and was still taking antiepileptic medications. At his recommendation, these were tapered—and the patient woke up! He returned to work 4 months later.

One must be careful not to counter the express wishes of family inappropriately and ignore what they believe the patient would have wanted (substitute decision making); culture-specific factors may underlie such differences. It is not ethical for physicians to make unilateral decisions in these contexts. It also is not appropriate to pressure family to stop treatments or to accept do not resuscitate (DNR) by considerations that might not be relevant. For example, portraying pounding on a patient's chest as terribly painful may not be appropriate for an unconscious patient. Also, statements that patients would never survive a procedure should not be made cavalierly without good reasons to back them up.

Physician-assisted suicide is now allowed in an increasing number of jurisdictions, following its original legalization in Oregon (Emanuel 2002). All of the assessment issues and the attention to potential ethical pitfalls come into play in physician-assisted suicide, where, obviously, the outcome is not reversible. The most careful attention must be paid to cognitive status as it relates to decision-making competence. Assessing the role of depression in the decision, whether the mood may be judged to be appropriate or to represent the emergence of a pathologic state, is also crucial (Ganzini et al. 2008), and any indication of influence that may be motivated for ulterior motives (such as caregiver fatigue or a desire to preserve one's inheritance) must be carefully analyzed.

Conclusion

The forensic psychiatrist can expect to be asked to evaluate older persons more frequently in coming years, since the numbers and percentage of aging persons, especially the "oldest old" (i.e., those older than 85 years), continue to increase in society. Other factors are the increasingly long survival of many persons with dementia or with severe medical illness, the large amount of wealth held by elderly persons, and the complexities of health care decisions.

Capacity and competence are the central concerns in the majority of issues in older age groups, together with vulnerability to influence. The prevalence of dementia and other cognitive disorders mandates careful assessment of cognitive functions as an essential part of the geriatric forensic psychiatry evaluation. Although older persons may be involved in many of the same forensic issues as younger persons, the forensic psychiatrist will be better prepared if there is knowledge and appreciation of the specific events and circumstances that older people either face or anticipate. Common issues include testamentary issues, the capacity for other financial decisions, decision making around medical and other care issues, violence, long-term care matters, and elder abuse and exploitation. Opinions regarding undue influence are complex, and most often the expert will be limited to delineating weaknesses and vulnerability, although analysis of influence may be warranted if suitable materials are available. Above all, forensic geriatric psychiatrists should be mindful of their ethical obligations for this frequently impaired and vulnerable group of patients. The forensic geriatric psychiatrist can make a major and critical contribution to protecting both the rights and the frailties of elderly persons, thereby improving the prospects for all of us, as we ourselves age.

Key Points

- Increase in the percentage of older persons in the population in coming decades will result in greater court involvement with geriatric issues by forensic psychiatrists.
- The high incidence of cognitive impairment in the elderly makes analysis of competence and capacity most often a central issue in a forensic evaluation of an older person.

- Familiarity with the dementias and the medical and social consequences of aging is an essential skill for a geriatric forensic psychiatry evaluation, with special emphasis on executive functions.
- Diagnosis of the cause of any impairment of mental functions is relevant to prognosis and of course to treatment issues, but is less important than the specifics of impairments in mental function for an opinion on decision-making capacity.
- An expert asked to evaluate allegations of undue influence will focus on susceptibility factors, including not only the subject's level of mental function but also dependency and other situational factors.
- Since elderly persons will be the source of a major proportion of the $40 trillion expected to change hands by inheritance in coming decades, will contests can also be expected to increase in frequency and importance.
- Decision making as regards medical care can raise complex issues of values and goals.
- Elder abuse is a common and growing problem in the United States. The typology of elder abuse includes physical, emotional/psychological, sexual, and financial abuse, although these do not occur in "pure culture" but generally coexist in various combinations.
- Elderly persons may commit violent acts but do so less frequently than younger persons and more often than not with a spectrum of motivations different from those of younger persons.
- Ethical issues must be kept constantly in mind in the forensic assessment of elders, perhaps most seriously in an assessment related to physician-assisted suicide.
- Cultural values may make major contributions to the valuations made by patients and/or families; the forensic psychiatrist must keep in mind the source of his or her own values and take care not to impose unethically on others.

Practice Guidelines

1. Assume that issues of decision-making autonomy will be raised by one party or another in evaluating older persons. Older persons may be referred for evaluation for the full spectrum of issues

involving younger persons, but in the evaluation of an older subject, it is prudent to assume that issues of decision-making autonomy, related to capacity and/or vulnerability to influence, will be raised.

2. Ascertain the statutory criteria for capacity in the relevant jurisdiction in addition to the criteria for the matter at issue.
3. Be aware of potential biases in the sources of collateral information. Collateral information is crucial in the evaluation of a living subject; the psychiatrist must, however, be aware of potential biases in the sources of this information.
4. Make analyses of specific mental functions and their effects on understanding and/or appreciation for capacity determinations in addition to determining the diagnosis per se.
5. Remember that in a retrospective capacity determination—for example, a will contest—the same analytical principles hold, except that the expert must rely on other materials that may be available to be able to comment on levels of the subject's mental function.

References

American Medical Association: Diagnostic and Treatment Guidelines on Elder Abuse and Neglect (Publ No AA22:92-698-20M). Chicago, IL, American Medical Association, 1994

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Boone KB: The Assessment of Feigned Cognitive Impairment: A Neuropsychological Perspective. New York, Guilford, 2007

Brunnstrom H, Englund E: Clinicopathological concordance in dementia diagnostics. Am J Geriatr Psychiatry 17:664–670, 2009

Buchanan A: Book reviews. J Am Acad Psychiatry Law 37:417–422, 2009

Cervantes M: Don Quixote. Translated by Edith Grossman. New York, HarperCollins, 2003, pp 936–938

Cialdini R: Influence—Science and Practice: Boston, MA, Allyn & Bacon, 2001

Cummings JL: "Mini-Mental State Examination": norms, normals, and numbers. JAMA 269:2420–2421, 1993

Devanand DP: Psychiatric assessment of the older patient, in Comprehensive Textbook of Psychiatry/VIII. Edited by Sadock BJ, Sadock VA. Philadelphia, Lippincott Williams & Wilkins, 2005, pp 3603–3610

Emanuel EJ: Euthanasia and physician-assisted suicide: a review of empirical data from the United States. Arch Int Med 162:142–152, 2002

Folstein M, Folstein S, McHugh P: 'Mini-Mental State:' a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 12:189–198, 1975

Ganzini L, Goy ER, Dobscha SH: Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. BMJ 337:a1682, 2008

Glimcher PW: Decisions, Uncertainty, and the Brain: The Science of Neuroeconomics. Cambridge, MA, MIT Press, 2003

Hall RCW, Hall RCW, Chapman MJ: Nursing home violence: occurrence, risks, and interventions. Annals of Long Term Care 17:25–31, 2009a

Hall RCW, Hall RCW, Myers WC, et al: Testamentary capacity: history, physicians' role, requirements, and why wills are challenged. Clin Geriatr 18:18–24, 2009b

Hankin M, Read S: Mental incapacity to marry. Estate Planning, Trust and Probate News. State Bar of California 14:46–52, 1994

Harris VM: Ancient, Curious, and Famous Wills. Boston, MA, Little Brown, 1911

Jorm AF: The value of informant reports for assessment and prediction of dementia. J Am Geriatr Soc 51:881–882, 2003

Marson DC, Ingram KK, Cody HA, et al: Assessing the competency of patients with Alzheimer's disease under different legal standards. Arch Neurol 52:949–954, 1995

National Center on Elder Abuse: National Elder Abuse Incidence Study. Washington, DC, American Public Human Services Association, 1998

Pillemer K, Finkelhor D: The prevalence of elder abuse: a random sample survey. Gerontologist 28:51–57, 1988

Rabins PV, Mace NL, Lucas MJ: The impact of dementia on the family. JAMA 248:333–335, 1982

Read S: Vascular dementias, in Comprehensive Review of Geriatric Psychiatry, 3rd Edition. Edited by Grossberg GT, Jarvik LF, Meyers BS, et al. New York, WW Norton, 2004, pp 511–524

Read S: Ethical issues (in geriatric psychiatry), in Comprehensive Textbook of Psychiatry/VIII. Edited by Sadock BJ, Sadock V. Baltimore, MD, Lippincott Williams & Wilkins, 2005, pp 3806–3813

Rogers J: The Second Best Bed: Shakespeare's Will in a New Light. London, Greenwood Press, 1993

Royall DR, Mahurin FK, Gray K: Bedside assessment of executive dyscontrol: the executive interview (EXIT). J Am Geriatr Soc 40:1221–1226, 1992

Schneider LS: Mild cognitive impairment. Am J Geriatr Psychiatry 13:629–632, 2005

Silver IL, Herrmann N: Comprehensive psychiatric evaluation, in Comprehensive Textbook of Geriatric Psychiatry, 3rd Edition. Edited by Grossberg GT, Jarvik LF, Meyers BS, et al. New York, WW Norton, 2004, pp 253–279

Simon RI: Suicide risk assessment forms: form over substance? J Am Acad Psychiatry Law 37:290–293, 2009

Spielman BJ: Rethinking paradigms in geriatric ethics. J Religion Health 25:142–148, 1986

Strub RL, Black FW: The Mental Status Examination in Neurology, 4th Edition. Philadelphia, PA, FA Davis, 2000

Tombaugh TN, McIntyre NJ: The "Mini-Mental State Examination": a comprehensive review. J Am Geriatr Soc 40:922–935, 1992

Towner B: The new face of America. AARP Bulletin, June 2009, p 31

Weinberg AD: Issues involving sexual abuse of nursing facility residents. J Am Med Directors Assoc 3:395–396, 2002

Weinstock R: Informed consent and competence issues in the elderly, in Geriatric Psychiatry and the Law. Edited by Rosner R, Schwartz HI. New York, Plenum, 1987, pp 49–78

Weinstock R, Read S, Leong GB, et al: The elderly, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Publishing, 2008, pp 381–406

Wilbanks W, Murphy D: The elderly offender, in Elderly Criminals. Edited by Newman D, Newman ES, Gewirtz M. Cambridge, MA, Oelgeschlager, Gunn & Hain, 1984

Suggested Readings and Relevant Web Sites

Dementia: A Clinical Approach by Mario F. Mendez and Jeffrey L. Cummings (Philadelphia: Butterworth Heinemann, 2003) is a thorough review by experienced clinicians.

The Comprehensive Review of Geriatric Psychiatry, Third Edition (edited by Grossberg GT, Jarvik LF, Meyers BS, and Sadavoy J; New York, WW Norton, 2004) and the geriatrics section (edited by G.W. Small) of *Comprehensive Textbook of Psychiatry*/VIII (edited by Sadock BJ and Sadock V. Baltimore, MD, Lippincott Williams & Wilkins, 2005) provide thorough reviews of aspects of geriatric psychiatry, including treatments of forensic and ethical issues.

U.S. Census Bureau: An aging world: 2008. Washington, DC, U.S. Department of Commerce, June 2009. Available at: http://www.census.gov/prod/2009pubs/p95-09-1.pdf. Accessed January 28, 2010.

There are a plethora of journals and Web sites related to specific aspects of this chapter; the American Academy of Psychiatry and the Law (www.aapl.org), the American Association for Geriatric Psychiatry (www.aagponline.org), the American Medical Directors Association (for long-term care: www.amda.com), and the American Geriatrics Society (www.americangeriatrics.org) are all professional organizations with valuable information on topics relevant to the forensic geriatric psychiatrist.

Chapter 20

Personal Violence

Alan R. Felthous, M.D.

Potentially violent patients are the concern of every psychiatrist and mental health professional. Assessment and treatment of clinical violence have been described in various texts and articles with which the reader is undoubtedly familiar. Here, I focus on contexts of special relevance to forensic psychiatric consultations.

Despite common themes in consultations regarding past or potential violence, contextual distinctions warrant the consultant's attention. Forensic psychiatrists are likely to be consulted in response to one of two situations involving potentially violent individuals: 1) determining how to appropriately deal with a potentially violent person within the criminal justice system or in the community, and 2) determining a legal duty to protect when a clinician is accused of professional negligence in failing to take reasonable action to prevent the patient from inflicting violence on others.

Forensic consultations concerning acts of personal violence can arise in the criminal justice system when the actor is charged with a criminal offense. The emphasis in this context is on risk assessment and prevention, not criminal competencies or adjudication of guilt. In this chapter, I address consultation within the criminal justice system involving jail risk assessments, pretrial dispositions, dispositional determinations, not guilty by reason of insanity (NGRI) dispositions, and criminal sentencing and release decisions.

Consultations regarding potentially violent individuals free in the community are also preventive in aim, designed to assess and diminish the risks. Contexts for consultations in the civil sphere include workplaces, schools, and homes, as well as other situations.

Professional negligence cases that have involved the death or injury of a third person are of particular relevance to forensic consultants. Contexts to be addressed in claims of professional negligence include inpatient violence, posthospital discharge violence, and outpatient violence.

The Evaluation of Violence

Principles in risk assessment and approaches to preventing violence that cut across contexts include documentation, character pathology, and impulsive aggression. Any discussion of good practices and risk management appropriately emphasizes the importance of quality documentation in the medical record (Tardiff 2002). Assessment, treatment, and management of clinical violence should be supported by data and logic. Quality documentation in the evaluation and management of potentially violent patients forces clarity of thought and enhances the utility of the record as a clinical tool. Although "treatment of the chart" is certainly secondary to treatment of the patient, quality treatment must be based on data, sound clinical logic, and effective implementation—all supported by documentation. In claims of professional negligence, absence of charted information does not mean absence of care; however, establishing that appropriate care was provided becomes more difficult to demonstrate convincingly.

Character pathology presents a paradox for clinical assessment and management of future violence. Typically, the most effective method for a clinician to protect the public from a patient's violence is to hospitalize the patient. Clinicians hospitalize patients for the treatment of major mental illness, including psychotic disorders. However, hospitalization for the purposes of treatment is not as universally accepted for patients whose primary pathology is that of a personality disorder absent an acute Axis I condition. Yet psychopathy, a severe form of character pathology, is a better predictor of future violence than any disorder of major mental illness, especially when assessed with the Hare Psychopathy Checklist—Revised (Hare 1991; Hare et al. 2000; Hart et al. 1994). Some research suggests conventional treatments can make psychopathy worse (Hare 1991; Hare et al. 2000; Rice et al. 2002), although the verdict on the "treatability" of psychopathy is still out (D'Silva et al. 2004; Skeem et al. 2002) The obvious paradox is that measurement of psychopathy

will improve assessments of the risk of future violence among individuals for whom the safest short-term clinical intervention, hospitalization, may be antitherapeutic and, indeed, may enhance the future risk of violence (Pajerla and Felthous 2007). The consultant must confront this troublesome paradox and place appropriate emphasis on clinical issues and currently accepted standards of care.

A person's risk for violent behavior is dynamic and subject to change—sometimes dramatic change. The most violent of individuals is not violent all of the time or even most of the time. Internal changes involving toxic or metabolic factors can lead to altered mental states with increased potential for aggressive behavior. External events that result in frustration, provocation, losses, and other acute stresses, as well as social influences such as gang activity, can also increase the potential for violence. In addition, these internal and external changes are interactive and cannot always be separated. For example, environmental changes commonly lead to physical discomfort or autonomic arousal. Therefore, effective risk assessment is an ongoing dynamic process, wherein an evaluator or treater looks for environmental and internal changes that promote or diminish the individual's likelihood of acting aggressively. Concurrent ongoing assessment can also be coupled with efforts to gain a more complete and accurate history of static factors and a better understanding of the sensitive issues most likely to trigger an aggressive response.

Clinicians basically follow one or more of four approaches to the assessment of potential for personal violence: 1) diagnostic, 2) behavioral, 3) actuarial, and 4) phenomenological. Although overshadowed in research literature by actuarial risk assessment and sometimes diminished as poorly predictive of future violence, the traditional medical model of assessment is the most useful and common approach in psychiatry. Some individuals are violent only as a result of a mental disorder. Once the disorder is effectively treated, the risk of violence due to the disorder is lessened. Mania, for example, is one of several disorders that can, in some individuals, present with violent behavior (El-Mallakh et al. 2008; Tardiff 2007). If impulsive aggression is due to mania, pharmacotherapy with lithium or valproate should diminish the risk of violence (Moeller and Swann 2007). The understated advantage of the diagnostic approach over the actuarial approach is that it guides treatment measures toward prevention and correction of violence due to brain dysfunction.

Behavioral assessments examine factors that reinforce and perpetuate recurrent aggression and those that lead to lessening of such behavior. Behavioral assessments are useful for correcting problematic, aggressive behaviors, especially for chronic behavior in individuals in institutional settings. Actuarial assessments aim to quantify the risk of future aggression with reason-

able accuracy, not identifying and treating the underlying cause. Weak as any methods of predicting future violence are, actuarial assessments can, in principle, provide the most accurate percentage probability predictions. They have been used increasingly, but not universally, for dichotomous decision making with legal significance, such as whether or not to release a patient from a maximum-security hospital. Ontological assessments aim to identify the nature of the aggression itself (e.g., impulsive or premeditated), regardless of pathological context. The ontology of aggression begins with its opposite, the phenomenology of aggression; the assessment is descriptive, yet the behaviors are based on different causal mechanisms.

Barratt (1991) has classified the nature of aggression into premeditated, impulsive, and medically related aggression. The third category is useful in its recognition that effective treatment for the disorder will cause the aggression to subside. A slightly modified classification, emphasizing involvement of emotion and thought more than disorder, recognizes that even medically related aggression can vary, as follows (Felthous 2008): 1) impulsive aggression, with much emotion and little thought ("hot blooded" and sudden); 2) spontaneous aggression, with little emotion and thought (e.g., sudden aggression with "devil may care" indifference); 3) compulsive aggression, with much emotion and thought (e.g., planned revenge); 4) premeditated aggression, with little emotion and much thought ("cold-blooded" and planned).

Impulsive aggression (Barratt et al. 1997a, 1997b; Felthous and Barratt 2003; Moeller and Swann 2007; Stanford et al. 2001) is increasingly recognized as a treatable condition that is manifested by violent behaviors. The consultant who addresses violent individuals within and outside the criminal justice system must be prepared to identify the presence of impulsive aggression when assessing the intensity, severity, and frequency of violent acts. Impulsive aggression is a condition probably better recognized by researchers than by clinicians. Thus, its full assessment and appropriate treatment, arguably, are not yet mandated by standards of practice. Nonetheless, the favorable response of impulsive aggression to pharmacotherapy can result in better control of impulsive aggression, even among individuals with antisocial personality disorder (Barratt et al. 1997a; Citrome 2008; Moeller and Swann 2007), who might otherwise be considered resistant to treatment efforts.

The relevance of the concept of impulsive aggression to consulting forensic psychiatrists may not be immediately obvious. It is not a formal *Diagnostic and Statistical Manual of Mental Disorders* (DSM) disorder (American Psychiatric Association 2000), and it has much in common with intermittent explosive disorder (Coccaro 2003), which *is* a DSM disorder. However, consultants familiar with the literature on impulsive aggression and intermittent explosive disorder will be better informed about the nature of com-

mon forms of abnormal aggression. They will, therefore, be better able to evaluate, treat, and manage aggression and to provide opinions regarding the clinical performance of other clinicians in cases of claimed professional negligence.

The concept of impulsive aggression has been and continues to be more inclusive yet more precise in its description and, therefore, more often indicative of potentially efficacious therapeutic approaches. The importance of its familiarity to consultants is the disorder's conceptual constancy, construct validity, psychological and physiological manifestations, frequency, comorbidity with other disorders, and favorable response to treatment (Barratt et al. 1997a, 1997b; Felthous and Barratt 2003). In fact, a case has been made for recognizing impulsive aggression as a disorder (Felthous and Barratt 2003). Already well validated by empirical research, impulsive aggression is now well accepted by clinical and forensic practitioners generally (e.g., Barratt 1994; Coccaro 2003; Quanbeck and McDermott 2008; Wakai and Trestman 2008).

Despite the commonality of such issues in the forensic assessment of violence, context will clearly be of major significance in any assessment. Space does not allow inclusion of all the contexts in which the forensic evaluation of personal violence may arise or the comprehensive treatment in any single context. For example, a discussion of the assessment prevention and management of inpatient violence alone could easily occupy an entire chapter. Accordingly, I do not attempt to address every possible situation but, rather, emphasize issues specific to each context. The reader is encouraged to examine other treatises for a more complete understanding of aggression and risk assessment in a particular setting.

Two principles relative to any situation will determine the focus and depth of the evaluation of violence: the apparent need (e.g., the subject is threatening violence vs. the subject is showing no signs of aggression) and the clinical situation (e.g., providing anxiety reduction for people trying to give up cigarette smoking vs. treating hospitalized insanity acquittees).

Potentially Violent Persons in the Criminal Justice System

Forensic consultations in the criminal justice system subserve the general purpose of preventing future violence. In criminal law, however, the consultant can also be called on to provide input regarding assessment of guilt and, after adjudication, of punishment. Courts may not always use or require

clinical information in making their determinations. Nevertheless, many courts may use psychiatric assessments of the risk of violence in determining whether to deny bail, whether restoration of competency should take place in a secure hospital setting, or whether after conviction it is safe to release the defendant on probation. Parole boards may rely on psychiatric or psychological assessments in determining whether a prisoner is sufficiently risk free to warrant early parole.

Jail

Case Vignette 1[1]

A 29-year-old jail inmate was referred for a psychiatric consultation after he assaulted another inmate. His family history and childhood behaviors were consistent with an assaultive predisposition. Mother and father fought physically when intoxicated, and mother once shot father. She left him and married a man who abused the subject. Mother also punished the subject excessively by whipping him with extension cords, coat hangers, and a water hose and slapping him in the face.

Childhood behavior consistent with conduct disorder included school truancy, behavior leading to school suspensions, fighting, destruction of property, window-breaking, and recurrent, severe cruelty to animals, including many cats.

After mental status examination and further studies, diagnoses included antisocial personality disorder and mixed personality disorder with schizotypal, borderline, and paranoid features, as well as a history of alcohol and cocaine abuse.

The night before the assault that occasioned his psychiatric referral, the inmate dreamed that another inmate attempted to harm him. Although not in any other way psychotic or delusional, he was convinced by virtue of his dream that this particular inmate would seriously harm him if he did not attack the other inmate first. Careful history revealed that the same pattern had surfaced at least twice before. On two previous occasions, a nocturnal dream had identified someone in the subject's social environment as a threat. Both times, he attacked the other person preemptively, once with a knife.

In an attempt to favorably alter the inmate's sleep architecture and to decrease the sense of tension, the consultant prescribed doxepin, which had no effect. Though the inmate was seen by the consultant with increased regularity, the violent dream-threatening belief–violent act sequence occurred again. This time the inmate attempted to enucleate another inmate's eye. Doxepin was replaced with thiothixene concentrate 10 mg/day, which was apparently

[1]Felthous 1993; condensed and reprinted with permission from Whurr Publishers, Ltd.

effective in treating the encapsulated persecutory beliefs associated with violent dreams. No further troubling dreams or acts of violence occurred for the duration of the inmate's jail detainment.

Comment

Sometimes, the pathology behind a violent act is an uncommon and unstudied but exquisitely treatable condition. In looking for commonly recognized factors in individual assessments, psychiatrists should remain alert for unusual psychological processes that can benefit from appropriate treatment (Felthous 1993). In this case, if the evaluation had concluded after the mental status exam and other studies, a critically important clinical finding would have been overlooked.

A common task for psychiatrists who consult to jails is to conduct risk assessments of inmates. Even though suicide is a more frequent risk than homicide for suspects booked into a jail, the criminal behaviors for which individuals are arrested are often aggressive. Some attempt to assess for the risk of violence is useful. Occasionally, recent threats, preparatory behaviors, or recent overt acts make such an assessment imperative.

Serious assaults and homicides can occur inside jails. These acts can be impulsive and without warning or carefully planned well in advance. All inmates who are seen for the first time should be screened for homicidal ideation. When special reason for concern arises, the consultant should examine recent and past acts of violence, motivations, circumstances, methods of execution, seriousness of injuries, and other outcomes. Assaultive ideation should be evaluated for seriousness of intention and care in planning and should be probed for the degree of absolutistic (no alternatives) and deterministic (strong and unwavering) thinking. When an identifiable victim resides in the jail and the risk is high, some physical separation may be indicated. When the identifiable victim is in the community, an attempt to warn the victim and notify police may be indicated (see "The Potentially Violent Person in the Community" section later in this chapter).

The consulting psychiatrist's initial assessment should include, at a minimum, a review of the index offense, especially if it is violent in nature. As in any psychiatric evaluation, a history of prior violent acts and a mental status exam that includes inquiry about current thoughts of homicide or other acts of violence should also be obtained. When the risk of violence appears to be imminent and high, the psychiatrist should make reasonable preventive recommendations. For an inmate who is already in ongoing treatment, the question of imminence can be operationally addressed by the psychiatrist asking, "Is there a substantial likelihood that, without protective intervention, the [inmate] will harm another person before our next regularly scheduled appointment?" (Felt-

hous 1999, p. 54). If the inmate is mentally ill as well as potentially violent, appropriate care and management should include arrangements for psychiatric treatment and follow-up care. Such planning is complicated by the fact that the consultant may not know when the inmate will be released from jail.

Assessment of the risk of violence for any individual requires that the consultant follow the two-step process of first determining the diagnosis, if one exists, and then characterizing the nature of the potential aggression. If the most likely next act of violence is expected to be impulsive and the inmate is without evidence of other mental illness or defect, the consultant should evaluate for intermittent explosive disorder (American Psychiatric Association 1994, 2000; Felthous et al. 1991; Wakai and Trestman 2008) or impulsive aggression (Felthous and Barratt 2003). Therapeutic interventions in these conditions may prevent violent acts.

Pretrial Dispositions

Case Vignette 2

A young man arrested and jailed in connection with an apparent homicide was referred for a forensic consultation to address competency to stand trial and the need for psychiatric hospitalization. Anamnesis revealed that he did not have a significant history of assaulting people. However, he had tortured and killed cats and dogs over the years for sadistic pleasure. Close relatives confirmed cruelty to animals. He explained the homicide as an extension of his acts of cruelty to animals, motivated by pleasure, not by passion or personal gain. Diagnoses included antisocial personality disorder and malingering. On the basis of these diagnoses, hospitalization was not recommended.

During the course of the evaluation, the defendant threatened to kill the evaluator, the evaluator's secretary, and several principals in the upcoming trial once he had an opportunity to do so. He was detained in jail and could be convicted and transferred to prison. Nonetheless, the risk of violence was substantial and, if the defendant were to be released, was within his means. Moreover, he had already demonstrated the capacity for such violence. Hospitalization was not an option. Therefore, careful documentation and warnings to the identifiable victims were made. The court and the head of the jail were also notified, as was the defendant's attorney, to ensure that his legal rights were protected. All of these measures were explained to the defendant to further enhance protection for potential victims and to benefit the defendant himself. After a short time in prison, the man was released. No one was notified, but he was reportedly soon rearrested, this time for robbery.

Comment

A psychiatric disposition was not indicated in this case. Nonetheless, the defendant's credible threats raised the question of what other safety measures,

if any, were appropriate. Some might advise against warnings in this situation, because the risk of violence, though substantial, was not clearly imminent. The state supreme court would later find that no duty to warn identifiable victims exists and that such warnings could violate confidentiality laws. Arguably, confidentiality in the face of a violent peril is not paramount in *forensic* evaluations performed at the request of the court. Nevertheless, the warnings and notifications in the case seemed practical, helpful, and consistent with the *Tarasoff* case (*Tarasoff v. Regents of the University of California* 1976) and other appellate decisions in the state. Perhaps the fact that this man did not follow through on his homicidal threats once released indicates the risk was short-lived. On the other hand, he may have been deterred from carrying out his threats by the warnings and notifications and by the informing of the defendant about the necessity for these disclosures. The interventions may have avoided any wrongful death litigation by lessening the risk of homicide, even if, retrospectively after the state supreme court's holding, the disclosures created some risk of liability.

Dispositional Determinations

A number of dispositional determinations can require risk assessments. These include hospitalization, placement on parole, placement on probation, and various other placements associated with special offender adjudications. In some jurisdictions, the statute on competency to stand trial requires the consultant to address in a separate report the dispositional needs of the defendant, such as hospitalization or placement in a facility for the retarded. Criteria for hospitalization in order to provide treatment and restore to competency include danger to self or others. Such dispositional recommendations serve therapeutic and humanitarian rather than penal purposes. They assist the court in placing the defendant in the least restrictive and most therapeutically appropriate setting while protecting the public. Sometimes, when hospitalization is not appropriate, other protective measures are nonetheless reasonable.

Not Guilty by Reason of Insanity Dispositions

Some offenses are inherently violent (e.g., murder vs. illegal possession of a controlled substance). However, the presence or degree of violence is not an element of a mental illness defense. Tests for insanity do not include a criterion as to whether or not the defendant acted violently at the time of the offense. A consultant addressing the defendant's mental state at the time of the

offense should make every effort to remain objective and honest and to avoid any bias from the nature of the criminal act. It would obviously be improper if, for example, an expert were to offer findings in support of sanity because the charge is murder rather than a nonviolent offense.

Once a defendant is found NGRI, a consultant may be called on to conduct a diagnostic and risk assessment for appropriate placement. Options may include an outpatient setting or a nonsecure, medium-security, or maximum-security hospital. A determination regarding the level of security required involves assessment of the risk of escape as well as the risk of violent behavior. After an NGRI acquittee is hospitalized, the patient should be assessed and monitored for inpatient violence potential to ensure safe management. The acquittee should be reassessed for risk of violence prior to any dispositional decision such as discharge or transfer to a less restrictive hospital setting. If the patient is in a maximum-security hospital, a critical question is when the patient can be transferred to a less restrictive hospital setting. The risk assessment for a patient found NGRI of a violent offense such as murder should be especially thorough and methodical.

The effort to separate therapy and treatment from forensic evaluations is clinically and ethically important to avoid conflicting roles vis-à-vis the patient. This does not mean, however, that all clinical assessments should be hermetically compartmentalized from clinical treatments. If the treating clinician is to be optimally effective, legal objectives such as restoration of competency to stand trial and restoration of sanity must be kept in mind. For example, one of the most common treatment goals in a maximum-security facility is rendering the patient suitable for transfer to a less restrictive setting by increased symptom control as well as reduced risk of violence. Both accurate diagnostic assessment and effective treatment are ongoing processes. Similarly, safe management during treatment requires a dynamic process of continuous risk assessment.

Analysis of past violent acts, with studied attention given to their relationship to the perpetrator's mental state and mental disorder at the time of the act, is of special importance in treating NGRI acquittees, making discharge decisions, and planning for aftercare. Tardiff (2002, 2007) has nicely summarized the relationship between common mental disorders and violence to assist the clinician in understanding, anticipating, and minimizing the risk of future violence.

The evaluation of violence risk in the context of insanity acquittal of an individual who committed a violent act is held to a higher standard for thoroughness and detail than the evaluation of violence risk in other contexts, such as a routine civil inpatient admission. Moreover, a second-level review process, such as that conducted by a hospital transfer committee or dangerousness review board, is recommended practice before the insanity acquittee

patient is placed in a less protective setting. An adequate period of inpatient observation can be useful for evaluation as well as treatment. Step-down phases can assist in ongoing risk assessment, in ensuring least restrictive treatment, and in protecting the public in cases in which mentally ill persons have committed acts of extreme violence. For example, instead of being confined in a maximum-security hospital until ready for release directly into the community, patients in a maximum-security hospital are first transferred to a lower-level security or behavioral unit. From there, they are transferred to a typical inpatient setting, followed by supervised grounds passes, unsupervised grounds passes, and, eventually, total ambulatory care in the community. More will be said about evaluating a potentially violent patient prior to hospital discharge under the appropriate subsection on professional negligence consultations (see "Postdischarge Violence" subsection later in this chapter).

Administrative notification of victims and/or witnesses of a violent criminal act may apply to NGRI acquittees as well as convicted prisoners (Felthous 2006). As I will explain, this is an administrative requirement, not to be confused with the *Tarasoff* protective duties of clinicians. Nonetheless, the consultant should be aware that the notification process can impact the dynamics of risk assessment and management.

Criminal Sentencing Dispositions and Release Decisions

The American Psychiatric Association's Task Force on the Role of Psychiatry in the Sentencing Process (1984) advises psychiatrists against making dispositional recommendations but approves of disclosing factors that can increase or decrease the risk of violence. Apart from insanity verdicts, in which defendants are found not guilty of an offense, psychiatric input may be requested to assist the court in decisions regarding probation. Information about diagnoses, recommended treatments, and risk assessment is a useful component of presentencing evaluations. The consultant can list and attempt to weigh those factors that enhance the risk of future violence and those expected to promote rehabilitation and control over recidivistic behaviors without making a recommendation for or against probation (Felthous 2007).

Risk assessments for purposes of sentencing will be most effective from an adjudicative perspective if the psychiatrist addresses contextual issues. For example, if the offender is an alcoholic given to binge drinking on weekends and barroom fights while intoxicated, the consultant may advise initiating rehabilitation in jail and then continuing rehabilitation efforts, including

Alcoholics Anonymous and avoidance of bars, when the individual is placed on probation. If the defendant is found guilty, the judge may use the consultant's recommendations to order the defendant placed on probation with the conditions that he attend Alcoholics Anonymous and substance abuse counseling and that he be prohibited from visiting bars. Although less restrictive than imprisonment, these conditions could be experienced by the offender as less lenient than total confinement (Felthous 1989d). Nonetheless, the consultant will have addressed appropriate risk and contextual factors without recommending a specific disposition.

Consultations regarding parole are informed by similar considerations. The Hare Psychopathy Checklist—Revised (Hare 1991; Hare et al. 2000) is especially useful in assessing the risk of reoffending and violent behaviors in this context. Actuarial methods provide more accurate predictions of future violence than clinical methods (Monahan et al. 2001), and static variables are more predictive than dynamic ones (Rice et al. 2002). Thus, actuarial risk assessment instruments with static predictors are especially useful for early-release decisions in which concerns for future dangerousness are more compelling than need for immediate interventions. Ironically, some of the most powerful predictors of future violence are clinical disorders: psychopathy and drug or alcohol abuse (Monahan et al. 2001). Recent research indicates that early onset of criminal behavior predicts later violence in men diagnosed with schizophrenia (Tengström et al. 2001). These findings are consistent with the association between antisocial disposition and future violent behavior.

A reasonable predictor of future violence is a history of violent behavior (Klassen and O'Connor 1988; Resnick and Scott 1997), especially an ongoing pattern of aggressive acts. A thorough risk assessment, in either a civil or criminal context, will include a detailed history of prior acts of violence. Such a review should address the nature, frequency, and severity of such acts and the contextual or other factors that seem to have exacerbated or diminished the risk. Offense records, criminal records, and records of incidents within prison can be especially useful when the subject is already within the criminal justice system.

The prisoner who is potentially violent because of mental illness and whose sentence is about to expire should be considered for transfer to an appropriate mental hospital. This disposition should be considered whether or not the victim of the violence is identifiable. Civil commitment may be necessary if the individual is unwilling to admit himself or herself. In the next section, I will discuss assessing and managing situations involving verbally threatened individuals who could foreseeably be victimized by the subject if given the opportunity.

If the prisoner does not meet criteria for hospitalization (e.g., is not mentally ill) and another person is in foreseeable peril after appropriate threat as-

sessment, warning the likely victim and notifying police may be prudent, and even legally required, depending on state law. In the event that the prisoner expresses a threat against a person whom he or she has already victimized and who has requested notification, the consultant should be aware of the administrative notification procedure. Specifically, the consultant should be familiar with the applicable victims' rights act, which may require a victim of a violent crime to be notified of the offender's release, if such notification is requested in advance and in writing by the victim (e.g., Rights of Crime Victims and Witnesses Act in Illinois). The required notification does not require a verbal threat by the prisoner, a threat assessment, or a mental health evaluation of the offender by a mental health professional. The notification is handled administratively through the appropriate state's attorney's office (Felthous 2006).

The Potentially Violent Person in the Community

Workplace Violence

A forensic psychiatrist may be called on to consult to corporate personnel regarding an employee who is feared to have the potential for acting violently at the workplace (Schouten 2006). Lion (1999) has provided a useful discussion of such consultations, which the reader is encouraged to reference. Here, some contrasts will be made between consultations regarding violence in employment settings and those within a more typical civil context.

In workplace violence consultations, the consultant evaluates the risk of violence before it happens and addresses what can be done to prevent future violence. Documentation and audio or visual recordings of threats, if they exist, should be reviewed. However, this type of risk assessment involves interviewing people more than reading records. Interviews should be conducted with supervisors, managers, coworkers, and, if cooperative, subjects themselves. The consultant then makes specific recommendations about helpful interventions for the individual and violence prevention for the company. Although actuarial approaches to risk assessment associate violence with youth, the risk of violence within the workplace may actually be increased with advancing age and tenure within the company (Lion 1999).

The Americans With Disabilities Act (1990) sets some parameters for dealing with employees who are mentally disabled and who present some risk of

violence at the workplace. Two questions that first must be addressed are whether the employee has a *disability* and whether the individual presents a *direct threat* (Wylonis 1999; Wylonis and Sadoff 2007). The employer must provide reasonable accommodation for the employee with qualifying psychiatric disabilities, unless such efforts would cause an undue hardship for the employer or the employee presents a direct threat at the workplace. Thus, the consulting psychiatrist, in addition to addressing diagnosis and assessing the risk of violence to others, will assist in resolving the question of whether the employee in question poses "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation" (Americans With Disabilities Act 1990, § 101–3, Title I [42 U.S.C. § 12111]).

Other Civil Issues

Forensic consultants conduct risk assessments that address an individual's potential for violence in a variety of other civil legal contexts. Examples of such situations are domestic violence, including abuse of children; violence potential in developmentally disabled persons, elderly persons, or partners (Resnick and Scott 1997); potential for violence by children or adolescents at school; independent assessment for civil commitment; and fitness for inherently risky job assignments. Some of these assessments involve unique circumstances and inquiry needs, and some require assessment of other risks as well (e.g., risk of nonviolent child neglect). All such assessments should follow the two-phase process of addressing first diagnostic issues and then any psycholegal issue involving risk assessment (Felthous et al. 2000). The psychiatrist should bear in mind that risk assessment for violence potential is, to some degree, inherent in and flows from the diagnostic assessment (Billick and Jackson 2007). Such assessments should also include nondiagnostic considerations, such as circumstances that could increase or decrease risks.

Professional Negligence and Third-Party Litigation

When a psychiatric patient injures or kills another person, the treating psychiatrist can be named in the subsequent lawsuit. In such situations, a forensic psychiatrist is typically consulted by attorneys either for the plaintiff or for the defendant clinician. Framed either as medical malpractice or as public

policy, the assertion is that the clinician had a protective duty to the victim(s) and failed to conduct an adequate risk assessment or to take reasonable measures to protect the victim, or both. One of the most important considerations in the determination of a legal duty to protect in such cases is the amount of control the psychiatrist had over the patient assailant. A psychiatrist is thought to have more control over an inpatient than an outpatient and more control over a court-committed patient than a voluntary inpatient. Three contexts warrant separate consideration: inpatient violence, postdischarge violence, and outpatient violence.

Inpatient Violence

If an inpatient assaults and injures another patient or a staff member, the victim may sue the assailant's psychiatrist. Typically, the victim claims that the psychiatrist knew or should have known of the assailant's violent propensities and should have taken reasonable protective action. The forensic psychiatrist who receives a consultation request regarding third-party violence in a hospital should first determine whether jurisdictional law creates or circumscribes protective duties when an inpatient is the assailant. A psychiatrist, or the hospital, may have a duty to protect other hospitalized patients from assault, since they are less able to protect themselves by virtue of being confined and dependent on treaters. Whether protective duties exist at all depends on the relationship between the victim and the psychiatrist as much as that between the attacking patient and the psychiatrist.

The consultant should therefore first clarify whether case or statutory law in the jurisdiction would create, support, delimit, or bar protective duties involving inpatient violence against the particular victim. For example, a protective relationship does not necessarily pertain to hospital employees. Courts are divided on whether a psychiatrist has a duty to protect a hospital employee (Felthous and Kachigian 2001). In some cases, the appellate courts have held that the lack of an exceptional relationship with the staff victim precluded the imposition of protective duties for the victim nurse (e.g., *Charleston v. Larson* 1998). In contrast, the Supreme Court of Tennessee (*Turner v. Jordan* 1997), finding the act and the victim to have been foreseeable, considered this sufficient to allow protective duties to flow directly to the victim nurse.

Third-party liability may also arise in an inpatient setting when the treating psychiatrist or another staff member is accused of deliberately harming an inpatient (e.g., *Almonte v. New York Medical College* 1994). The plaintiff will argue that the treater's therapist or supervisor should have foreseen and prevented the act. In such cases, the issue is not one of control. Rather, ar-

guments center on whether the treater's supervisor should have foreseen the act and failed to take reasonable protective actions. A duty to protect inpatients from their treaters is actually more akin to outpatient protective duties (see "Duty to Warn" subsection later in this chapter).

Such evaluations require an assessment of whether the standard of care was followed. The consultant should remain aware of the hospital clinician's continuous need to weigh the indications of restraining and other intrusive or coercive measures against the mandate to provide the least restrictive treatment (Appelbaum 1983). Thus, the consultant should recognize the need for inpatient psychiatrists to have enough flexibility to exercise clinical discretion. The consultant should examine available clinical findings and note omissions or oversights in the diagnostic and risk assessments, treatment, management, and application of protective measures. The consultant should, at the same time, systematically note the appropriate actions of the responsible psychiatrist. The final report may predominately support the defendant psychiatrist's case, criticize, or constitute a mixture of support and criticism.

Some attempt to assess for violence potential should be conducted on every hospital admission, even if this means including just a question or two about aggressive behaviors and ideation. If aggressive behavior was the occasion for the admission or otherwise a prominent part of the initial presentation, a more extensive risk assessment for externally directed aggression would be expected. Patients may demonstrate no signs of abnormal aggression on admission but later make threats of harm or show excessive agitation. In these cases, the patient should be evaluated again, with an attempt to identify precipitants and potential victims, and monitored accordingly.

Diagnosis and risk assessment go hand in hand. The consultant will look for adequacy of both assessments. Focus on risk of violence includes history with emphasis on frequency, severity, circumstances, predisposing factors and targets, behavior observed in the hospital, and mental status examination. The mental status exam should have addressed presence of irritability, impulsivity, anger, hostility, perceptions of mistreatment or delusions of persecution, and auditory hallucinations accompanied by intolerable affect or experienced as commands from familiar voices and congruent with delusions. Much like assessment for suicide, the mental status exam should also have addressed assaultive and homicidal ideation, plans, and seriousness of intent.

Beyond simply assessing the risk of violence, the clinician should have attempted to determine the *nature* of actual or potential aggressive behavior. Was the aggression or potential aggression secondary to a mental disorder, and was it predominately impulsive, spontaneous, compulsive, or premeditated? Aggression that is the direct result of the primary psychiatric disorder gen-

erally improves once the symptoms are brought under control with treatment. Most aggression among hospitalized patients, even those with schizophrenia, is impulsive (Felthous 2008; Felthous et al. 2009; Nolan et al. 2005; Quanbeck et al. 2007).

Thus, the provision of the most appropriate treatment is one of the best means of preventing hospital violence (Felthous 1984). A psychiatrist who allows a patient's psychotic agitation to go unmedicated, for example, could be courting disaster. Impulsive aggression (Felthous and Barratt 2003), with intermittent, Vesuvian outbursts, may have responded to anticonvulsant, antimanic, or beta-blocker medication.

However, in many cases, aggression is a shifting, fluid phenomenon, a hybrid of several types, and is resistant to intervention. Therefore, failure of clinical response does not necessarily mean that the clinician provided substandard care. Premeditated, self-serving aggression, for instance, is least amenable to a medical approach in the course of hospitalization (Moeller and Swann 2007). Even purely medically related aggression does not always respond immediately to the first medicine or combination of medicines. Examination of the appropriateness and timeliness of treatment modalities specific to the disorder is an important task for the forensic consultant.

Consultants reviewing the pharmacotherapeutic management of an uncooperative inpatient should also consider whether emergency-enforced medication should have been given. The most commonly prescribed medications for emergencies in which there is a risk of violent behaviors are antipsychotics and benzodiazepines. Indications for considering this intervention include agitation, impending violence, and a mental condition for which emergency medication is indicated. The use of emergency medication is restricted by jurisdictional law, and specific medications may have been contraindicated by the patient's medical condition or history of adverse side effects. If such medication was administered, consultants should check to ensure that it was properly prescribed. They should also review whether the patient was appropriately monitored for any adverse or paradoxical effect, such as intolerable akathisia or behavioral disinhibition.

Typically, use of emergency medication will have been followed by a petition for court-ordered medication. Court-ordered administration of medicine does not, however, invariably follow emergency administration. For example, the patient may have consented to take the medicine after the first forced administration and prior to the hearing. Likewise, depending on the mental health code, petitioning the court for enforced medication may have been appropriate, even essential, because of the substantial risk of violence to others without medication. This may be the case even when emergency administration was not legally justifiable because the risk, though substantial, was not yet immediate.

The consultant must consider, and look for, reasons both for and against each protective intervention that a prudent psychiatrist would have considered. The consultant should address not only whether less intrusive interventions were appropriate for preventing the violent incident but also whether the more restrictive measures of seclusion or restraint should have been implemented. Tardiff (1996) lists three indications that apply to both seclusion and restraint and two other indications that pertain only to the use of seclusion. Even with clinical indications present, the patient may have had a medical contraindication to seclusion or restraint. Appropriate documentation and review of restraint and seclusion application is critical (Tardiff 2008). Especially if applied with improper technique, physical restraints themselves can result in injury or death and, therefore, liability (Tardiff 2008). Alternatively, jurisdictional law and regulatory organizations may have restricted application, such that seclusion or restraint was not possible after all.

As in assessing risk for suicide, higher standards for evaluation and prevention of violence are expected in inpatient than in outpatient settings. Clinicians have more opportunity to evaluate, observe, monitor, and control patients' risky behaviors in a hospital setting. On the other hand, because they are in need of hospitalization, such severely and acutely disturbed patients can be extremely challenging. For this reason, sometimes despite everyone's best efforts, a patient acts violently, even when the patient is in a hospital, and even when a thorough evaluation has been made and appropriate measures taken.

Inpatient care is likely to be provided by a treatment team or an array of professionals from different disciplines. Just as good care is the result of combined efforts, substandard care may be due to poor care from several different individuals or, not uncommonly, from poor communication among members of the treatment team. The psychiatrist may be considered to have oversight and directional accountability for other members of a treatment team. However, forensic experts may have to examine the performance of several individuals and make independent assessments about the role of each in contributing or not contributing to a failure to protect a victim of inpatient violence.

Postdischarge Violence

Proper risk assessment and its application to the discharge decision are important considerations for the consulting psychiatrist. Wrongful discharge may be claimed as a cause of action against the responsible psychiatrist or the hospital, if a foreseeably violent inpatient is discharged, released into the community, and then seriously injures or kills someone. A number of third-

party liability cases involve claims of negligent discharge or release (e.g., *Cairl v. State* 1982; *Canon v. Thumudo* 1985; *Chrite v. United States* 1983; *Davis v. Lhim* 1983; *Durflinger v. Artiles* 1981; *Holmes v. Wampler* 1982; *Paul v. Plymouth General Hospital* 1987; *Perriera v. State* 1986; *Sharpe v. S.C. Department of Mental Health* 1987).

As with third-party liability cases involving violent injury caused by inpatients, the consulting psychiatrist should first reference the jurisdictional law. The rules regarding liability are different in various states. As discussed in an earlier report (Felthous 1989c), California psychiatrists enjoy statutory immunity for wrongful discharge decisions (*Karash v. County of San Diego* 1986; *Tarasoff v. Regents of the University of California* 1976). Michigan psychiatrists who are state employees have sovereign immunity (*Canon v. Thumudo* 1985). In Kansas (*Hokansen v. United States* 1989), Texas (*Peavy v. Home Management of Texas* 1999; *Thapar v. Zezulka* 1998), and Virginia (*Nasser v. Parker* 1995), there is no liability associated with wrongful discharge unless the patient was civilly committed or under the psychiatrist's actual legal control.

Nonetheless, one would expect a reasonably prudent physician to conduct a risk assessment before discharging a patient with known violent propensities, even if the physician faces no professional liability for not doing so. At a minimum, basic questions about homicidal ideation and violent history should have been asked at admission and again prior to discharge. A specific claim, such as wrongful discharge, is typically accompanied by other traditional claims, such as failure to properly diagnose and provide appropriate treatment. Risk assessment may be subsumed under diagnosis, and discharge decisions and aftercare planning can be considered aspects of treatment. The consultant should look for and note both proper and improper or insufficient diagnostic assessment and treatment, especially as such procedures pertain to the decision to discharge the patient and the timing of the discharge.

Diagnosis, risk assessment, treatment, and symptom control, including the control of violent behavior, are all interrelated efforts. Accordingly, the consulting psychiatrist should ascertain that members of the treatment team did not overly rely on a single, simple formula such as a no-harm contract in deciding when to discharge the patient. An extended period of time in the hospital without violent behavior supports discharge decisions, but this must be considered together with other clinical findings. For example, a patient who is violent as a result of psychotic agitation in the pathological context of schizophrenia, disorganized type, should be ready for discharge when violent behaviors have been brought under control with appropriate pharmacotherapy.

In contrast, a patient with delusional disorder, persecutory type, who acted violently when he or she had free access to weapons and victims in the

community, may not behave aggressively while under the supervision and structure afforded by the hospital milieu. Yet the delusions that drove the patient to act violently in the community are as undiminished and compelling as they were before hospitalization. An extended period of nonviolence in the hospital is not as supportive of a release decision for this patient as it was for the schizophrenic patient whose aggressive behavior and psychotic symptoms improved concurrently as a result of effective treatment. Although most delusions are not associated with violence, some are, and the motivation for the violent act often appears congruent with or even driven by the delusions (Taylor et al. 1994). Thus, beyond comportment in the hospital, the consultant should attempt to look for a relationship between the delusion and the act and, prior to transfer of the patient to a less structured setting, ask, "What has changed?"

Managed care companies and other parties may encourage a pattern of premature discharge to contain costs. The consultant must bear in mind that such external pressures do not by themselves alter the standard of care for critically important clinical decisions such as when to discharge a patient who has demonstrated violent propensities (Felthous 1999; Simon 2001, pp. 179–214). For example, a patient may suddenly promise to control his or her aggression and show no aggressive behavior over the course of 24 hours. However, over the previous week in the hospital, he or she acted aggressively on five separate occasions. This patient's recent improvement may therefore represent only a brief interval and does not necessarily establish the patient's readiness to be released. Similarly, the consultant should not place undue emphasis on the patient's no-harm contract when numerous other signs indicated that the patient could not be expected to follow such a contract.

Some would advocate administration of a standardized risk assessment instrument prior to discharge. Such formal assessment instruments may increase the accuracy, limited as it is, of assessing the risk of postdischarge violence. The Psychopathy Checklist—Screening Version, for example, has been shown to be a relatively strong predictor of violence among civil psychiatric patients (Skeem and Mulvey 2000).

Nevertheless, the omission of a risk assessment instrument does not in itself fall short of the present standard of care (Tardiff 2002). Although such instruments offer useful information, some contextual limitations should be appreciated. Recommended instruments tend not to focus on the nature of the mental disorder for which the patient received hospital treatment in the first place. Rather, the predictors are simply actuarial, or they support a finding of some degree of psychopathology or antisocial behavior, or both. For decisions about whether to release prisoners on parole, as already discussed, assessment of psychopathy can be important. However, when the purpose of hospitalization is treatment, high scores on such instruments could favor

preventive detention under the guise of treatment. Until this dilemma is more satisfactorily resolved, the consultant should hesitate to find that omission of a standardized risk assessment instrument constitutes a departure from the standard of care. Likewise, when such instruments are used, scores can be taken into account but should not form the sole basis for a decision of whether or not to discharge a patient.

Littleton Guidelines

The Supreme Court of Ohio in *Littleton v. Good Samaritan Hospital* (1988) addressed the problem of how to determine whether a psychiatrist exercised professional judgment upon deciding to discharge a patient (Felthous 1989b; Felthous et al. 1991). In this case, the court formulated a legal standard that is sufficiently reasonable to provide general guidance in determining whether a reasonable, prudent psychiatrist standard was satisfied. The court held that a hospital psychiatrist should not be liable for the violent acts of a mental patient after discharge if any one of the following conditions is satisfied:

> 1. the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge, or
> 2. a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant factors, and a good faith decision was made by the psychiatrist that the patient had no violent propensity, or
> 3. the patient was diagnosed as having violent propensities, and after a thorough evaluation of the severity of the propensities and a balancing of the patient's interest and the interests of the potential victims, a treatment plan was formulated in good faith, which included discharge of the patient. (*Littleton v. Good Samaritan Hospital* 1988)

The *Littleton* guidelines emphasize the importance of titrating the extent of assessment and intervention to the apparent need. The standard defined in this decision is not binding in other jurisdictions. However, it proffers well-reasoned parameters that can guide the forensic consultant's assessment of standard of care in cases in which violence has occurred after discharge.

Duty to Warn

Forensic consultants may be asked to offer opinions regarding a clinician's duty to notify identifiable victims and/or police of a patient's potential for violence if a suit arises under circumstances such as those of *Tarasoff*. In that case, Prosenjit Poddar, a graduate student at the University of California at

Berkeley, became infatuated with Tatiana Tarasoff, who was far less invested in their relationship. When Tatiana went to Brazil for the summer, Prosenjit felt dejected and began seeing a therapist at the university clinic. In the course of therapy, Prosenjit told his therapist "that he was going to kill an unnamed girl readily identifiable as Tatiana" (*Tarasoff v. Regents of the University of California* 1976, p. 341) after her return from Brazil. Upon consultation with a clinic psychiatrist, the therapist notified the campus police and sent a letter to the chief of the campus police requesting police assistance in delivering Prosenjit to the hospital for admission. The police interviewed Prosenjit, obtained his promise not to go near Tatiana, and, without consulting his therapist, released him.

After this episode, Prosenjit dropped out of therapy. Two months later, Prosenjit went to Tatiana's place with a kitchen knife and a pellet gun. He attempted to talk with her and then stabbed her to death.

Tatiana's parents brought complaints against his treaters and the police officers. After a succession of appeals, the case reached the Supreme Court of California. The court articulated what has become known as the *Tarasoff principle,* or the therapist's duty to protect, which is most explicit about the obligation to issue *warnings*:

> When a psychotherapist determines, or pursuant to the standards of his or her profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. That discharge of such duty may require the therapist to take one or more of various steps, depending on the nature of the case, including warning the intended victim or others likely to apprise the victim of the danger, notifying the police, or taking whatever steps are reasonably necessary under the circumstances. (*Tarasoff v. Regents of the University of California* 1976 at 340)

Traditionally, hospitalization was the most frequent and presumably the most effective intervention made by mental health professionals to prevent their patients from seriously harming others in the foreseeable future. In 1976, the California Supreme Court put psychiatrists and psychologists on notice that another protective intervention, warning potential victims or notifying police of the risk, existed. Failure to take these measures could result in liability.

Appelbaum (1985) recommended a three-step approach for dealing with *Tarasoff* duty-to-warn situations: 1) assessment of dangerousness, 2) selection of a course of action, and 3) implementation. This process applies to any clinical situation involving potential violence and is also consistent with the *Littleton* guidelines in the context of hospital discharge. Psychiatrists should not incur liability if they have documented their findings, reasoning, conclusions, and their acts of notification and warning (Felthous 1989c, pp.

108–109). The forensic consultant can use these models to come to an opinion regarding the standard of care in such situations.

Liability due to failure to warn upon discharging a patient should not be a frequent issue. Any danger to others caused by mental illness should have been brought substantially under control as a result of treatment in the hospital or the patient would not have been discharged. Nonetheless, such cases may arise and require evaluation by a forensic consultant. Several situations can occur in which warnings are prudent, if not legally required, by jurisdictional law. For example, even when the potential for violence is no longer present because of favorable response to treatment, clinicians who assume responsibilities for aftercare should be informed of any serious risks encountered earlier in the patient's treatment.

A patient known to be violent who escapes from the hospital should trigger concerns about warnings. The assistance of police will be required to have the patient safely returned if he or she was already involuntarily committed at the time of elopement or the psychiatrist had initiated commitment procedures. Police should be informed of specific risks presented by the patient. If the patient is targeting specific individuals who can best protect themselves if forewarned, then someone should warn them. When deciding who to warn, the clinician will have to consider which warnings are most practical and likely to be protective, on the one hand, and what the jurisdictional law allows, on the other.

A second situation in which the duty to warn may arise is when the judicial system fails and a patient who is known to be dangerous is allowed to be lawfully discharged. An example of such a situation would be when a judge decides that a patient does not satisfy civil commitment criteria and the patient insists upon discharge, but the psychiatrist has good reasons to believe the patient would seriously harm or kill an identifiable victim if he or she were to be released. A record supporting this scenario would establish the prudence of the psychiatrist's having notified the police and any identifiable victims of the specific danger. In evaluating any of these scenarios, the consultant will have to weigh prudent care against what the law permits and requires in the way of warnings.

A more difficult judgment for the clinician is whether to warn an identifiable victim when the risk is substantial but not imminent and the unwilling patient does not satisfy commitment criteria. Here, the patient can be involved in the warning process, or, at the very least, aftercare treatment providers can be apprised so they can monitor the risk accordingly.

Vehicular Crashes

An automobile is a potentially lethal machine. Litigation involving psychiatrists has resulted when a hospitalized patient, after discharge, caused a two-

vehicle accident with death or injuries to one or more victims in the other car (*Cain v. Rijken* 1986; *Hasenei v. United States* 1982; *Naidu v. Laird* 1988; *Petersen v. State* 1983; *Schuster v. Altenberg* 1988). Such cases involve three different types of scenarios. One is the vehicular crash that results from the patient's medication-induced drowsiness at the wheel and the prescribing physician's failure to inform the patient that the medicine could cause oversedation and impair driving (*Gooden v. Tips* 1983; *Kirk v. Michael Reese Hospital and Medical Center* 1985). The second scenario is when the crash is a true accident but is unrelated to any prescribed medication. Rather, the patient's driving is impaired by the disabling effects of mental illness and/or recent consumption of nonprescribed drugs or alcohol. The third situation is when the patient deliberately crashes into another vehicle. Neuropsychiatric conditions that can be associated with an increased risk of vehicular crash include psychotic exacerbation of schizophrenia, profound or suicidal depression, dementia, and disturbances in consciousness, such as epilepsy and narcolepsy (Felthous et al. 2008). A forensic consultant could be called on to assess whether the standard of care was followed by the responsible hospital clinicians. Should the hospital psychiatrist have foreseen the patient causing a vehicular crash and taken measures to prevent it? If the patient had a pattern of deliberate crashes or expressed crash ideation or threats, the reasonable physician should have evaluated such expressions and history as he or she would any other form of recurrent or threatened violence.

A task force of the American Psychiatric Association (1993) has stated that psychiatrists should not be responsible for determining whether their patients are safe and competent drivers. Several authors (Godard and Bloom 1990; Pettis 1992) recommend that psychiatrists resist acknowledging responsibility for predicting and ensuring their patients' safe driving. Nonetheless, the issue has arisen in the past and is likely to occur in the future (Felthous 1989a; Felthous et al. 2008). Appellate court decisions range from disapproving of holding psychiatrists responsible for their patients' automobile accidents (*Hasenei v. United States* 1982) to acknowledging valid claims in such litigation (*Naidu v. Laird* 1988; *Petersen v. State* 1983; *Schuster v. Altenberg* 1988). Thus, the consultant must again be aware of the appropriate jurisdictional law.

Outpatient Violence

If the assailant who violently attacks or kills another person is an outpatient, the surviving victim or relatives of the deceased victim may claim that the psychotherapist or treating psychiatrist failed to take reasonable measures to protect the victim. Jurisdictional law defines whether protective measures, such

as warning the victims and/or notifying the police, are legally required or even permissible. These laws vary widely (Felthous 1989b, 1989c; Felthous and Kachigian 2001; Simon and Sadoff 1992; Walcott et al. 2001). Even within a given state, appellate court holdings on whether therapists have a duty to take protective measures do not necessarily predict what the state's supreme court will determine (Felthous and Scarano 1999). In those states where legislatures have attempted to bring statutory clarity to the issue, the state appellate courts do not necessarily follow, or in some cases even acknowledge, the protective disclosure statute (Kachigian and Felthous 2002).

If jurisdictional law establishes a legal duty for psychiatrists to make protective disclosures but none were made before the patient acted violently, the consultant should address whether such omissions would have been reasonable and within current standards of practice. Was the seriousness of the threat assessed and found insufficiently serious to warrant warning disclosures? Appelbaum's (1985) assessment, plan, and implementation approach described earlier (see "Duty to Warn" subsection earlier in this chapter) is especially appropriate in dealing with verbal threats by outpatients and is general and basic enough to be considered the standard of practice. Borum and Reddy (2001) offer a well-reasoned, methodical approach to assessing the seriousness of a threat. The Borum and Reddy model, like other guidelines also available for threat assessment, is not widely enough used to be considered the standard of practice. Nonetheless, a reasoned, data-based decision that addresses magnitude of the threatened harm (e.g., lethality), undeterrability of the intent, and the elements discussed by Borum and Reddy may well justify decisions to make or decline making protective disclosures.

Felthous (1999) has proffered an algorithm that can assist the forensic consultant beyond addressing the seriousness of the threat alone. He identified two questions critical in the assessment of the clinician's actions. The first is whether the patient should have been hospitalized. The second is whether protective disclosures should have been made to prevent harm to third persons. These two necessarily dichotomous decisions are based on four critical assessments:

1. Whether the patient was dangerous (i.e., risk for violence considered high)
2. Whether the patient's potential for violence was likely due to mental illness
3. Whether the risk of violence was imminent
4. Whether potential victims were identifiable

The consultant should describe the legal standard, including inconsistencies, if any. He or she should then discuss whether the clinician's decision

to issue or not to issue protective warnings was reasonable. If the law requires or permits protective disclosures and such disclosures were issued by the defendant clinician, the consultant should point out the appropriate action that was taken. Conversely, the issue from a legal point of view could be undisputed if the state supreme court prohibits disclosures. A treating clinician should not be faulted for failing to take a measure that was illegal. On the other hand, sometimes even an illegal measure can be eminently logical and even lifesaving. In some cases, the law itself is contradictory, for example, as when the statutory and judicial laws are inconsistent.

The most common questions evaluated by forensic consultants regarding outpatient treatment and management of potentially violent patients tend to be more relevant to clinical issues than to protective disclosures. Was the patient appropriately diagnosed? Did the clinician perform a risk assessment? Was the patient seen with appropriate frequency? Was the treatment plan appropriate? Was hospitalization attempted when the patient's behavior demonstrated that he or she could not continue to be safely managed as an outpatient? Even in jurisdictions where no legal duty to hospitalize a dangerous patient exists, hospitalization of a patient who is manifestly dangerous to others because of an acute, serious mental illness clearly falls within the standard of practice.

Conclusion

I have directed the discussion in this chapter toward assessing potential violence of individuals within the criminal justice system and responding to allegations of professional negligence when a psychiatric patient harms another person. These tend to be the contexts in which forensic consultants are asked to offer opinions regarding the appropriate evaluation and management of potentially violent patients. Unfortunately, despite the best efforts of clinicians and forensic consultants, the law may impose certain limitations on the ability to manage potentially violent patients. Not every patient who will foreseeably act violently and refuses voluntary hospitalization meets civil commitment criteria. Not every patient whose violence would be better controlled with medication but who refuses to give consent meets criteria for court-ordered medication. And, the law does not always permit, let alone require, the issuance of protective warnings. Whether the consult is in regard to management and treatment or to professional negligence, the forensic psychiatrist must always take into account the contours of jurisdictional law.

Key Points

- The most common forensic consultations concerning acts of personal violence arise in the criminal justice system and in civil litigation alleging negligence against a defendant psychiatrist whose patient commits an act of violence.
- Risk assessments of violence, regardless of context, should consider diagnosis, amenability to treatment interventions, nature of the potential aggression, history of violent behavior, and imminence of future violent behavior.
- One of the best ways to decrease the potential for violent behavior in a hospitalized patient whose aggression is causally related to mental illness is to provide adequate treatment for the underlying medical condition. This may include the administration of emergency medication on an involuntary basis.
- Jurisdictional law regarding the duty to warn potential victims of the possibility of harm varies. Clinicians should be aware of their responsibilities as defined by the law, but in extreme cases they should also consider taking prudent and reasonable steps to warn identifiable victims, even if they are not legally required to do so.

Practice Guidelines

1. Identify internal and external factors, including underlying character pathology, that may interact to increase or decrease potential risk of violence. Remember that risk of violent behavior is dynamic and subject to change.
2. Be sure to include in assessments of the risk of violence a review of history of prior violent acts and a determination of diagnosis and nature of potential aggression.
3. Consider the need for civil commitment for a prisoner who is potentially violent due to mental illness and whose sentence is about to expire.
4. Consider the extent of the assessment and intervention relative to the apparent need in the evaluation of the standard of care in liability cases.

5. Be familiar with the legal responsibilities according to jurisdiction in the evaluation of liability due to failure to warn. Remember that the duty to warn varies according to jurisdictional law. Evaluate the clinician's assessment of dangerousness, selected course of action, and implementation of that action.

References

Almonte v New York Medical College, 851 F.Supp. 34 (D. Conn. 1994)

American Psychiatric Association: A report of the Task Force on the Role of Psychiatry in the Sentencing Process, in Issues in Forensic Psychiatry. Washington, DC, American Psychiatric Press, 1984, pp 181–215

American Psychiatric Association: The Role of the Psychiatrist in Assessing Driving Ability (Position Statement No 930004). Washington, DC, American Psychiatric Association, 1993

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Americans With Disabilities Act, Publ L 101-336, stat. 327, July 26, 1990, § 2 (42 U.S.C. §§ 12101, 12111)

Appelbaum PS: Legal considerations in the prevention and treatment of assault, in Assaults Within Psychiatric Facilities. Edited by Lion JR, Reid WH. New York, Grune & Stratton, 1983, pp 173–190

Appelbaum PS: Rethinking the duty to protect, in The Potentially Violent Patient and the Tarasoff Decision in Psychiatric Practice. Edited by Beck J. Washington, DC, American Psychiatric Press, 1985, pp 110–130

Barratt ES: Measuring and predicting aggression within the context of a personality theory. J Neuropsychology Clin Neurosci 3(2):S35–S39, 1991

Barratt ES: Impulsivity and aggression, in Violence and Mental Disorders: Developments in Risk Assessment. Edited by Monahan J, Steadman HJ. Chicago, University of Chicago Press, 1994, pp 61–79

Barratt ES, Stanford MS, Felthous AR, et al: The effects of phenytoin on impulsive and premeditated aggression: a controlled study. J Clin Psychopharmacol 17:341–349, 1997a

Barratt ES, Stanford MS, Kent TA, et al: Neurological and cognitive psychophysiological substrates of impulsive aggression. Biol Psychiatry 41:1045–1061, 1997b

Billick SB, Jackson MB: Evaluating parents in child custody and abuse cases and the utility of psychological measures in screening for parental psychopathy or antisocial personality, in International Handbook of Psychopathic Disorders and the Law, Vol II, Laws and Policies. Edited by Felthous AR, Saß H. Chichester, UK, Wiley, 2007, pp 95–112

Borum R, Reddy G: Assessing violence risk in Tarasoff situations: a fact-based model of inquiry. Behav Sci Law 19(3):375–386, 2001

Cain v Rijken, 717 P.2d 140 (Ore. 1986)

Cairl v State, 323 N.W.2d 20 (Minn. 1982)

Canon v Thumudo, 144 Mich. App. 604, 375 N.W.2d 773 (1985)

Charleston v Larson, 297 Ill.3d 540; 696 N.E.2d 793; 231 Ill. Dec. 497 (Ill. App. Ct. 1998)

Chrite v United States, 564 F.Supp. 341 (E.D. Mich. 1983)

Citrome L: Psychopharmacology and electroconvulsive therapy, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Publishing, 2008, pp 301–323

Coccaro EF: Intermittent explosive disorder, in Aggression: Psychiatric Assessment and Treatment. Edited by Coccaro EF. New York, Marcel Dekker, 2003, pp 149–166

Davis v Lhim, 335 N.W.2d 481 (Mich. App. 1983)

D'Silva K, Duggan C, McCarthy L: Does treatment really make psychopaths worse? A review of the evidence. J Personal Disord 18:163–177, 2004

Durflinger v Artiles, 563 F.Supp. 322 (D. Kan. 1981)

El-Mallakh RS, Roberts RJ, El-Mallakh PL: Mood disorders, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Publishing, 2008, pp 77–104

Felthous AR: Preventing assaults on a psychiatric inpatient ward. Hosp Community Psychiatry 35:1223–1226, 1984

Felthous AR: The duty to warn or protect to prevent automobile accidents, in American Psychiatric Press Annual Review of Clinical Psychiatry and the Law, Vol 1. Edited by Simon RI. Washington, DC, American Psychiatric Press, 1989a, pp 221–238

Felthous AR: The ever confusing jurisprudence of the psychiatrist's duty to protect. J Psychiatry Law 17:575–594, 1989b

Felthous AR: The Psychotherapist's Duty to Warn or Protect. Springfield, IL, Charles C Thomas, 1989c

Felthous AR: The use of psychiatric evaluations in the determination of sentencing, in Criminal Court Consultations. Edited by Rosner R, Harmon RB. New York, Plenum, 1989d, pp 189–208

Felthous AR: Unusual case report: do violent dreams cause violent acts? Crim Behav Ment Health 3:12–18, 1993

Felthous AR: The clinician's duty to protect third parties. Psychiatr Clin North Am 22:49–60, 1999

Felthous AR: Warning a potential victim of a person's dangerousness: clinician's duty or victim's right? J Am Acad Psychiatry Law 34:338–348, 2006

Felthous AR: Criminal sentencing: the role of mental health professionals with special consideration for psychopathic disorders, in International Handbook on Psychopathic Disorders and the Law, Vol II. Edited by Felthous AR, Saß H. Chichester, UK, Wiley, 2007

Felthous AR: Schizophrenia and impulsive aggression: a heuristic inquiry with forensic and clinical implications. Behav Sci Law 26:735–758, 2008

Felthous AR, Barratt ES: Impulsive aggression, in Aggression: Psychiatric Assessment and Treatment (Medical Psychiatry Series 22). Edited by Coccaro EF. New York, Marcel Dekker, 2003, pp 123–148

Felthous AR, Kachigian C: The fin de millénaire duty to warn or protect. J Forensic Sci 46:1103–1112, 2001

Felthous AR, Scarano VR: Tarasoff in Texas. J Texas Med 95(3):72–78, 1999

Felthous AR, Bryant SG, Wingerter CB, et al: The diagnosis of intermittent explosive disorder in violent men. Bull Am Acad Psychiatry Law 19:71–80, 1991

Felthous AR, Kröber H, Saß HL: Forensic evaluations for civil and criminal competencies and criminal responsibility in German and Anglo-American systems, in Psychiatry for Today. Edited by Henn F, Sartorius N, Helmehen H. Heidelberg, Germany, Springer-Verlag, 2000, pp 287–302

Felthous AR, Meuser TM, Ala T: Vehicular crashes and the role of mental health clinicians, in Textbook of Violence Assessment and Management. Edited by Simon SI, Tardiff K. Washington, DC, American Psychiatric Press, 2008, pp 521–536

Felthous AR, Weaver D, Evans R, et al: Assessment of impulsive aggression in patients with major mental illness and demonstrated violence: interrater reliability of rating instrument. J Forensic Sci 54:1470–1474, 2009

Godard SL, Bloom JD: Driving, mental illness, and the duty to protect, in Confidentiality Versus the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry. Edited by Beck JC. Washington, DC, American Psychiatric Press, 1990, pp 191–204

Gooden v Tips, 651 S.W.2d 364 (Tex. App. 1983)

Hare RD: The Hare Psychopathy Checklist—Revised. Toronto, ON, Multi-Health Systems, 1991

Hare RD, Clark D, Grann M, et al: Psychopathy and the predictive validity of the PCL-R: an international perspective. Behav Sci Law 18:623–645, 2000

Hart SD, Hare RD, Forth AE: Psychopathy as a risk marker for violence: development and validation of a screening version of the revised psychopathy checklist, in Violence and Mental Disorder: Developments in Risk Assessment. Edited by Monahan J, Steadman HJ. Chicago, IL, University of Chicago Press, 1994, pp 81–98

Hasenei v United States, 541 F.Supp. 999 (1982)

Hokansen v United States, 868 F.2d 372 (Tenth Cir. 1989)

Holmes v Wampler, 546 F.Supp. 500 (E.D. Vir. 1982)

Kachigian C, Felthous AR: Judicial responses to "Tarasoff" statutes (No 83B), in Syllabus and Proceedings Summary of the Annual Meeting of the American Psychiatric Association, Philadelphia, PA, May 18–23, 2002, p 155

Karash v County of San Diego, Court of Appeal, Fourth Appellate District One, State of California Superior Ct (No. 420863) (1986)

Kirk v Michael Reese Hospital and Medical Center, 483 N.E.2d 906 (Ill. App. 1 Dist. 1985)

Klassen D, O'Connor WA: A prospective study of predictors of violence in adult male mental health admissions. Law Hum Behav 12:143–158, 1988

Lion JR: The clinician's role in assessing workplace violence. Psychiatr Clin North Am 22(1):101–108, 1999

Littleton v Good Samaritan Hospital, 529 N.E.2d 449 (Ohio 1988)

Moeller FG, Swann AC: Pharmacotherapy of clinical aggression in individuals with psychopathic disorders, in International Handbook on Psychopathic Disorders and the Law. Edited by Felthous AR, Saß H. Chichester, UK, Wiley, 2007, pp 397–416

Monahan J, Steadman H, Silver E, et al: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York, Oxford University Press, 2001

Naidu v Laird, 539 A.2d 1064 (1988)

Nasser v Parker, 455 S.E.2d 502 (Va. 1995)

Nolan KA, Volavka J, Czobar P, et al: Aggression and psychopathology in treatment-resistant inpatients with schizophrenia and schizoaffective disorder. J Psychiatr Res, 39:109–115, 2005

Pajerla S, Felthous AR: The paradox of psychopathy. Psychiatric Times 24:53–56, 2007

Paul v Plymouth General Hospital, 408 N.W.2d 492 (Mich. App. 1987)

Peavy v Home Management of Texas, 7 S.W.2d 795 (First Dist., Houston 1999)

Perriera v State, 738 P.2d 4 (Colo. App. 1986)

Petersen v State, 100 Wash.2d 421, 671 P.2d 230 (Wash. 1983)

Pettis RW: Tarasoff and the dangerous driver: a look at the driving cases. Bull Am Acad Psychiatry Law 20(4):427–437, 1992

Quanbeck CD, McDermott BE: Inpatient settings, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Press, 2008, pp 259–276

Quanbeck CD, McDermott BE, Lam J, et al: Categorization of aggressive acts committed by chronically assaultive state hospital patients. Psychiatr Serv 58:521–528, 2007

Resnick PJ, Scott SL: Legal issues in treating perpetrators and victims of violence. Psychiatr Clin North Am 20(2):473–487, 1997

Rice ME, Harris GT, Cormier CA: An evaluation of a maximum-security therapeutic community for psychopaths and other mentally disordered offenders. Law Hum Behav 16:399–412, 1992

Rice ME, Harris GT, Quinsey VL: The appraisal of violence risk. Current Opinion in Psychiatry 15:589–593, 2002

Rights of Crime Victims and Witnesses Act, Illinois Compiled Statutes, ch. 725, § 120

Schouten R: Workplace violence and the clinician, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Press, 2006, pp 501–520

Schuster v Altenberg, 424 N.W.2d 159 (Wis. 1988)

Sharpe v S.C. Department of Mental Health, 354 S.E.2d 788 (S.C. App. 1987)

Simon RI: Concise Guide to Psychiatry and Law for Clinicians, 3rd Edition. Washington, DC, American Psychiatric Publishing, 2001

Simon RI, Sadoff RL: Violent behavior toward others, in Psychiatric Malpractice: Cases and Comments for Clinicians. Washington, DC, American Psychiatric Press, 1992, pp 191–232

Skeem JL, Mulvey EP: Psychopathy and community violence among civil psychiatric patients: results from the MacArthur Risk Assessment Study. J Consult Clin Psychol 69:358–374, 2000

Skeem JL, Monahan J, Mulvey EP: Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. Law Hum Behav 26:577–603, 2002

Stanford MS, Houston RJ, Mathias CW, et al: A double-blind placebo-controlled crossover study of phenytoin in individuals with impulsive aggression. Psychiatry Res 103:193–203, 2001

Tarasoff v Regents of the University of California, 17 Cal.3d 425 (1976)

Tardiff K: Assessment and Management of Violent Patients, 2nd Edition. Washington, DC, American Psychiatric Press, 1996

Tardiff K: The past as prologue: assessment of future violence in individuals with a history of past violence, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 181–207

Tardiff K: Violence: psychopathology, risk assessment and lawsuits, in International Handbook on Psychopathic Disorders and the Law. Edited by Felthous AR, Saß H. Chichester, UK, Wiley, 2007, pp 117–133

Tardiff K: Seclusion and Restraint, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Press, 2008, pp 339–356

Taylor PJ, Garety P, Buchanan A, et al: Delusions and violence, in Violence and Mental Disorders: Developments in Risk Assessment. Edited by Monahan J, Steadman HJ. Chicago, University of Chicago Press, 1994, pp 161–182

Tengström A, Hodgins S, Kullgren G: Men with schizophrenia who behave violently: the usefulness of early versus late-start offender typology. Schizophr Bull 27:205–218, 2001

Thapar v Zezulka, 994 S.W.2d 635 (1998)

Turner v Jordan, 957 S.W.2d 8125 (Tenn. 1997)

Wakai ST, Trestman RL: Impulsivity and aggression, in Textbook of Violence Assessment and Management. Edited by Simon RI, Tardiff K. Washington, DC, American Psychiatric Press, 2008, pp 211–234

Walcott DM, Gerundolo P, Beck JC: Current analysis of the Tarasoff duty: an evolution towards the limitation of the duty to protect. Behav Sci Law 19(3):325–343, 2001

Wylonis L: Psychiatric disability, employment and the Americans with Disabilities Act. Psychiatr Clin North Am 22(1):147–158, 1999

Wylonis L, Sadoff R: The psychopath in the workplace: disability, direct threat and the ADA, in International Handbook on Psychopathic Disorders and the Law, Vol II. Edited by Felthous AR, Saß H. Chichester, UK, Wiley, 2007, pp 125–135

Suggested Readings

Felthous AR, Saß H: International Handbook on Psychopathic Disorders and the Law, Chichester, UK, Wiley, 2007

Resnick PJ, Scott SL: Legal issues in treating perpetrators and victims of violence. Psychiatr Clin North Am 20(2):473–487, 1997

Simon RI, Sadoff RL: Violent behavior toward others, in Psychiatric Malpractice: Cases and Comments for Clinicians. Washington, DC, American Psychiatric Press, 1992, pp 191–232

Simon RI, Tardiff K: Textbook of Violence Assessment and Management. Washington, DC, American Psychiatric Press, 2008

Tardiff K: Assessment and Management of Violent Patients, 2nd Edition. Washington, DC, American Psychiatric Press, 1996

Tardiff K: The past as prologue: assessment of future violence in individuals with a history of past violence, in Retrospective Assessment of Mental States in Litigation: Predicting the Past. Edited by Simon RI, Shuman DW. Washington, DC, American Psychiatric Publishing, 2002, pp 181–207

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Chapter 21

Understanding Risk Assessment Instruments

Douglas Mossman, M.D.

Psychiatrists make decisions based on risk assessments all the time, but usually without realizing it. For example, when psychiatrists decide to prescribe medication, they do not usually call what they are doing "assessing risk." Yet deciding to use a drug in a patient's treatment entails a belief about a future event (the drug might help the patient), beliefs about the risks of the drug, and beliefs about the risks of not prescribing the drug. Similarly, interpretations in psychotherapy involve implicit beliefs about how a patient will react. Patients can react badly to words as well as medications, and knowing this, psychiatrists temper what they say with judgments about the risks that their comments entail.

Although risk assessment is an intrinsic part of everyday clinical practice, being asked explicitly to make a probabilistic statement about what someone will do often makes psychiatrists uncomfortable. And, probably no assessment of people generates more anxiety than the attempt to say something about a person's likelihood of future "dangerousness."

One reason for the anxiety is that "dangerousness" is an ambiguous term: it can refer to harm-causing acts, acts with potential to cause harm, behavior that seems threatening but does not itself cause harm, a high proba-

bility for acting violently, or simply any propensity to act violently. A second reason risk assessment causes anxiety is that since the 1970s, the *Tarasoff* decision (*Tarasoff v. Regents of University of California* 1976) in California and other related cases have imposed on mental health professionals a duty to determine whether "a patient poses a serious danger of violence to others," along with the threat of malpractice liability for failing to do this.

A third source of anxiety comes from the magnitude and gravity of the potential consequences of being wrong about dangerousness. Wrong guesses about psychotropic medication rarely amount to more than a failed treatment effort or an intolerable side effect—problems that can easily be solved with another clinical intervention. Wrong guesses about a patient's potential for violence, however, can have a devastating effect on the patient, the victim (often a family member or acquaintance of the patient), and the psychiatrist's emotional well-being.

Few psychiatrists can avoid assessing the risk of dangerous behavior, because dozens of common clinical actions require implicit judgments about the violence potential of a patient or evaluee. More than three decades ago, Shah (1978) identified 15 areas of forensic decision making that require mental health professionals to assess the risk of violence. More recently, Hall and Ebert (2002, pp. 167–168) noted 27 circumstances that require assessments of dangerousness. Their list includes activities common to most psychiatric practices, such as releasing patients from hospitals, treating potentially violent patients in psychotherapy, and initiating emergency hospitalization or civil commitment.

Depending on their work setting and clientele, psychiatrists make many other kinds of assessments of dangerousness. Fitness-for-duty determinations, sentencing recommendations, custody assessments involving previously abusive parents, intervention recommendations concerning stalkers or their victims, and planning treatment for individuals with substance abuse who commit violent crimes to support their habit all require implicit estimates of the risk of violence. For some hospital release decisions (e.g., discharging previously violent patients, or allowing insanity acquittees to return to the community), preventing or minimizing potential risk to the public dwarfs all other considerations in shaping patients' clinical management. The increasing frequency and ongoing popularity of continuing education seminars on "risk assessment" attest to the concern and anxiety mental health practitioners experience when they have to make judgments about future violence.

Until the 1990s, mental health professionals who made decisions about dangerousness had to rely primarily on what their "gut" told them. Expressed more formally, mental health professionals used their *clinical judgment* to assess future violence risk and to plan treatment interventions to reduce that

risk. In recent years, however, researchers have developed several tools with demonstrated accuracy in "predicting" violent behavior or, more precisely, in ranking persons according to their probability of acting violently in the future. Psychologists refer to these tools—which allow clinicians to exercise "actuarial judgment" about future violence—as "actuarial risk assessment instruments" (ARAIs) (Hart et al. 2007).

The term *actuarial* refers to the types of risk assessment methods used by insurance companies to make decisions about whether to issue insurance or how much to charge for policies (Dawes et al. 1989). Actuaries help insurance companies develop empirically based formulas that relate certain characteristics (e.g., age, sex, and past driving record) to the risks of particular events (e.g., having an auto accident in the next 12 months). ARAIs attempt to provide the same kind of guidance about the risk of violence. To exercise "actuarial judgment" about violence, a clinician gathers information about a (usually small) number of factors concerning an individual who is being evaluated. The clinician then categorizes the information by using an explicit scoring system and combines the scores into an overall numerical value that summarizes the individual's risk of violence. Published manuals for various ARAIs explain their development and rationale while guiding clinicians through the process of assembling the data needed to make actuarially based judgments.

It is easy to underestimate both the value of ARAIs and the advantages they afford over the old way of doing things. It is also easy to attribute more significance to results produced by ARAIs than the developers of these measures intend. In this chapter, I explain how ARAIs improve on clinical judgments about violence while showing readers why even fairly accurate predictions may have limited practical importance. I will begin by examining results from a make-believe contest about the accuracy of violence risk assessment.

The Contest

Once upon a time, two psychiatrists, Drs. Sybil Commitment and Lesley Faire, worked in a psychiatric emergency service at Gevalt Hospital. They respected each other's clinical talents but often disagreed about which patient needed to undergo hospitalization. Dr. Commitment hospitalized many patients because she worried about their violence potential; Dr. Faire hospitalized patients less frequently because she thought doctors should minimize the use of coercion.

The two doctors had a contest to prove whose approach was better. Each of them evaluated 1,000 patients whom a third colleague, Dr. Maven, had decided to admit to Gevalt Hospital. Drs. Commitment and Faire each rated these patients on a 5-point scale (1 implying lowest risk, 5 implying highest). The contestants also made yes-or-no predictions for each patient about whether he or she would become violent within 72 hours of admission. Because Gevalt Hospital staff carefully watched patients and kept good records about them, Drs. Commitment and Faire knew that any act of violence (which they carefully and unambiguously defined for purposes of their contest) would be noticed and recorded. The doctor whose predictions were more accurate would be the contest's winner.

Several months later, Dr. Maven had admitted 1,000 patients, 100 of whom actually became violent, and Drs. Commitment and Faire were ready to learn who had been the better predictor. Some terminology (summarized in Table 21–1) will help us understand how Drs. Commitment and Faire tried to interpret the results of their contest:

- If a doctor predicted violence and the patient subsequently acted violently, the doctor's prediction was a true positive (TP) prediction.
- A false negative (FN) prediction was one in which the doctor did not predict violence for a patient who actually was violent.
- A true negative (TN) was a prediction of nonviolence that turned out to be correct.
- A false positive (FP) was a prediction of violence that was incorrect.

By examining their predictions and the patients' actual behavior, the doctors could calculate what percentage of predictions was correct in light of subsequent events. They could also calculate the ratio of TP to FP predictions to find the odds that a prediction of violence was correct.

Imagine the doctors' discussion of their results, which appear in Table 21–2. Dr. Commitment was right only 36% of the time, whereas Dr. Faire was correct for about 86% of the patients. Yet Dr. Faire was wrong about 75% of the patients who acted violently, whereas Dr. Commitment missed just 10% of these patients. Dr. Commitment felt her performance reflected her concern about a psychiatrist's responsibility to protect the community. But Dr. Commitment made more than seven wrong predictions of violence for every correct one. Because Dr. Faire made fewer wrong predictions of violence, she believed that her performance vindicated her preference for decisions that preserved patients' freedom.

In fact, both psychiatrists did significantly better than chance at predicting violence, but you would not know this from looking at either the fraction of predictions that were correct or the ratio of TP to FP predictions. A doctor

TABLE 21–1. Definitions of some terms used to describe prediction accuracy

Actual behavior	Predicted violent	Predicted not violent
Violent	True positive (TP)	False negative (FN)
Not violent	False positive (FP)	True negative (TN)

Correct fraction (CF) = (TP+TN)/(TP+FP+FN+TN)

TP:FP ratio = TP/FP

True positive rate (TPR) = Sensitivity = TP/(TP+FN)

True negative rate (TNR) = Specificity = TN/(TN+FP)

False positive rate (FPR) = (1 – specificity) = FP/(FP+TN)

TABLE 21–2. Results of the violence prediction contest

	Dr. Commitment's predictions		Dr. Faire's predictions	
Actual behavior	Violent	Not violent	Violent	Not violent
Violent	90	10	25	75
Not violent	634	266	70	830
Correct fraction	0.356		0.855	
TP:FP ratio	1:7		1:2.8	
Sensitivity	0.900		0.250	
Specificity	0.296		0.922	

who simply had said everybody was not violent would have been correct 90% of the time. If one-half of the patients had been violent, a doctor who randomly predicted violence for one-half of the patients would have a TP:FP ratio of about 1, despite exercising no judgment about actual risk.

The lower part of Table 21–1 lists accuracy indices that allow investigators to describe results in ways that do not conflate accuracy with the effects of base rates (Kraemer 1985; Somoza and Mossman 1990). Medical publications often use the terms *sensitivity* and *specificity* to quantify diagnostic accuracy. If we interpret the psychiatrists' predictions as "diagnoses" of future violence, then sensitivity is the probability that a prediction of violence was made for an actually violent patient, and specificity is the probability that a prediction of nonviolence was made for a nonviolent patient. The sensitivities and specific-

ities for the doctors appear in Table 21–2. Notice, however, that these values still do not help much in deciding who predicted more accurately.

In fact, as Table 21–3 shows, the psychiatrists made identical *classifications* of patients' risk of violence, but they used different *decision thresholds* to make predictions. Dr. Commitment minimized false negative outcomes and avoided missing violent patients, and her decision threshold has high sensitivity but low specificity. Dr. Faire minimized false positive outcomes and predicted violence only when she had a very strong suspicion that a patient would become violent, and her decision threshold has high specificity but low sensitivity.

These observations suggest that we should measure diagnostic accuracy using techniques that are not affected by base rates or clinicians' preferences for certain types of outcomes (Swets 1979). Single pairs of results from yes-or-no predictions will not tell the full picture about the accuracy of risk assessments. Ideally, our descriptions of accuracy should reflect inevitable trade-offs between sensitivity and specificity and should be independent of a clinician's actual cut-off or decision threshold.

As Table 21–3 shows, one can calculate four sensitivity-specificity pairs using the divisions between the clinicians' five rating categories as potential decision thresholds. At Dr. Faire's strict threshold, violence is predicted only for patients rated "5." At this strictest threshold, the violence detection rate, or the *true positive rate* (TPR), is only 0.25, but the "false alarm" rate, or *false positive rate* (FPR), is just 0.078. (Note that TPR=sensitivity and FPR=1−specificity.) At the second strictest threshold, violence is predicted for patients rated 4 or 5; the FPR increases to 0.19, and the TPR increases to 0.45. One obtains the FPR and TPR for the two other thresholds in Table 21–3 similarly.

In the mid-1990s, several writers (Mossman 1994a, 1994b; Rice and Harris 1995; Gardner et al. 1996) recognized that adjustable thresholds are a feature of most violence prediction techniques and that the accuracy of violence prediction methods should therefore be described by using *receiver operating characteristic* (ROC) analysis. This term, originally derived from World War II radar applications (Lusted 1984), suggests that detection is characterized by the threshold at which the "receiver" (here, a clinician) operates. ROC analysis allows investigators to characterize the trade-offs between errors and correct identifications that arise from the intrinsic discrimination capacity of a detection method and to distinguish these features from the threshold or operating point used to make a decision (Mossman and Somoza 1991). ROC analyses often include a ROC graph, which succinctly summarizes the results of a detection method as the threshold is moved throughout its range of possible values. A ROC graph customarily plots the TPR as a function of the FPR and depicts how the TPR increases as the FPR increases.

Figure 21–1 is an example of such a graph, based on the results shown in Table 21–3. Notice that the four possible thresholds lie along a ROC curve

TABLE 21–3. Future violence ratings and decision thresholds

		Ratings				
Doctor's name	Actual behavior	1	2	3	4	5
Sybil Commitment	Violent	10	15	30	20	25
	Not violent	266	209	252	103	70
Lesley Faire	Violent	10	15	30	20	25
	Not violent	266	209	252	103	70
	True positive rate	0.90	0.75	0.45	0.25	
	False positive rate	0.70	0.47	0.19	0.078	

Note. Vertical bars indicate doctor's decision threshold.

joining them. (To learn more about the mathematical assumptions used to fit ROC curves to data points, see Somoza and Mossman 1991 and Mossman 1994b.) The better a test or detection system, the greater the *area under the ROC curve* (AUC) that describes the performance of the test or detection system. The AUC of a test or detection system has a direct, practical interpretation (Hanley and McNeil 1982). In the context of quantifying the accuracy of violence prediction, AUC equals the probability that the detection method would rate a randomly selected actually violent person as more likely to be violent than a randomly selected nonviolent person. A prediction method that always rated violent and nonviolent persons correctly would have an AUC of 1.0; a prediction method that gave no information would have an AUC of 0.5 and would be described by the diagonal line in Figure 21–1. For the hypothetical results from Table 21–3, AUC=0.701±0.028, implying an accuracy level that is significantly better than chance and is fairly typical of clinical judgments about future violence (Mossman 1994b).

These results can help us understand why mental health professionals once thought that predictions of violence—especially long-term predictions—are inaccurate (Krauss 2005; Mossman 2000; Schlesinger 2004). In the 1980s and 1990s, mental health professionals thought that, as the U.S. Supreme Court put it, "[p]sychiatric predictions of future violent behavior by the mentally ill are inaccurate" (*Heller v. Doe* 1993). The Court's view reflects conclusions in John Monahan's influential monograph, *The Clinical Prediction of Violent Behavior* (1981), which summarized previously published studies of violence prediction in support of this conclusion. Looking at results such as those shown in Table 21–2 for Dr. Commitment and Dr. Faire, Professor Monahan correctly concluded "that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior" (Monahan 1981, p. 92). As we have seen, however, Dr. Commitment's and Dr. Faire's predictions were much better than chance at categorizing patients according to their risk of violence. Their error pattern (the low TP:FP ratio) was a consequence of the low "base rate" of violence among the 1,000 subjects, only 10% of whom were violent during the follow-up.

By quantifying accuracy using ROC methods, we keep low base rates from fooling us. Because neither FPR nor TPR is affected by base rates, ROC methods describe the accuracy of violence predictions in a way that separates properties of the detection process from the frequency of violence in the population being studied. As Mossman (1994b, 2000) and Buchanan and Leese (2001) have shown, reanalyses of previously published data (including those from the studies that Monahan described) show that short-, medium-, and long-term clinical predictions of violence all have a roughly similar, modestly better-than-chance level of accuracy.

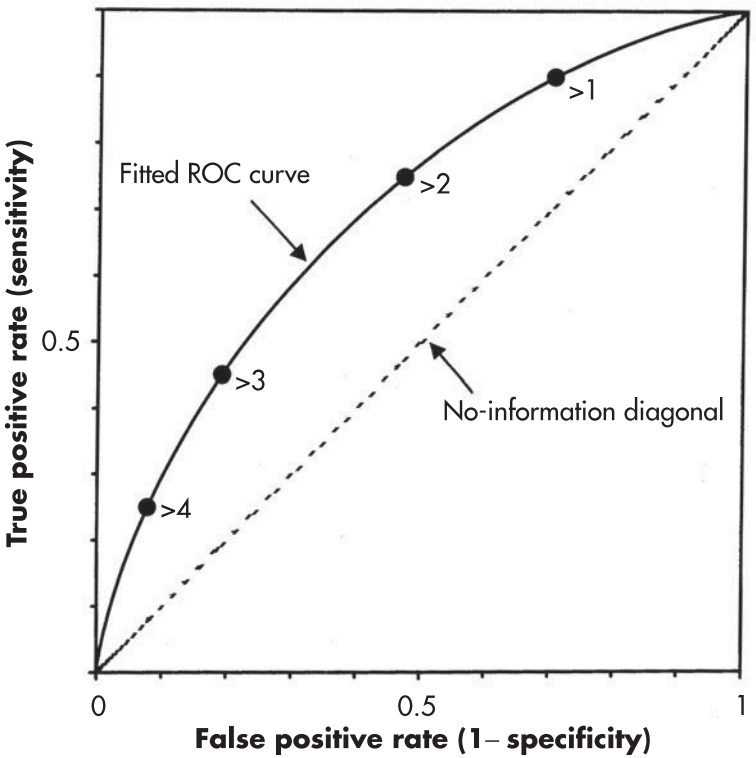

FIGURE 21–1. ROC graph based on the results shown in Table 21–3. The four possible thresholds are fit to ROC curve, the area under which is 0.701. The no-information diagonal (ROC area = 0.5) is also shown.

Actuarial Prediction Methods

Clinical Versus Actuarial Prediction Methods

Our discussion of a make-believe contest looks at how well two hypothetical doctors used their clinical judgment to assess violence risk and make predictions about it. Most decisions about psychiatric care, and probably most decisions in medicine, are made this way. That is, doctors gather information

using their intuition about what seems most relevant and then combine the information with their general background knowledge, their specific knowledge about the person they are evaluating, their intuition, their "gut instincts," and/or whatever else they think is relevant to anticipate (predict) what will happen. Then doctors intervene with a treatment decision.

Psychologists who study human decision-making contrast decisions based on "clinical" judgments (also called "subjective" or "impressionistic" judgments) with decisions based on "actuarial" judgments using formulas, algorithms, or other "mechanical" means of combining data. As stated earlier, ARAIs direct the clinician's attention to specific items, behavior, or other features of the individual he or she is evaluating. The clinician then uses these data to come up with a numerical value that summarizes the evaluee's risk of violence.

HCR-20

The HCR-20 (Webster et al. 1997) is a straightforward example of the process of combining data to assess risk. This instrument, whose name is an acronym for its overall structure, directs the clinician's attention toward 20 factors—10 **h**istorical items, 5 **c**linical items, and 5 **r**isk management items—associated with violence. The manual for the HCR-20 succinctly describes research that supported inclusion of each item when the second version was published. One can find often-updated reports of additional supporting research at http://kdouglas.wordpress.com/hcr-20/.

To use the HCR-20, a clinician gathers the information about each of the risk factor items and then, using the manual's instructions about coding information related to each risk factor, gives each item a score of 0, 1, or 2. An individual's score on the HCR-20 can thus range from 0 to 40, with higher scores implying higher probabilities of future violence.

A brief look at a few items on the HCR-20 will help readers appreciate how its creators have tried to identify a few salient risk factors for violence and have used these factors to produce a straightforward, reliable instrument for risk assessment:

- An example of an historical item on the HCR-20 is H5, "Substance Use Problems." The authors justify including this item on the basis of several studies, including the finding by Swanson (1994), based on data originally obtained in the Epidemiologic Catchment Area study, that "having a substance abuse diagnosis yielded much stronger associations with violence than did having a mental disorder" (Webster et al. 1997, p. 36). On Item H5, an evaluee receives a score of 0 if he has "no substance use problems," a score of 2 for "definite/serious substance use problems" that

interfere with functioning, and a score of 1 for "possible/less serious substance use problems" (Webster et al. 1997, p. 37).

- Item C3, "Active Symptoms of Major Mental Illness," serves as a good example of a clinical item in the HCR-20. Inclusion of this item gains support from research that associates active psychotic symptoms with violence (e.g., Swanson et al. 1996). A clinician codes this item 0 if an evaluee has "no active symptoms of major mental illness," 1 for "possible/ less serious active symptoms," or 2 for "definite/serious active symptoms" (Webster et al. 1997, p. 55).
- Item R4, "Noncompliance With Remediation Attempts," asks the evaluator to score the probability that a patient will not take medication or adhere to other therapeutic regimens. A score of 0 implies a "low probability of noncompliance"; 1, a "moderate probability"; and 2, a "high probability." Again, the authors cite research available in 1997 (e.g., Bartels et al. 1991; Haywood et al. 1995) to support inclusion of this risk factor. Subsequent studies (e.g., Swartz et al. 1998; Swanson et al. 2003) have confirmed the importance of noncompliance as a predictor of posthospitalization violence.

Figure 21–2 is based on a study of the HCR-20 by Douglas and colleagues (1999) and is presented to help readers understand the relationships among patients' actual scores on ARAIs, future violence, and the ways that ROC techniques quantify the accuracy of predictions. In their study, Douglas and colleagues used the HCR-20 assessment scheme to code information about 193 former inpatients who had been civilly committed. Patients had subsequently been released to the community for an average of almost 2 years, during which time 73 of the patients became violent. Figure 21–2 contains histograms showing the patients' HCR-20 scores (which one can figure out from data in the authors' original paper). Notice that the violent patients tended to score higher than did the nonviolent patients. Superimposed on the histograms are two bell-shaped (Gaussian) curves that represent a best fit of the data (produced by using maximum likelihood estimation software available from the University of Chicago Department of Radiology, available at http://www-radiology.uchicago.edu/krl/KRL_ROC/software_index6. htm). Looking at the curves, one sees that using the HCR-20 shifts the distributions of violent and nonviolent patients about one standard deviation apart from each other.

Figure 21–2 also contains arrows representing a few possible cut-offs and the values of the FPR and TPR associated with those cut-offs. For example, a cut-off score of >20 (i.e., patients with scores above 20 are predicted to be violent, and those with scores of 20 or less are predicted to be nonviolent) can be expected to identify 61% of the violent patients and to mislabel 24% of the nonviolent patients (i.e., specificity is 76%). For the smooth ROC curve

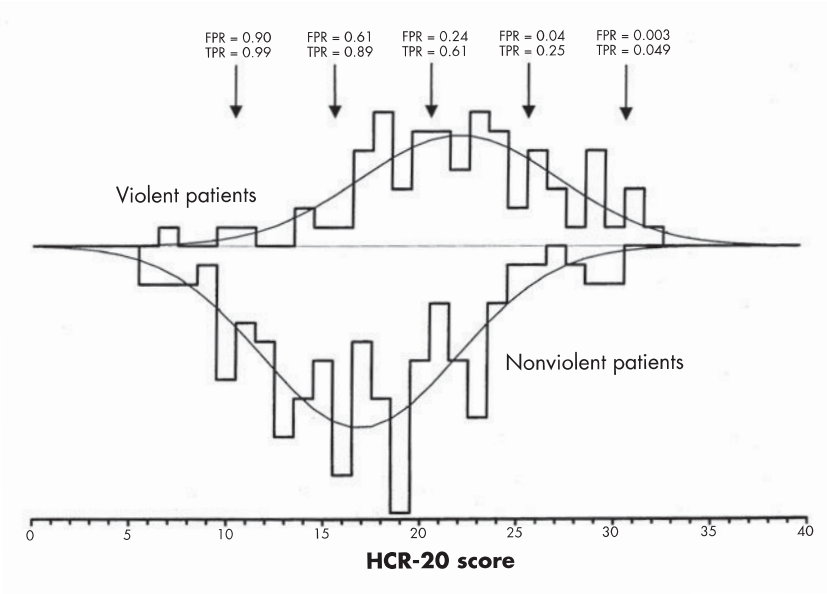

FIGURE 21–2. Histograms showing HCR-20 scores of 73 violent patients and 120 nonviolent patients studied by Douglas et al. (1999).
Superimposed on the histograms are two "bell-shaped" (Gaussian) curves that represent a best fit of the data. Also shown are the values of FPR and TPR associated with five possible cut-offs. The bell-shaped curves imply that the effect of using the HCR-20 is to shift the distributions of violent and nonviolent patients about one standard deviation apart from each other. This is equivalent to saying that about three-quarters of the time, the HCR-20 score of a randomly chosen violent patient will be higher than the score of a randomly chosen nonviolent patient.

implied by the best-fit bell-shaped curves in Figure 21–2, AUC=0.758± 0.035. In other words, Douglas and colleagues' study suggests that about three-quarters of the time, the HCR-20 score of a randomly chosen violent patient will be higher than the score of a randomly chosen nonviolent patient. When committing a violent crime was the outcome criterion, Douglas and colleagues (1999) found that the HCR-20 was an even better predictor—it had an AUC of 0.80.

Since its development in the 1990s, other investigators have evaluated the HCR-20 in several countries and many other clinical contexts, and violent evaluees consistently receive higher scores than nonviolent evaluees (Douglas and Reeves 2009; Douglas et al. 2008). In other words, using the HCR-20 consistently helps an evaluator make a better-than-chance ranking of the likelihood of future violence in a mental health population.

Other Actuarial Methods

The HCR-20 is just one of several ARAIs now available. Examples of other methods are described ahead.

Violence Risk Appraisal Guide

The creators of the Violence Risk Appraisal Guide (VRAG; Quinsey et al. 1998, 2006) developed their instrument using data on forensic patients and offenders with mental disorders originally detained in a Canadian prison psychiatric facility between 1965 and 1980. Post-incarceration follow-up data on their violent behavior (ranging from assault to murder) were collected from Royal Canadian Mounted Police files. Over the past decade, the ability of the VRAG to rank likelihood of reoffending has been confirmed in many other populations, including offenders with mental disorders in Europe (e.g., Endrass et al. 2008; Grann et al. 2000; Pham et al. 2005), previously incarcerated sex offenders (Harris et al. 2003; Langton et al. 2007), intellectually disabled offenders (Lindsay et al. 2008), and wife assaulters (Hilton et al. 2008).

Using the VRAG, an evaluator collects information relevant to 12 scored items and then assigns empirically derived weights to the items to generate a total VRAG score. The item weights are based on what the VRAG's creators found had worked in their original data sample. Thus, because having schizophrenia decreased the risk of future violence in the original sample, this condition is weighted so as to lower predicted risk of violence. Available research (e.g., Rice and Harris 1995) suggests accuracy levels for the VRAG that are comparable with those for the HCR-20.

Psychopathy appears as a risk item in both the HCR-20 and the VRAG. It turns out that an evaluee's psychopathy score, as measured by the Hare Psychopathy Checklist—Revised (PCL-R; Hare 2003) or the Psychopathy Checklist—Screening Version (PCL-SV; Hart et al. 1995), is itself a decent predictor of violent behavior (Grann et al. 1999; Ho et al. 2009; Urbaniok et al. 2007), though perhaps not as accurate a predictor as are the HCR-20 and VRAG (e.g., Douglas et al. 1999; Glover et al. 2002). To use the PCL-R, the evaluator takes interview information and collateral data (from clinical files, police records, etc.) to assign scores of 0, 1, or 2 to 20 items, so that a total PCL-R score ranges from 0 to 40. Statistical analyses suggest that the PCL-R items refer to at least two "factors" that characterize PCL-R-defined psychopathy: 1) callous, unremorseful use of others (as reflected, e.g., in glibness, lying, manipulation of others, lack of remorse, and unwillingness to accept responsibility) and 2) a chronically unstable and antisocial lifestyle (as reflected in, e.g., early behavioral problems, stimulation seeking, impulsiveness, and multiple sexual relationships). A number of writers (e.g., Vitacco et al. 2005) suggest that four factors—interpersonal, affective, behavioral-lifestyle, and antisocial behavior—underlie psychopathy.

Iterative Classification Tree

The Iterative Classification Tree (ICT) method (Monahan et al. 2000; Steadman et al. 2000), available in computer form (Monahan et al. 2005) as the Classification of Violence Risk (COVR), represents another way to assess violence risk. Using a sequence set out by the ICT, an evaluator asks an initial question about an evaluee. Depending on the answer to the first question, the evaluator asks one of two second questions and continues with this procedure until the evaluee is classified in one of the terminal categories on the tree's branches. Membership in particular categories allows the assignment of evaluees to subgroups with risks that are lower than, higher than, or not distinguishable from the full group's base rate of violence. Although the authors report high accuracy for their risk assessment scheme (AUC=0.80–0.82), their ICT was designed specifically for their test sample, and their statistical analyses do not tell us how well their ICT would perform in another sample (Mossman 2000). In a validation study, Monahan and colleagues noted that their findings implied lower accuracy that "may reflect the 'shrinkage' expected in moving from construction to validation samples" (2005, p. 810).

Instruments for Assessing Sex Offender Recidivism

The Sex Offender Risk Appraisal Guide (SORAG; Quinsey et al. 1998) and Static-99 (Hanson and Thornton 2000) are examples of currently available ARAIs designed to assess the risk of recidivism by individuals convicted of sex offenses. They both have modestly better-than-chance accuracy in predicting who will be convicted of a new sex offense during long periods (10 years or more) of community release. The SORAG is very similar in structure to the VRAG, but the former instrument appears to be a bit better at predicting sexual recidivism (Hanson and Morton-Bourgon 2009). The Static-99 focuses evaluators on just a few historical items about the offender—including the number of prior sex offenses, offender's age, sex of victim(s), and relationship to victim(s)—and yields scores that are significantly correlated with long-term likelihood of recidivism.

Clinical or Actuarial Judgment?

If a psychiatrist has a choice between using unaided clinical judgment and using an ARAI to assess violence risk, which method is better? The best current

answer is "probably the actuarial method." The reason is that in a broad variety of prediction tasks, actuarial methods consistently yield better judgments than those made by unaided clinicians (Grove and Meehl 1996; Grove et al. 2000). To readers who are not familiar with studies comparing clinical and actuarial predictions, this finding may come as a surprise. After all, clinical judgments presumably incorporate factors such as detailed lessons from experience, human pattern recognition abilities, and subtle nuances that simple formulas leave out. It would seem, therefore, that clinical predictions must be more accurate than predictions generated by algorithms or formulas.

The scientific literature strongly suggests that the opposite is true, however. The reason may be that clinicians do not assign proper significance to the kinds of information used in actuarial prediction formulas or that clinicians may just not reliably and consistently weigh the information they use. In most cases, making a prediction or assessing the probability of a future event may be more like figuring out a grocery bill than deciding whether a portrait accurately depicts its subject. It is very difficult to program a computer to identify faces (something people do easily and well), but to calculate a grocery bill, it is much more accurate to check prices and use a simple calculator than to eyeball a shopping cart and estimate the total cost (Dawes et al. 1989).

Most authors (e.g., Gardner et al. 1996; Harris et al. 2002; Mossman 1994a; Quinsey et al. 2006) now interpret available research as indicating that actuarial measures are superior to clinical judgments about future violence. Actuarial methods also have other advantages over clinical judgment. When used properly, actuarial methods are impartial, systematic, and thorough. They also have the virtue of "transparency," in that they use fairly objective data and an explicitly prescribed method of combining those data. This makes actuarial methods and their results open to inspection, questioning, and, when necessary, critique.

A question that remains, however, is whether using clinical information in addition to the ARAIs might improve on the assessment powers of ARAIs alone. From their own research findings and the general finding that actuarial measures outperform clinical predictions, Quinsey and colleagues (2006) argue for "the complete replacement of existing practice with actuarial methods" (p. 192), though they still see an important role for clinicians as *gatherers* of those data that have empirically demonstrated relevance to risk assessment.

Most authors and investigators think ARAIs are best used as part of "structured risk assessment" (Hanson and Thornton 2000) or "structured clinical judgment" (Douglas and Kropp 2002; Douglas and Reeves 2009; Kropp et al. 2002) about future risk or violence. For example, the designers of the HCR-20 believe that gathering data for ARAIs should be just the first

step in a process of evaluating violence risk; the ARAIs should function "as an *aide-mémoire*" (Webster et al. 1997, p. 5), guiding the evaluator toward data that are important in risk assessment. Using ARAIs as a starting point forces the evaluator to proceed from and appropriately consider a set of known factors associated with violence risk. Having done this, the evaluator may then (and usually should) consider additional factors specific to an evaluee's situation—for example, dynamic factors not included in the risk assessment, characteristics and availability of known potential victims, the evaluee's known response to treatment, the evaluee's anticipated future situation, and the degree to which the actuarial measure fits the population from which the evaluee is drawn—to make an ultimate judgment about risk. An accumulating body of evidence suggests that structured clinical judgment is a more accurate gauge of risk than using the HCR-20 as a purely actuarial instrument (Douglas and Reeves 2009).

Whatever one thinks about strictly actuarial versus structured clinical judgment, the power of ARAIs' judgment should not lead evaluators to ignore common sense. As even ardent proponents of actuarial judgment (e.g., Grove and Lloyd 2006) acknowledge, we sometimes have data not considered by established ARAIs with clear empirically established relationships to an outcome of interest. Not all data relevant to violence risk appear in ARAIs. For example, a clearly stated intent to kill someone following an acute precipitant—a clinical event too unusual to include in a risk assessment instrument, but one that many clinicians eventually encounter—puts a person at high, imminent risk to act violently. As Hart (1999) has pointed out, assessors would be negligent if they ignored an individual's prior history of violence or homicidal ideation and threats. Moreover, research links these factors to future violence (Grisso et al. 2000; McEwan et al. 2007).

The Practical Usefulness of Predictions

The fact that ARAIs such as the HCR-20 and the VRAG can rank violence risk accurately clearly indicates that mental health professionals can make valid distinctions about individuals' long-term predisposition to violence. But the practical usefulness of ARAIs in ordinary clinical care is unclear.

To understand the problem, consider two more hypothetical psychiatrists, Dr. Jones and Dr. Smith, who have created a hypothetical actuarial risk assessment instrument—the Violence Prediction Scale (VPS)—to make de-

cisions concerning their patients' future violence. After thorough testing, Drs. Jones and Smith have learned that the VPS performs as well as or better than other currently available instruments: the area under its ROC curve is 0.83. The ROC curve for the VPS passes through the point where the FPR is 0.25 and the TPR is 0.75, and Drs. Jones and Smith decide to use the VPS score corresponding to this cutoff as their decision threshold. They now plan to evaluate inpatients for whom they are responsible. From past experience, they know that one out of four of the inpatients (25%) will engage in a seriously violent act, a typical base rate of violence in studies of inpatients (Borum 1996).

Imagine two situations in which the doctors might put the VPS to use. In the first situation, Dr. Jones must assign 160 new, simultaneously arriving inpatients to treatment units. Of the available hospital beds, 100 are in general treatment units and 60 of the available beds are in special care units. The special care units are distinctively designed and especially well staffed, and they reduce patients' violence by 50% compared with what it would be otherwise. If Dr. Jones were to assign patients to the special and general units at random, the rate of violence for the 60 patients in the special care unit would be 1 out of 8 (i.e., one-half the base rate=0.125), and 8 patients would become violent. On the general treatment units, 25 of the 100 patients would become violent. Overall, the rate of violence would be 33 out of 160 patients. Now, by using the VPS at the cut-off, where FPR=0.25 and TPR=0.75, Dr. Jones can divide the patients into two subgroups: a 60-member "predicted violent" group for whom the rate of violence is 0.50 (1 out of 2), and a 100-member "predicted nonviolent" group for whom the rate is 0.10 (1 out of 10). If the "predicted violent" patients go to the special care units, their rate of violence is halved from what it would be otherwise, so only 15 of them become violent. On the general units, 10 "predicted nonviolent" patients become violent. The system is imperfect, but by using the VPS, Dr. Jones has reduced the total rate of violence by one-quarter (from 33 to 25 patients out of 160).

The preceding paragraph shows how VPS-like instruments might prove useful in public health contexts where policies require decision-makers to rationally implement limited resources (Zagar et al. 2009). But resource allocation—like Dr. Jones's clinical task of evaluating 160 new arrivals and assigning them to one of two types of treatment units—is not the sort of problem that most clinicians encounter. A more typical problem is faced by Dr. Smith. He, too, is responsible for 160 inpatients, but his patients are placed in similar treatment units. (For purposes of this illustration, it does not matter whether the patients are already present in the hospital or arrive individually over a period of time.) Like Dr. Jones, Dr. Smith can use the VPS to sort the patients into a "high-risk" group, 50% of whose members will act violently, and a "low-risk" group, of whom 10% will be violent. But how might

Dr. Smith react to this information? He probably would be more concerned about those patients to whom the VPS assigns a 50% chance of becoming violent. But would he want to do *nothing* about the potential dangerousness of the "low-risk" patients, who have "only" a 10% risk of acting violently? If the violent behavior of one of these "low-risk" patients resulted in a *Tarasoff*-type lawsuit, Dr. Smith probably would not want to tell jurors that having a 1-in-2 chance of serious violence implied a need for special attention, but a 1-in-10 chance was too low to warrant thoughtful efforts to prevent harm to others. Under most circumstances, it would be hard to justify treating patients with a 10% risk of serious violence very differently from those with a 50% risk. For both groups of patients, Dr. Smith—and, I suspect, most real-life psychiatrists—would probably exercise similar precautions when formulating inpatient treatment, making follow-up plans, and completing other treatment arrangements. In fact, there is little or no societal agreement on what risk of violence is low enough to ignore (Mossman 2006).

Conclusion

Several years ago, G.E. Dix (1983) wrote, "Intuition suggests that psychiatrists' predictive ability is substantially greater when it is called into play concerning the short-term risk posed by persons whose assaultive tendencies are related to symptoms of identifiable serious mental illnesses" (p. 256). Yet research since the mid-1990s has suggested that a person's likelihood of being violent is also a function of several enduring characteristics. Psychiatric impairments affect how well a person can interpret behavior, resolve conflicts, and get along with others (Swanson et al. 1998). This may help explain why having a mental illness—particularly schizophrenia (Fazel et al. 2009)—statistically increases a person's likelihood of being physically aggressive. Substance use problems and many nonpsychiatric factors (e.g., sex, age, income, past history of violence, and contextual stressors) contribute far more to violence risk, however (Elbogen and Johnson 2009). Enduring clinical, historical, and dispositional factors that statistically influence the likelihood of violence provide information that lets one make reasonable rankings of individuals' long-term violence risk. As a result, simple formulas that focus on known risk factors can help clinicians implement "actuarial" judgment and identify patients with higher or lower probabilities of becoming violent.

Recent research suggests that ARAIs let clinicians make better predictions than they would by using their unaided clinical judgment. Yet clinicians may often find that predictions made with these tools do not change

how they manage patients. The reason is that for typical clinical tasks, even fairly accurate prediction techniques do not sort patients into subgroups with meaningfully different levels of risk.

The practical value of violence prediction measures may inhere in the help they give psychiatrists in focusing on important aspects of clinical management of present problems, a role that psychiatrists see as central to their profession (Simon 2006). For example, noncompliance with treatment and substance abuse—two items found in the HCR-20—are risk factors for violent behavior following hospital discharge (Elbogen et al. 2006; Steadman et al. 1998; Swartz et al. 1998). By addressing these problems (e.g., by finding ways to improve patients' adherence to community treatment and avoidance of intoxicants), mental health professionals and social institutions (e.g., mental health courts) might reduce their patients' risk of acting violently (Binder and McNiel 1998).

Of course, improving compliance and preventing substance abuse are good things for patients, whether these interventions reduce violence or not (Mullen 2006). Perhaps the greatest current value of actuarial prediction instruments rests not in their predictive powers, but in their ability to translate what current research tells us about violence risk into knowledge that clinicians can use to make evidence-based decisions about treatment.

Key Points

- Short-term and long-term rankings of violence risk have comparable, better-than-chance levels of accuracy.
- In recent years, researchers have developed actuarial risk assessment instruments (ARAIs) for gauging the likelihood of future violence.
- ARAIs, which are based on empirically established risk factors for violence, lead to risk judgments that are more accurate than assessments based solely on clinical judgment.
- Using ARAIs may help psychiatrists improve their assessments of the risk of violence.
- ARAIs also may let clinicians identify factors that can potentially be addressed in treatment and that should be considered in any violence risk assessment.

Practice Guidelines

1. Familiarize yourself with actuarial risk assessment instruments when making formal assessments of the risk of violence.
2. Focus on research-proven factors that influence an individual's risk of violence when conducting a risk assessment.
3. Consider using ARAIs in standard risk assessments when possible, because these tools force you to proceed from and give appropriate consideration to a set of known factors associated with violence risk.
4. Take into account additional factors specific to an evaluee's situation—for example, the availability of known potential victims—when making judgments about violence risk.

References

Bartels SJ, Drake RE, Wallach MA, et al: Characteristic hostility in schizophrenic outpatients. Schizophr Bull 17:163–171, 1991

Binder RL, McNiel DE: Effects of diagnosis and context on dangerousness. Am J Psychiatry 145:728–732, 1988

Borum R: Improving the clinical practice of violence risk assessment: technology, guidelines, and training. Am Psychol 51:945–956, 1996

Buchanan A, Leese M: Detection of people with dangerous severe personality disorders: a systematic review. Lancet 358:1955–1959, 2001

Dawes RM, Faust D, Meehl PE: Clinical versus actuarial judgment. Science 243:1668–1674, 1989

Dix GE: A legal perspective on dangerousness: current status. Psychiatr Ann 13:243–256, 1983

Douglas KS, Kropp PR: A prevention-based paradigm for violence risk assessment: clinical and research applications. Criminal Justice and Behavior 29:617–658, 2002

Douglas KS, Reeves K: HCR-20 violence risk assessment scheme: rationale, application and empirical overview, in Handbook of Violence Risk Assessment. Edited by Otto RK, Douglas KS. Oxford, UK, Routledge/Taylor & Francis, 2009

Douglas KS, Ogloff JRP, Nicholls TL, et al: Assessing risk for violence among psychiatric patients: the HCR-20 risk assessment scheme and the Psychopathy Checklist: Screening Version. J Consult Clin Psychol 67:917–930, 1999

Douglas KS, Guy LS, Reeves KA, et al: HCR-20 Violence Risk Assessment Scheme: Overview and Annotated Bibliography (current up to November 24, 2008). Available at: http://kdouglas.wordpress.com/hcr-20/. Accessed June 17, 2009.

Elbogen EB, Johnson SC: The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 66:152–161, 2009

Elbogen EB, Van Dorn RA, Swanson JW, et al: Treatment engagement and violence risk in mental disorders. Br J Psychiatry 189:354–360, 2006

Endrass J, Rossegger A, Frischknecht A, et al: Using the Violence Risk Appraisal Guide (VRAG) to predict in-prison aggressive behavior in a Swiss offender population. Int J Offender Ther Comp Criminol 52:81–89, 2008

Fazel S, Långström N, Hjern A, et al: Schizophrenia, substance abuse, and violent crime. JAMA 301:2016–2023, 2009

Gardner W, Lidz CW, Mulvey EP, et al: Clinical versus actuarial predictions of violence in patients with mental illness. J Consult Clin Psychol 64:602–609, 1996

Glover AJJ, Nicholson DE, Hemmati T, et al: A comparison of predictors of general and violent recidivism among high risk federal offenders. Criminal Justice and Behavior 29:235–249, 2002

Grann M, Langstrom N, Tengström A: Psychopathy (PCL-R) predicts violent recidivism among criminal offenders with personality disorders in Sweden. Law Hum Behav 23:205–217, 1999

Grisso T, Davis J, Vesselinov R, et al: Violent thoughts and violent behavior following hospitalization for mental disorder. J Consult Clin Psychol 68:388–398, 2000

Grove WM, Lloyd M: Meehl's contribution to clinical versus statistical prediction. J Abnorm Psychol 115:192–194, 2006

Grove WM, Meehl PE: Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: the clinical-statistical controversy. Psychology, Public Policy, and Law 2:293–323, 1996

Grove WM, Zald DH, Lebow BS, et al: Clinical versus mechanical prediction: a meta-analysis. Psychol Assess 12:19–30, 2000

Hall HV, Ebert RS: Violence Prediction: Guidelines for the Forensic Practitioner, 2nd Edition. Springfield, IL, Charles C Thomas, 2002

Hanley JA, McNeil BJ: The meaning and use of the area under a receiver operating characteristic (ROC) curve. Radiology 143:29–36, 1982

Hanson RK, Morton-Bourgon KE: The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis. Psychol Assess 21:1–21, 2009

Hanson RK, Thornton D: Improving risk assessments for sex offenders: a comparison of three actuarial scales. Law Hum Behav 24:119–136, 2000

Hare RD: Manual for the Hare Psychopathy Checklist—Revised, 2nd Edition. Toronto, ON, Multi-Health Systems, 2003

Harris GT, Rice ME, Cormier CA: Prospective replication of the Violence Risk Appraisal Guide in predicting violent recidivism among forensic patients. Law Hum Behav 26:377–394, 2002

Harris GT, Rice ME, Quinsey VL, et al: A multi-site comparison of actuarial risk instruments for sex offenders. Psychol Assess 15:413–425, 2003

Hart SD: Assessing violence risk: thoughts and second thoughts.Violent offenders: appraising and managing risk. Contemporary Psychology 44:486–488, 1999

Hart SD, Cox DN, Hare RD: The PCL: SV-Psychopathy Checklist: Screening Version. Toronto, ON, Multi-Health Systems, 1995

Hart SD, Michie C, Cooke DJ: Precision of actuarial risk assessment instruments: evaluating the "margins of error" of group vs individual predictions of violence. Br J Psychiatry Suppl 190:S60–S65, 2007

Haywood TW, Kravitz HM, Grossman LS, et al: Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. Am J Psychiatry 152:856–861, 1995

Heller v Doe, 509 U.S. 312 (1993)

Hilton NZ, Harris GT, Rice ME et al: An in-depth actuarial assessment for wife assault recidivism: the Domestic Violence Risk Appraisal Guide. Law Hum Behav 32:150–163, 2008

Ho H, Thomson L, Darjee R: Violence risk assessment: the use of the PCL-SV, HCR-20, and VRAG to predict violence in mentally disordered offenders discharged from a medium secure unit in Scotland. J Forens Psychiatry Psychol 20:523–541, 2009

Kraemer HC: The robustness of common measures of 2 × 2 association to resist bias due to misclassifications. American Statistician 39:286–290, 1985

Krauss DA: Predicting school violence, in Violence in Schools: Cross-National and Cross-Cultural Perspectives. Edited by Denmark FL, Krauss HH, Wesner RW, et al. New York, Kluwer, 2005, pp 253–274

Kropp PR, Hart SD, Lyon DR: Risk assessment of stalkers: some problems and possible solutions. Crim Justice Behav 29:590–616, 2002

Langton CM, Barbaree HE, Seto MC, et al: Actuarial assessment of risk for reoffense among adult sex offenders. Crim Justice Behav 34:37–59, 2007

Lindsay WR, Hogue T, Taylor JL, et al: Risk assessment in offenders with intellectual disability: a comparison across three levels of security. Int J Offender Ther Comp Criminol 52:90–111, 2008

Lusted LB: ROC recollected. Med Decis Making 4:131–135, 1984

McEwan T, Mullen PE, Purcell R: Identifying risk factors in stalking: a review of current research. Intern J Law Psychiatry 30:1–9, 2007

Monahan J: The Clinical Prediction of Violent Behavior (DHHS Publ No ADM 81-921). Rockville, MD, National Institute of Mental Health, 1981

Monahan J, Steadman HJ, Appelbaum PS, et al: Developing a clinically useful actuarial tool for assessing violence risk. Br J Psychiatry 176:312–319, 2000

Monahan J, Steadman HJ, Robbins PC, et al: An actuarial model of violence risk assessment for persons with mental disorders. Psychiatr Serv 56:810–815, 2005

Mossman D: Assessing predictions of violence: being accurate about accuracy. J Consult Clin Psychol 62:783–792, 1994a

Mossman D: Further comments on portraying the accuracy of violence predictions. Law Hum Behav 18:587–593, 1994b

Mossman D: Commentary: assessing the risk of violence—are "accurate" predictions useful? J Am Acad Psychiatry Law 28:272–281, 2000

Mossman D: Critique of pure risk assessment or, Kant meets Tarasoff. University of Cincinnati Law Review 75:523–609, 2006

Mossman D, Somoza E: ROC curves, test accuracy, and the description of diagnostic tests. J Neuropsychiatry Clin Neurosci 3:330–333, 1991

Mullen PE: Schizophrenia and violence: from correlations to preventive strategies. Advances in Psychiatric Treatment 12:239–248, 2006

Pham TH, Ducro C, Marghem B, et al: Evaluation du risque de récidivie au sein d'une population de délinquants incarceréré ou interné en Belgique francophone. Annales Médico Psychologiques 163:842–845, 2005

Quinsey VL, Harris GT, Rice ME, et al: Violent Offenders: Appraising and Managing Risk. Washington, DC, American Psychological Association, 1998

Quinsey VL, Harris GT, Rice ME, et al: Violent Offenders: Appraising and Managing Risk, 2nd Edition. Washington, DC, American Psychological Association, 2006

Rice ME, Harris G: Violent recidivism: assessing predictive validity. J Consult Clin Psychol 63:737–748, 1995

Schlesinger LB: Sexual Murder: Catathymic and Compulsive Homicides. Boca Raton, FL: CRC Press, 2004

Shah SA: Dangerousness: a paradigm for exploring some issues in law and psychology. American Psychologist 33:224–238, 1978

Simon RI: The myth of "imminent" violence in psychiatry and law. Cincinnati Law Review 75:631–644, 2006

Somoza E, Mossman D: Introduction to neuropsychiatric decision making: binary diagnostic tests. J Neuropsychiatry Clin Neurosci 2:297–300, 1990

Somoza E, Mossman D: ROC curves and the binormal assumption. J Neuropsychiatry Clin Neurosci 3:436–439, 1991

Steadman HJ, Mulvey EP, Monahan J, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 55:393–401, 1998

Steadman, HJ, Silver E, Monahan J, et al: A classification tree approach to the development of actuarial violence risk assessment tools. Law Hum Behav 24:83–100, 2000

Swanson JW: Mental disorder, substance abuse, and community violence: an epidemiological approach, in Violence and Mental Disorder: Developments in Risk Assessment. Edited by Monahan J, Steadman HJ. Chicago, University of Chicago Press, 1994, pp 101–136

Swanson JW, Borum R, Swartz MS, et al: Psychotic symptoms and disorders and the risk of violent behavior in the community. Crim Behav Ment Health 6:317–338, 1996

Swanson J, Swartz M, Estroff S, et al: Psychiatric impairment, social contact, and violent behavior: evidence from a study of outpatient-committed persons with severe mental disorder. Soc Psychiatry Psychiatr Epidemiol 33 (suppl 1):S86–S94, 1998

Swanson JW, Swartz MS, Elbogen EB, et al: Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. Behav Sci Law 21:473–491, 2003

Swartz MS, Swanson JW, Hiday VA, et al: Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. Am J Psychiatry 155:226–231, 1998

Swets JA: ROC analysis applied to the evaluation of medical imaging techniques. Invest Radiol 14:109–121, 1979

Tarasoff v Regents of University of California, 551 P.2d 334 (Calif. 1976)

Tengström A: Long-term predictive validity of historical factors in two risk assessment instruments in a group of violent offenders with schizophrenia. Nord J Psychiatry 55:243–249, 2001

Urbaniok F, Noll T, Rossegger A, et al: Die prädiktive Qualität der Psychopathy Checklist—Revised (PCL-R) bei Gewalt- und Sexualstraftätern in der Schweiz: Eine Validierungsstudie. Fortschr Neurol Psychiatr 75:155–159, 2007

Vitacco M, Neumann CS, Jackson RL: Testing of a four-factor model of psychopathy: associations with gender, ethnicity, intelligence and violence. J Consult Clin Psychol 73:466–476, 2005

Webster CD, Douglas KS, Eaves E, et al: HCR-20: Assessing Risk for Violence, Version 2. Burnaby, BC, Simon Fraser, 1997

Zagar RJ, Zagar AK, Bartikowski B, et al: Accepted legal applications of actuarial testing and delinquency interventions: examples of savings in real-life situations. Psychol Rep 104:339–362, 2009

Suggested Readings

Grove WM, Meehl PE: Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: the clinical-statistical controversy. Psychol Public Policy Law 2:293–323, 1996

Mossman D: Critique of pure risk assessment or, Kant meets *Tarasoff*. University of Cincinnati Law Review 75:523–609, 2006

Quinsey VL, Harris GT, Rice ME, et al: Violent Offenders: Appraising and Managing Risk, 2nd Edition. Washington, DC, American Psychological Association, 2006

Webster CD, Douglas KS, Eaves E, et al: HCR-20: Assessing Risk for Violence, Version 2. Burnaby, BC, Simon Fraser, 1997

Chapter 22

Forensic Psychiatry and the Internet

Patricia R. Recupero, J.D., M.D.

Since the explosive growth of the Internet in the 1990s into the early twenty-first century, surprisingly little research has been published on the importance of the Internet to the practice of psychiatry. The news media are replete with accounts of crimes in which evidence found on computers or in Internet service provider archives figured heavily into the outcome of a case. The Internet has also led to new problems for society, with such phenomena as *cyberbullying* and *cyberstalking*. Patients are researching medical conditions online, doctors are being disciplined for issuing Internet prescriptions to patients they have never seen, and our own lives and those of our patients and evaluees are changing dramatically with the endless stream of new technology that we integrate into our lives. McGrath and Casey (2002) provide an informative discussion of the Internet's relevance to forensic psychiatry, focusing especially on sexual predators and *cyberharassment*. They note unique aspects of the Internet that can be helpful to the psychiatrist, such as the existence of full transcripts of victim-offender communication and other forms of digital evidence. It is important for psychiatrists to pay more attention to the development of the Internet and related technology as it grows increasingly relevant to the work that we do. In this

chapter, I describe the context in which the Internet may play a role in the care or evaluation of patients and evaluees, as well as offer some information on the use of the Internet in psychiatric practice.

General Issues

Disinhibition

In the 1990s, social science researchers began to describe a characteristic aspect of computer-mediated communication: it tended to elicit disinhibited behavior. People would behave online in ways that they would not have behaved in person. Arguments escalated rapidly, conversations tended to be peppered with profanity, taunts, and sexual allusions, and people online showed little concern for the social norms of polite behavior and decorum traditionally observed in face-to-face settings. Calling this the "online disinhibition effect," John Suler (2004) described the implications of this effect for psychotherapy and social psychology. Internet disinhibition helps to explain some of the more scurrilous behavior noted among Internet users, such as *flaming* (rude, hostile language between Internet users) and *cyberporn*.

Projection and Transference

The concept of the "online disinhibition effect" (Suler 2004) is crucial to the understanding of some of the seemingly outrageous and absurd cases that may arise in relation to Internet use. A related concept, which helps to explain scenarios such as the one described in the true story described in the following vignette, is that of Internet users' tendency to develop "phantom emotions" in response to events experienced online (Barak 2007). Barak (2007) compares these outwardly illusory but subjectively real experiences to the physical sensations that an amputee often experiences when he or she feels as if the missing limb is still part of his or her body. "Phantom emotions" may be one way to understand the intense projection and transference that can occur in Internet-based communications.

Case Vignette 1

In 2005, a 45-year-old former marine, Thomas Montgomery, created a fake online persona of an 18-year-old boy, and subsequently began chatting on-

> line with a 17-year-old girl named Jessica. A virtual romance blossomed between "Tommy" and "Jessi," photos were shared, and, eventually, Montgomery's wife discovered the ruse and wrote to Jessi to warn her of the truth. Not wanting to believe her, Jessi contacted one of Montgomery's coworkers, Brian Barrett, a 22-year-old, to get more information. Barrett told Jessi the truth, a new virtual romance blossomed between Barrett and Jessi, and a vicious rivalry developed between Barrett and Montgomery. One night, as Barrett was leaving work, he was fatally shot in the neck with a rifle. Investigating the murder, detectives learned that "Jessi" was actually a 45-year-old mother who had used her daughter's identity (even sending pictures of her daughter) to flirt with the two men. The Assistant District Attorney assigned to the case noted of Montgomery: "He was a guy who prior to this happening was a very dedicated father. To make that much of a transformation, as a result of communicating with a fictitious person, is pretty frightening" (Labi 2007).

Although Montgomery's amorous feelings were directed toward a fictional persona who did not exist offline, his emotional experience was no less real to him than if the affair had occurred in real life. Clearly, phantom emotions can exert a powerful hold over Internet users if they can drive a man to murder. The tendency for the Internet and computer technology to blur boundaries between fantasy and reality (McGrath and Casey 2002) may have special implications for developmental psychology (see, e.g., Toronto 2009; Turkle 1995) and the course of illness in persons with psychotic or delusional disorders (see, e.g., Ichimura et al. 2001).

The Information Revolution

As news stories in the popular press have shown, evidence gathered from the Internet or from personal computers and data storage logs is playing an increasingly important role in investigations and court hearings, particularly in the area of criminal justice and law enforcement. Judges and prosecutors have used defendants' social networking profiles and unflattering photos on those sites in consideration for sentencing. In one case, a college student who seriously injured a woman in a drunk-driving accident was photographed at a Halloween party shortly following the accident, dressed in a prisoner costume and grinning. Someone posted the photographs on Facebook, and a victim of the crash forwarded them to the prosecutor. The judge sentenced the young man to a 2-year prison sentence, noting the defendant's evident lack of remorse or concern in the photos (Tucker 2008). In a recent murder trial, a witness for the prosecution produced digital evidence that the defendant had been researching information on ways of killing someone through an Internet search engine (Ellement 2008). Law enforcement agencies have also begun using technology, such as global position system monitoring, to

help enforce restraining orders and to monitor offenders at high risk for recidivism (Green 2009).

The so-called information revolution has also increased the risk of crimes relating to the loss of personal privacy, such as identity theft and hacking. The movement of more personal data (such as medical records) onto Internet-accessible databases has raised additional privacy concerns. The large amount of available personal information about people online has spurred an industry that specializes in collecting and selling such information to third parties. As the amount of information accessible via the Internet continues to grow, forensic psychiatrists can expect to see an increase in cases of bribery, extortion, stalking, or harassment, wherein personal information is used as a bargaining chip or a weapon to intimidate victims. As McGrath and Casey observed with respect to sexual predators and obsessional harassers, "Because such criminals depend heavily on information, cyberspace is an ideal environment, giving them access to a great deal of information about a large pool of potential targets" (2002, p. 84). Risks may be greater when a prospective perpetrator works in the information technology field or when he or she has a great deal of technological expertise. In one cyberstalking case, "[a] former employee of eBay was sued over allegations that he used his position at eBay to obtain personal information about the plaintiff and then used this information to stalk her online for over 2 years" (Glancy et al. 2007, p. 217).

Social Networking

Many have noted the Internet's value for enhancing social communication and connecting people who suffer from alienation or discrimination in their offline lives. However, the formation of identity groups and communities online may also lead to an increase in social capital and "empowerment" among people with extremist and harmful beliefs. For example, street gangs have begun using social networking sites such as Facebook and YouTube to recruit new members, often at very young ages (Vazquez 2008). The Internet's versatility for social networking has been exploited by extremist religious groups (e.g., terrorist organizations and the Heaven's Gate cult), hate groups (e.g., neo-Nazi social communities online), and individuals with deviant sexual desires, such as pedophilia (Durkin and Bryant 1999). Commenting on self-disclosure in cyberspace, Ben-Ze'ev makes the following observation:

> In light of the greater moral freedom and anonymity of cyberspace, moral emotions such as shame and guilt are likely to be less prevalent and less intense in that space than in our offline environment. Conversely, emotions that are often

> considered as immoral, such as hate and sexual desire, are likely to be more prevalent and more intense in cyberspace. Indeed, the number of sexual and hate sites in cyberspace is enormous. (Ben-Ze'ev 2003, p. 464)

Internet-based social networking through Web sites and discussion forums has also been recognized in the formation of suicide pacts (Recupero et al. 2008).

As forensic psychiatrists encounter more cases in which the Internet plays a prominent role, understanding the ways that people use the Internet and how the Internet relates to human psychology and the law will be crucial to assisting the courts in these types of cases. An exhaustive listing of the types of cases in which the Internet may play some role for forensic psychiatrists is beyond the scope of this chapter, but I will attempt to present several important topics for consideration in the hope that readers will take this chapter as a starting point for further research.

The Internet's Impact on Forensic Psychiatry: Civil and Criminal Cases

In this section, I present several examples of the types of cases in which the Internet may play a significant role for forensic evaluations. The following descriptions are not intended to be exhaustive, and new types of cases may emerge as the Internet continues to evolve. This discussion merely introduces some of the more common issues to help the psychiatrist who may encounter similar cases.

Problematic Internet Use

In 1995, psychiatrist Ivan K. Goldberg humorously proposed a new disorder called "Internet addictive disorder" to satirize the diagnostic criteria in DSM-IV (Wallis 1997). To his surprise, he received an outpouring of interest from colleagues who had encountered *problematic Internet use* (PIU) personally or in the course of their clinical practices. Although Goldberg had cautioned that the use of the term "addiction" might not be appropriate in describing the problem, many clinicians disagreed. The controversy continues to this day, with some researchers referring to the behavior as "Internet addiction" and others using different terms. At the time of this writing, there is significant debate among members of the psychiatric community as to

whether PIU (in some formulation) should be added to DSM-V as a new diagnostic category (Block 2008; Douglas et al. 2008). Although a full discussion of the controversy surrounding terminology and etiology of PIU is beyond the scope of this chapter, it is clear that Internet use can indeed be extremely problematic for some individuals. Typically, problematic use includes excessive or otherwise troublesome use of chat rooms, *cyberporn*, *cybersex*, or online gaming or gambling.

Since Goldberg's suggestion nearly 15 years ago, reports of PIU have increased dramatically in the popular press as well as in the medical literature. Proposed diagnostic criteria for PIU or "Internet addiction" vary widely, in part due to disagreement over how best to characterize the problem. Goldberg's criteria for "Internet addictive disorder" (Goldberg 2002) modified current DSM-IV (American Psychiatric Association 1994) criteria for substance abuse and dependence, but the criteria were not intended to be taken seriously as a new diagnosis. Shapira and colleagues (2000, p. 268) proposed a broader set of criteria; to qualify as PIU, an individual's Internet use would have to be "(a) uncontrollable, (b) markedly distressing, time-consuming or resulting in social, occupational or financial difficulties, and (c) not solely present during hypomanic or manic symptoms." Numerous other scales and tools have been published to help in the assessment of individuals with PIU (see, e.g., Douglas et al. 2008). Recupero (2008) offers suggestions for the forensic evaluation of individuals with PIU, including an overview of the types of cases in which PIU may arise, and suggests questions to help guide psychiatric interviews and case formulation. Goldsmith and Shapira (2006) provide an overview of clinical aspects of PIU and offer some suggestions for treatment.

PIU, particularly gaming, appears to be prevalent among adolescents and young adults (Allison et al. 2006; Ko et al. 2009). As Turkle (1995) points out, online role-playing games provide incentives for players to engage in excessive use—the more hours one spends on these games, the higher one's social status becomes within the online game community. Stories in the news media have included reports of gamers dying or developing severe health problems involving extended gaming "binges." Unsurprisingly, excessive use of video gaming is negatively correlated with students' grade point average and scores on the Scholastic Aptitude Test (SAT) (Anand 2007).

Studies investigating the impact of PIU on occupational performance in the workplace are currently lacking. However, employers have numerous reasons for concern, as the following vignette illustrates.

Case Vignette 2

In 2003, James Pacenza Sr., an IBM employee, was fired for accessing cybersex chats on company computers during business hours. Pacenza sued IBM,

alleging that his termination was wrongful discrimination under the Americans with Disabilities Act (*Pacenza v. IBM Corp.* 2009). Pacenza claimed that his use of the chats was related to posttraumatic stress disorder (PTSD) he had developed from service in the Vietnam War and that "his PTSD manifests itself through a variety of addictive behavior—including an addiction to sexually oriented material on the Internet" (*Pacenza v. IBM* 2009). After receiving a warning about his Internet use, Pacenza told his supervisor that he had a "long-standing Internet sexual addiction" (*Pacenza v. IBM* 2009). The company had been notified that Pacenza had received treatment in 1998 for a sexual disorder and psychiatric problems, but there was no evidence of any restrictions on his work functions to accommodate a disability, and the decision to fire Pacenza had been made by employees who were not aware of his PTSD. A federal district court upheld IBM's contention that Pacenza was terminated not because of a federally protected disability (i.e., his PTSD), but because his Internet use violated the company's policies, including rules regarding appropriate conduct for employees. As part of a zero-tolerance policy toward sexual harassment, IBM's harassment policy noted that "the display of sexually explicit or suggestive material" was unacceptable and prohibited conduct in the workplace (*Pacenza v. IBM* 2009), and IBM had terminated other employees for similar behavior.

PIU has important implications for forensic evaluations completed for employment law proceedings. Although Pacenza's claim was dismissed, forensic psychiatrists may be called on to assist in providing expert testimony or conducting forensic evaluations for similar cases in the near future. Personal Internet use (*cyberslacking*) in the workplace is common and "is significantly more frequent among those with higher workplace status, [i.e.] the organization's most valued employees…." (Garrett and Danziger 2008, p. 291). Pacenza had been an IBM employee for 19 years when the company fired him.

As the court in Pacenza noted (*Pacenza v. IBM* 2009), "Internet sex addiction" does not meet criteria for a disability as defined by the Americans with Disabilities Act. Some commentators have expressed concern that "if Internet addiction becomes a bona fide diagnosable disorder, it may become protected by the Americans with Disabilities Act" (Everton et al. 2005, p. 144). At this time, it is unknown what impact the recent passage of the Americans with Disabilities Act Amendments Act of 2008 and the upcoming revision of DSM will have for PIU and forensic psychiatry. Clinicians and evaluators alike would be well advised to pay attention to new developments in this area.

Cyberharassment

I use the term "cyberharassment" here to refer to several different types of harassing behavior that may occur in Internet communications. Psychiatrists should note that these behaviors frequently overlap, and in some cases,

the terms may be used interchangeably. Furthermore, the definitions I offer are not universal; state laws may define such behaviors differently in statutes (Jameson 2008).

Discriminatory Cyberharassment

As the *Pacenza v. IBM Corp.* (2009) case illustrates, individuals' Internet use can have important implications for discrimination. Over 10% of surveyed employees report having received sexist or racist e-mails at work (Whitty and Carr 2006). Flaming (rude, hostile language between Internet users) can exacerbate and escalate organizational conflict (Turnage 2007) and may create a hostile environment, particularly when it involves discriminatory and offensive content (Barak 2005). Discriminatory harassment is actionable under Title VII of the Civil Rights Act of 1964 as well as under additional state laws protecting victims of discrimination (Gold 2004; see Chapter 12, "The Workplace," this volume). Sexual harassment is widely prevalent in cyberspace, and the Internet is frequently a chosen vehicle for sexual harassment in the workplace (Barak 2005). In *Blakey v. Continental Airlines* (2000), a female pilot prevailed in a hostile environment sexual harassment case against male coworkers who posted harassing messages about her on work-related Internet message boards. Sexually explicit or sexually discriminatory e-mails have led to large settlements in several sexual harassment lawsuits (Biber et al. 2002).

Pacenza's "Net sex" problem was brought to the attention of management on one occasion when he left a sexually explicit chat room up and running while he stepped away from his computer; a coworker who used the computer after Pacenza noticed the chat room and notified Pacenza's supervisor. Similar incidents may give rise to lawsuits against companies for fostering a hostile environment and sexual harassment, and forensic psychiatrists may be called on to serve as expert witnesses or to evaluate plaintiffs for emotional injuries. Gold remarks that although "emotional injury does not have to be established for alleged discriminatory or harassing behavior to be actionable, . . . both lawyers and forensic evaluators often think that they must have a diagnosis for credibility. It may be difficult to establish damages or entitlement to compensation without a formal DSM diagnosis" (Gold 2004, p. 306). Discriminatory harassment frequently does have an emotionally damaging impact on the victim, and victims in some cases may also pursue civil claims such as intentional infliction of emotional distress.

Cyberbullying

Cyberbullying among students may also be discriminatory in nature, given that racist epithets, misogynistic language, and other discriminatory slurs

may be common. The term *cyberbullying* generally refers to Internet-facilitated harassment or intentional humiliation of a particular target, usually a child or adolescent. Analogous behavior directed toward adults is more commonly termed "cyberharassment." Cyberbullying has become a major problem among today's youth. The widely reported suicides of several cyberbullying victims in recent years have catalyzed the passage of anti-cyberbullying laws in several jurisdictions (Barnett 2009). Victims and perpetrators of cyberbullying are likely to have other psychosocial risk factors for violence and victimization, such as poor caregiver-child bonding, drug abuse, and delinquent behavior (Ybarra and Mitchell 2004).

Cyberbullying is not confined to the World Wide Web or the Internet per se. The behavior frequently involves the use of mobile phones to transmit text messages, videos, and photographs for the purpose of humiliating or harassing a victim. The case of 18-year-old Jesse Logan is illustrative (Celizic 2009). The young woman had sent nude photographs of herself to her boyfriend (a practice known as "sexting," named after "texting," i.e., the sending of text messages via mobile phones). After they broke up, he distributed the photos to her peers, prompting a barrage of hostile harassment toward her. She subsequently committed suicide by hanging. "Sexting" is common among adolescents, and some commentators have raised concerns about the impact on the victim when the images are distributed or forwarded to others. If the subject is a minor, the images may constitute child pornography.

A phenomenon known as "happy slapping" has gained popularity among adolescents. Youths use mobile phones to record videos of themselves or their friends committing violent assaults, sometimes resulting in death to the victims (BBC News 2008). The videos are then shared online or spread via mobile phones. They garner millions of hits on video-sharing Web sites; "On YouTube, viewers rate the action by brutality level and sometimes make profanity-laced observations" (Thanawala 2009). Although the recording of such videos can confer evidence to aid in investigations and prosecutions, the instant fame and attention they attract may outweigh the perpetrators' concerns about apprehension and discipline; the worse the violence and humiliation is, the more popular the video. The versatility of new media, such as camera phones and palm-sized digital camcorders, together with the potential anonymity and social nature of Internet communication, has aggravated an existing problem with bullying and other threatening or harassing behavior among school-age youth.

Cyberstalking

Like cyberbullying, cyberstalking is a type of harmful behavior directed at a particular victim and facilitated by the Internet and other information and

communications technology. McGrath and Casey (2002, p. 89) describe cyberstalking as "merely stalking that uses the Internet for information gathering, monitoring, and/or victim contact." As I noted in the introduction to this chapter, the Internet contains a large amount of personal information that can be accessed and exploited to intimidate, control, or obsessively follow a victim. Some stalkers make use of the Internet's easy access to information such as a victim's address, phone number, e-mail address, friends' contact information (e.g., via friend lists on social networking sites), and place of employment. Cyberstalkers may also send the victim threatening or harassing messages through e-mail, instant messaging, or other messaging capabilities, by posting defamatory comments on a person's social networking profile. "As [the] fatal shooting of a Wesleyan University student showed—the victim, Johanna Justin-Jinich, 21, told the authorities two years [before her death] that the suspect…had repeatedly sent harassing e-mail messages—stalking often includes sending threats online…" (Green 2009).

Cyberstalkers often employ another tactic, which would be more challenging to carry out without the Internet: the impersonation of the victim in order to inflict some kind of harm. In one case, a man impersonated his victim by posting personal ads in her name, claiming that she had rape fantasies and giving her home address for men to show up. When men did begin appearing at her apartment, the woman eventually learned of the ads and posted a note on her door indicating that the ads were not genuine. The man who had posted the ads then amended them, claiming that the note on the door was just part of her fantasy (McGrath and Casey 2002; Glancy et al. 2007).

Sex Crimes

The Internet's tendency to elicit disinhibited behavior as well as intense transference and projection may lead to conflict between a user's desired fantasy and objective reality. As I noted earlier, excessive or compulsive use of cyberporn or cybersex (i.e., sex chat) is frequently observed in severe cases of PIU. The perception of anonymity in cyberspace may embolden Internet users to seek out sexual material that they would not be comfortable viewing in the real world or that would be difficult to obtain offline. This may include some of the more bizarre paraphilias (McGrath and Casey 2002) as well as violent pornography. In one case, a man who had been watching violent pornography on the Internet was found dead in what appeared to be an accidental death by autoerotic asphyxiation (Vennemann and Pollak 2006).

Durkin and Bryant (1999) described the spread of pro-pedophilia ideology through Internet groups. Such groups appear to play an important role in creating a market for child pornography. Pedophiles in such groups trade

images and videos with one another through message boards and discussion groups, and may even share tips on identifying and grooming potential victims for child molestation. Commenting on sexual predators online, McGrath and Casey (2002) explain that

> the Internet effectively dissolves the boundaries between fantasy and reality, enabling individuals to explore and realize their fantasies. A man who would never approach a child in the real world may make such contact in cyberspace just to see what might happen. (p. 85)

As the popularity of television shows such as NBC *Dateline*'s "To Catch a Predator" illustrates, the public is concerned about the dangers of the Internet for children and teens, and undercover sting operations are frequently used to help identify and prosecute would-be sexual predators.

Threat Assessments

In recent years, cases of mass homicide and violence in school and public settings have created an increased demand for violence risk assessments or assessments of "dangerousness." Ash (2004) provides guidelines for conducting threat assessments in school settings. Among the materials he recommends for review are the presence of "Internet chatting on violence-related themes" and "leakage" of violent fantasies in other areas of the evaluee's life (Ash 2004, p. 465). For example, a recent review of the perpetrators' Internet activity prior to the Columbine High School shootings in 1999 revealed evidence of violent fantasies and suspicious planning (Block 2007). In another case, a "violent obsessional harasser published a web page with his plans to kill his target and then carried out the plan" (McGrath and Casey 2002, p. 89).

When threats or expressions of suicidal or homicidal ideation are brought to the attention of school officials or other authorities, forensic psychiatrists may be asked to offer their opinions regarding the seriousness of the threat. These types of cases may arise, for example, if a student's social networking profile or blog contains disturbing images or writings, such as gang symbols. Sometimes, a student's social networking profile contains photos of the person posing with weapons (Kornblum and Marklein 2006). Students have been suspended or disciplined on the basis of material posted online. In one case, a university student was investigated by the U.S. Secret Service in connection to a Facebook comment about assassinating the President (Hass 2006).

Torts

As I noted earlier in this chapter, plaintiffs in sexual harassment litigation may choose to sue for emotional injuries. If Pacenza had been persistently access-

ing violent sex chat rooms (for example, rape fantasy chats) on a female coworker's computer, she may have had grounds to sue him for intentional infliction of emotional distress or to sue the company for negligent infliction of emotional distress if the management was aware of the problem and failed to take corrective action.

Internet behaviors such as cyberharassment, cyberbullying, cyberstalking, and flaming may cause significant emotional harm to victims. In one widely reported case, a 13-year-old girl committed suicide after a malicious campaign of cyberbullying by a neighbor who had assumed the Internet persona of a teenage boy in order to gain the girl's trust (Fink 2008; Stelter 2008). Some state statutes allow criminal prosecution for cyberbullying, but victims and their families may also sue for damages through intentional infliction of emotional distress or defamation claims. Several deaths reported in the news media in recent years have involved Internet-based taunting or baiting of individuals to commit suicide or take lethal overdoses of drugs, and numerous individuals who committed or attempted suicide were found to have received assistance from others through the Internet (for instance, in obtaining poisons or through suicide pacts forged online) (Recupero et al. 2008). In such cases, assistance from forensic psychiatrists may be necessary to help the court evaluate emotional damages for intentional infliction of emotional distress litigation brought by survivors.

Attorneys frequently use Internet Web sites and banner or hyperlink advertisements to recruit plaintiffs in class action lawsuits (Klonoff et al. 2008). A patient who enters the name of a medication into a search engine in order to learn more about the treatment may find, among the top results, links to law firms soliciting clients for toxic torts against the pharmaceutical company that manufactures the drug. As stated by Wentz, medical information on the Internet may also affect the role of the forensic expert in consultations or in the courtroom:

> Lawyers can with ease and within minutes find cases of patients displaying certain symptoms which also include the correct diagnosis, which, they will suggest, a 'negligent' clinician missed. The excuse, used since time immemorial, 'I couldn't possibly know,' and providing comfort to the ignorant, has lost some of its credibility. (Wentz 2006)

This may be especially problematic for defendant physicians in malpractice litigation, as studies emerge suggesting that even individuals with little to no medical training can find accurate diagnoses for medical symptoms through Internet search engines (Siempos et al. 2008).

In some cases, a physician's use of the Internet may be relevant to establish negligence in malpractice proceedings. In one instance, when a student in California committed suicide, an investigation revealed that a doctor in

Colorado had prescribed antidepressants for the boy over the Internet without having conducted a face-to-face examination (Neimark 2009). The practice of medicine or *e-therapy* across state lines via the Internet carries legal and ethical risks for the practitioner (Recupero and Rainey 2005). Other torts in which the Internet may be relevant are numerous and may include suits for defamation of character, libel, and commercial disparagement (Lidsky 2000).

Disability and Fitness for Duty

The Internet may be especially relevant in independent medical evaluations and evaluations for disability and fitness for duty. In cases of alleged disability, forensic psychiatrists assist in assessing the degree and nature of impairment and may provide recommendations for treatment and reasonable accommodations. Because disability status may offer secondary gains, such as financial reimbursement and additional legal protections, there can be significant incentive for an evaluee to exaggerate or misrepresent the nature and extent of a psychiatric impairment. As observed by Thomson and colleagues (2004), "[C]linicians should be prepared to consider the possibility of malingering, particularly in forensic settings. They should also be prepared to engage in the detective work needed to make this diagnosis" (p. 427). A careful review of collateral information can help to shed light on the veracity or reliability of an evaluee's self-report. Neimark and colleagues (2006) recommend using the Internet as a "collateral informant," noting that Internet searches of an evaluee's name may yield unexpected results that are relevant to the psychiatric assessment.

Case Vignette 3

Dr. F has been asked to perform an independent medical evaluation for the purposes of assessing fitness for duty of a Dr. N, a physician in private practice, for the board of medical licensure. The board recently received a complaint from one of Dr. N's former patients, Ms. B, alleging that Dr. N had created a fake Internet persona to contact her online for the purpose of engaging in sexually explicit chats (cybersex) with her. Ms. B, who suffers from bipolar disorder, had been a patient of Dr. N's for several years before the incident in question. During manic phases of her illness, she frequented sexual chat rooms and engaged in cybersex with strangers she met through an adult-oriented Web site, occasionally meeting them in person to engage in sexual activity. Shortly before the incident in question, Ms. B had sought medical treatment for a sexually transmitted infection she had acquired from one such rendezvous. Last year, Ms. B began to chat with a man who went by the screen name "LoveDoc." On one occasion, "LoveDoc" sent her an explicit photograph. In the background of the photograph, Ms. B recognized

several distinctive items she had seen on the desk in Dr. N's office. Alarmed, she questioned her chat partner about his identity, and he abruptly signed off. When she attempted to confront him again the following day, she discovered that his profile and e-mail address had been deleted, and she subsequently contacted the medical board. It is not clear how Dr. N discovered Ms. B's screen name. Dr. N maintains that he was not aware that the woman with whom he was chatting was a former patient of his.

It might be difficult for the medical board to prove that Dr. N knowingly and intentionally violated a patient boundary. Indeed, Dr. N may be said to have acted appropriately in managing the unintended contact. Nonetheless, the board might still consider him to have engaged in "conduct unbecoming of a physician" for having sent the explicit photograph.

Although the hypothetical Case Vignette 3 may seem incredible, similar cases have occurred (see, e.g., Van Gelder 1996). The disinhibiting nature of computer-mediated communication can increase the risk of boundary violations and other unprofessional conduct (Bhuvaneswar and Gutheil 2008; Recupero and Rainey 2005). Similar cases may arise in other settings, for example, excessive self-disclosure by high school teachers who "friend" their students on Facebook. Forensic psychiatrists may help to explain the concept of boundary violations and their impact on patients, students, or other individuals in a relationship with an imbalance of power.

Family Law

Forensic psychiatrists may encounter divorce or child custody cases in which Internet-based behavior or evidence plays a central role, as shown in the following example:

A woman in the Pacific Northwest whose husband divorced her because she spent too much time in cyberspace continued to worship the World Wide Web so fervently that she forgot to take her children to the doctor, buy heating oil, or get the kids enough food. Her ex-husband sued for custody of the children. But he needed someone to vouch for her ailment. "I had to write a letter to the judge," said Dr. Jonathan Kandell, a psychologist. "The judge did not believe there was such a thing as Internet addiction." (Belluck 1996)

Net sex and "online affairs" have contributed to a significant number of divorce cases in recent years (Quittner 1997; Young et al. 2000). As the example described illustrates, individuals with severe PIU may neglect interpersonal and occupational responsibilities, which can have implications for custody determinations. As I mentioned in the introduction of this chapter, Internet-based evidence (such as e-mails, chat logs, and social networking profiles) can be used as character evidence against defendants in criminal

prosecution or sentencing. Attorneys may also use such evidence against witnesses or parties in litigation. When serving as an expert witness or consultant in family law cases, it will be helpful to review any available Internet-based documents that may be relevant to the proceedings.

Risk Assessment and Recommendations

The psychiatrist should conduct a thorough risk assessment prior to recommending forced removal of Internet access for persons with severe PIU or risk factors for violence. Because the Internet in some cases serves as an outlet for deep-seated psychological problems and aggressive impulses, forced and abrupt deprivation may lead to tragic consequences (see, e.g., Block 2007; Reuters 2007). Bergner (2002) offers a psychodynamic perspective for assessing compulsive use of Internet pornography and forming a treatment plan. Stein and colleagues discuss considerations for psychopharmacological treatment in similar cases (Stein et al. 2001). In describing two case examples of patients in psychoanalytic psychotherapy, Toronto (2009) illustrates how an evaluee's Internet use can provide valuable clues to problems that may need to be addressed in treatment. All recommendations should be made on a case-by-case basis.

The Internet's Impact on Clinical Psychiatry

As Internet technology makes more medical information available to the public, relationships between patients and physicians are changing. Patients often do not tell their physicians about what they learned or did online (Hart et al. 2004). Today, patients go online to research their symptoms and their illnesses, often arriving at the doctor's office with printouts or information they learned online. Pharmaceutical manufacturers have also been using the Internet for direct-to-consumer advertising of prescription medications. When a "RealAge" quiz became a popular link among users of social networking sites, a journalist found that the quiz was "a clearinghouse for [several large] drug companies…allowing them to use almost any combination of answers from the test to find people to market to, including whether someone is taking antidepressants, how sexually active they are and even if their marriage is happy" (Clifford 2009). Social networking sites for health, such as PatientsLikeMe (http://www.patientslikeme.com), are connecting geo-

graphically distant patients who suffer from the same or similar conditions. They post information and data related to their illness and treatment, and they exchange advice and support. Pooled or shared data are helping to direct research toward improved treatments or cures.

For doctors, this growth in patient autonomy has been a double-edged sword. On the one hand, empowered patients can help their doctors give them the best treatment possible for their ailments. On the other hand, as Alexander Pope so famously noted in his "Essay on Criticism," "a little learning is a dangerous thing." For example, unfounded public fears that vaccines cause autism have been linked to rumors spread via the Internet (Zimmerman et al. 2005). There is an abundance of inaccurate medical information on the Web, and Internet pharmacies often sell dangerous drugs without providing the warnings or monitoring that would normally apply in a traditional doctor-patient relationship. Researchers in Europe found "a range of medical misinformation (i.e., in one site, a product containing a powerful monoamine oxidase inhibitor compound was offered to clients without any warning regarding side effects and interactions)…" (Schifano et al. 2003, p. 409). Antipsychiatry groups such as the Scientologists and members of the psychiatric "survivor" movement have prominent Web sites that discourage patients from seeking treatment for psychiatric illness (see, e.g., http://www.antipsychiatry.org and http://www.cchr.org/#/home).

The Internet and Mental Health

It is not possible for a single chapter to present a thorough discussion of the relationship between Internet use and various psychiatric illnesses. In the interest of brevity, some relevant points are suggested in Table 22–1, which illustrates sample risk and protective factors by various diagnostic categories. Psychiatrists may find the use of a similar table or form to be helpful during case formulation.

Researchers have shown that individuals with PIU typically meet criteria for a diagnosis of impulse-control disorder, not otherwise specified (Shapira et al. 2000). Co-occurring psychiatric and substance abuse disorders may be common among persons with severe PIU and may include depression, attention-deficit/hyperactivity disorder, and social phobia. (Ko et al. 2008; Yen et al. 2007). (Further examples are nearly infinite; for a more detailed discussion of PIU as it relates to psychiatric symptoms and forensic psychiatry, see, e.g., Recupero 2008 and Goldsmith and Shapira 2006.)

Of particular interest to forensic psychiatrists, the Internet figures importantly into factitious illness and malingering. In one case, a patient downloaded and used images from the Internet in order to support a feigned

TABLE 22–1. Risks and protective factors for Internet use by persons with mental illness

Risk	Protective
Substance abuse	
Online pharmacies selling controlled substances without a valid prescription	Support groups branching out online
Web sites providing information on how to synthesize drugs and how to abuse different psychoactive substances	Online treatment for addictions; anonymity may make seeking help easier
Peer pressure on the Internet (e.g., baiting for overdoses in chat rooms, adolescents' promotion of drug abuse on SNS profiles)	Information on medical Web sites about how to get treatment for addictions
Depression	
Pro- and how-to-suicide material online (Recupero et al. 2008)	Depression and suicide/self-injury support groups
Baiting in Internet chat rooms	Use of Internet to seek support from friends and family
Relationship to problematic Internet use	Informative Web sites (e.g., APA, NIMH)
Bipolar disorder and mania	
Sexual risk-taking (e.g., locating sex partners through Internet)	Safe outlets for symptoms of hypersexuality (e.g., cybersex)
Impulse dysregulation (e.g., one-click ordering, bidding on auction sites)	Possible to chat with people in different time zones without calling friends at 2 A.M.

TABLE 22–1. Risks and protective factors for Internet use by persons with mental illness *(continued)*

Risk	Protective
Schizophrenia and psychosis	
Delusions (e.g., thought insertion by computer, conspiracy theory Web sites, persecutory delusions re: cookies, personal information, databases online)	Support groups where peers can help patients to recognize symptoms and learn/practice techniques for adapting
Perceptual disturbances and confusion about reality in virtual reality and Internet applications (Ichimura et al. 2001)	Informational resources for families and friends
Automatic written record of fantasies and delusions	Potential to expand research opportunities to advance treatments (e.g., through patient social networking)
Anxiety	
"Cyberchondia" (White and Horvitz 2008), "medical Googling" by patients	Use of technology (e.g., virtual reality) in treating phobias

Note. APA=American Psychiatric Association; NIMH=National Institute of Mental Health; SNS=social networking sites.

orthopedic injury (Griffiths et al. 2009). Feldman (2000) described four cases of people with "Munchausen by Internet," all involving the use of overdramatized, exaggerated, or fictional stories of severe illness in order to elicit sympathy and support from others online. Layperson-produced information about "Morgellons disease" via the Internet has been linked to delusional parasitosis in patients who insist that "Morgellons disease" is a valid, newly recognized disease and the cause of their symptoms (Lustig et al. 2009; Vila-Rodriguez and MacEwan 2008). Clearly, these types of cases have special implications for forensic psychiatrists. Evaluees may arrive at appointments armed with knowledge of diagnostic criteria and may behave in such a way as to convey the characteristics of a particular illness.

Practice-Related Issues

Practice Web Sites

Many forensic psychiatrists hang a shingle on the Net by creating Web sites to describe and advertise their practices. Practice Web sites can help to provide information about the forensic psychiatrist's areas of expertise, including prominent trials in which he or she has participated, a link to the psychiatrist's curriculum vitae, and contact information for prospective retaining parties. However, as Granacher warns, "Many lawyers still wish to use psychiatrists' Web sites to discredit them at trial. Therefore, it is recommended that the Web site be conservative, accurate, and not embellished" (Granacher 2004, p. 54). Aside from the risk of impeachment during expert witness testimony, Web sites also raise a significant number of additional legal concerns for psychiatrists.

In the law, Web sites are generally categorized according to the degree of interactivity each Web site allows. "Passive Web sites" function as business cards; they are not interactive, and they tend to contain contact information and brief descriptions of the business, with perhaps some educational material as well. In contrast, "business Web sites" are those that invite financial transactions or some other potentially contract-forming activity. For example, a practice Web site that allows visitors to submit clinical questions for the doctor would likely be deemed a business site. The more interactive a Web site is, the greater the associated legal risk for the practitioner. Legal risks for psychiatrists' practice Web sites are explained in more detail by Recupero (2006), but practitioners with highly interactive sites are advised to consult with an attorney or with professional malpractice insurance coverage services for more specific advice. Web sites must be in compliance with the applicable communications and commerce laws, a subject that is beyond the ken of the average forensic psychiatrist.

E-mail and Instant Messaging

The use of e-mail or instant messaging technology with evaluees or patients can raise many legal and ethical concerns. Psychiatrists who are seriously considering using e-mail in clinical or forensic practice should familiarize themselves with current ethical advice of the American Psychiatric Association and the American Medical Association regarding the use of e-mail. Ordinarily, due to the legal risks involved, physicians should not respond to unsolicited e-mail requests for advice from nonpatients (Kuszler 2000). However, in some instances it may be appropriate to communicate with current patients or evaluees by e-mail. Such a decision must not be made lightly. Forensic psychiatrists should be aware of the ethical (e.g., maintaining appropriate boundaries), clinical, and legal risks involved. Bhuvaneswar and Gutheil (2008) review the chief psychodynamic, ethical, and clinical risks associated with e-mail communication between psychiatrists and patients, and Recupero (2005) offers additional reflections on legal and ethical issues to consider.

Social Networking and Blogging

Social networking sites (e.g., Facebook, MySpace, Twitter, and PatientsLikeMe), video-sharing sites (e.g., YouTube), and virtual worlds (e.g., SecondLife) have gained an increasingly important role in the transmission of health information and education (Keelan et al. 2007; Vance et al. 2009). Many health organizations have begun advertising or mounting public health information campaigns on sites such as YouTube, and some practitioners use applications such as SecondLife to deliver treatments such as group therapy and exposure therapy for anxiety disorders. At the time of this writing, researchers at Drexel University in Philadelphia, Pennsylvania, are conducting a study of Internet-based treatment for social phobia via avatars and simulations in the virtual community SecondLife (see, e.g., http://www. drexel.edu/coas/psychology/AnxietyResearch/secondlife.html). As with e-mail communications between psychiatrists and patients or evaluees, significant boundary violations could easily develop—for example, if the psychiatrist accepts "friending" requests from patients on social networking sites or allows public comments on the clinician's blog. Blogging about patients or evaluees must be conducted extremely carefully to avoid ethical indiscretions. The accessibility of people through social networking site profiles and Internet searches is an important concern for psychiatrists who work with potentially dangerous evaluees. In many cases, the doctor's home address and other personal information can be easily located through a variety of Internet-based tools. Forensic psychiatrists should exercise caution in regulating their Web presence.

Legal Risk Management

Because the Internet introduces numerous additional legal risks while potentially increasing existing risks, it is advised that psychiatrists seek the advice of legal or risk management professionals in order to minimize their exposure to liability, as well as to ensure that they are in compliance with the applicable laws and rules. Malpractice insurance carriers frequently provide informational resources such as newsletters and updates on recent developments in mental health law. Consultation with an attorney may be advisable if the psychiatrist intends to have a significant Web presence (e.g., an interactive practice Web site, the use of instant messages with patients or evaluees, or the use of SecondLife or similar applications to conduct interviews or provide treatment). Attorneys can help to advise on the psychiatrist's malpractice exposure as well as licensure/jurisdiction issues that may arise if the doctor and evaluee/patient are in different states. Recupero and Rainey (2005) offer risk management suggestions to help minimize risk in the provision of e-therapy. Although these guidelines are aimed primarily at clinicians, many of their suggestions are valid for forensic experts as well.

Conclusion

The Internet has become one of the most critical defining factors for society in the twenty-first century. The pace of technological change is rapid, and the integration of technology into our lives has far-reaching implications for developmental psychology, social psychology, the law, psychiatry, and the practice of forensic psychiatry. The connection between the Internet and forensic psychiatry is an area of growing importance in the specialty, and the role of the Internet is likely to continue changing and growing as forensic psychiatry evolves as a profession. As McGrath and Casey (2002, p. 81) observe, "At the very least, forensic psychiatrists should be able to determine what need the Internet fulfills for a given individual, be it anonymity, information about victims, access to victims, or something else." In the coming years, it will be increasingly important for forensic psychiatrists to pay careful attention to the changes in Internet-related technology and culture and to incorporate the Internet into their professional work.

Key Points

- Disinhibition, projection, and transference are important concepts in helping to explain some of the unusual cases that may arise in the context of Internet use.
- Problematic Internet use (PIU) is common, and forensic psychiatrists may be asked to assist in cases in which PIU arises, including employment law, disability evaluations, and fitness for duty assessments.
- Severe harassment and other harassing, hostile behavior in cyberspace are common problems, and victims may sue for emotional damages.
- The anonymity and disinhibiting effect of Internet communication may have important implications for the commission of sex crimes such as child pornography and child molestation.
- Internet materials may be especially helpful in conducting threat assessments, as well as in obtaining collateral information in the course of the forensic evaluation.
- Medical information on the Internet has implications for malpractice, the physician-patient relationship, patient autonomy, factitious disorders, and malingering.
- There are numerous clinical, ethical, and legal concerns related to the Internet in the practice of forensic psychiatry. Forensic psychiatrists are advised to consult ethical guidelines and risk management professionals, such as attorneys, for guidance on specific questions.

Practice Guidelines

1. Educate yourself about the way the Internet is evolving and the ways in which people use the Internet.
2. Sign up for newspaper and content alerts and make time to follow current events. For example, the PsychCentral Web site (http://psychcentral.com/) features recent headlines in mental health news and has an informative weekly newsletter (you can subscribe via the PsychCentral home page). The MedlinePlus

Web site of the National Library of Medicine and the National Institutes of Health has a listing of medical and health news organized by date (see http://www.nlm.nih.gov/medlineplus/newsbydate.html). Pay attention to well-publicized cases in which the Internet has played a role (e.g., criminal defendants researching homicide methods online or using the Internet to locate victims).

3. Ask your patients and evaluees if they use the Internet and, if so, how they use it.
4. If you are asked to do an evaluation of an individual with PIU or "Internet addiction," determine what role the Internet plays in that person's life, and clarify what standard you are using to define PIU.
5. As suggested by Neimark and colleagues (2006), use the Internet and any available digital evidence as sources of collateral information, particularly in the context of assessing risk, credibility, and impairment.
6. Ask the referring party what digital evidence may be available from an investigation.
7. Be aware that evaluees may research symptoms of psychiatric illnesses or other medical conditions on the Internet and may attempt to behave in a way that suggests a particular illness.
8. Develop and implement a risk management policy for your own use of the Internet, both personal and professional. Your malpractice insurance carrier may have a risk management newsletter that can help you to reduce risks.
9. Be attentive to boundary issues as well as the legal and ethical implications of your "Web presence."
10. If you have or plan to have a significant Web presence, consider consulting an attorney to help reduce your exposure to liability.

References

Allison SE, von Wahlde L, Shockley T, et al: The development of the self in the era of the internet and role-playing fantasy games. Am J Psychiatry 163:381–385, 2006

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

Anand V: A study of time management: the correlation between video game usage and academic performance markers. CyberPsychol Behav 10:552–559, 2007

Ash P: Children and adolescents, in Textbook of Forensic Psychiatry, 1st Edition. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 449–470

Barak A: Sexual harassment on the Internet. Social Science Computer Review 23:77–92, 2005

Barak A: Phantom emotions: psychological determinants of emotional experiences on the Internet, in The Oxford Handbook of Internet Psychology. Edited by Joinson A, McKenna K, Postmes T, et al. New York, Oxford University Press, 2007, pp 303–329

Barnett C: Cyberbullying: a new frontier and a new standard: a survey of and proposed changes to state cyberbullying statutes. 27 Quinnipiac Law Review 579, 2009

BBC News: "Happy slap" death girl convicted. BBC News [online], February 14, 2008. Available at: http://news.bbc.co.uk/2/hi/uk_news/england/west_yorkshire/7244782.stm. Accessed June 16, 2009.

Belluck P: Stuck on the web: the symptoms of Internet addiction. The New York Times, December 1, 1996, Section 4, p 5

Ben-Ze'ev A: Privacy, emotional closeness, and openness in cyberspace. Computers in Human Behavior 19(44):451–467, 2003

Bergner RM: Sexual compulsion as attempted recovery from degradation: theory and therapy. J Sex Marital Ther 28:373–387, 2002

Bhuvaneswar CG, Gutheil TG: E-mail and psychiatry: some psychotherapeutic and psychoanalytic perspectives. Am J Psychother 62:241–261, 2008

Biber JK, Doverspike D, Baznik D, et al: Sexual harassment in online communications: effects of gender and discourse medium. CyberPsychol Behav 5:33–42, 2002

Blakey v Continental Airlines, Inc, 751 A.2d 538 (N.J. 2000)

Block JJ: Lessons from Columbine: virtual and real rage. Am J Forensic Psychiatry 28(2):5–34, 2007

Block JJ: Issues for DSM-V: Internet addiction. Am J Psychiatry 165:306–307, 2008

Celizic M: Her teen committed suicide over "sexting." The Today Show, via MSNBC.com, March 6, 2009. Available at: http://www.msnbc.msn.com/id/29546030/. Accessed May 26, 2009.

Clifford S: Online age quiz is a window for drug makers. The New York Times, March 26, 2009. Available at: http://www.nytimes.com/2009/03/26/technology/Internet/26privacy.html. Accessed April 3, 2009.

Douglas AC, Mills JE, Niang M, et al: Internet addiction: meta-synthesis of qualitative research for the decade 1996–2006. Computers in Human Behavior 24:3027–3044, 2008

Durkin KF, Bryant CD: Propagandizing pederasty: a thematic analysis of the on-line exculpatory accounts of unrepentant pedophiles. Deviant Behav 20(2):103–127, 1999

Ellement FR: Witness details Entwistle's web surfing on sex, slay sites: active searches preceded slayings. The Boston Globe, June 19, 2008. Available at: http://www.boston.com/news/local/massachusetts/articles/2008/06/19/witness_details_entwistles_web_surfing_on_sex_slay_sites/. Accessed June 16, 2009.

Everton WJ, Mastrangelo PM, Jolton JA: Personality correlates of employees' personal use of work computers. CyberPsychol Behav 8:143–153, 2005

Feldman MD: Munchausen by Internet: detecting factitious illness and crisis on the Internet. South Med J 93:669–672, 2000

Fink PJ: The case of a teenager who committed suicide after being bullied online shows that the Internet can be a weapon against the psychiatrically vulnerable: what can we do to help these patients? Clinical Psychiatry News 36(2):30, 2008

Garrett RK, Danziger JN: Disaffection or expected outcomes: understanding personal Internet use during work. Journal of Computer-Mediated Communication 13:937–958, 2008

Glancy GD, Newman AW, Potash MN, et al: Cyberstalking, in Stalking: Psychiatric Perspectives and Practical Approaches. Edited by Pinals DA. New York, Oxford University Press, 2007, pp 212–226

Gold LH: The workplace, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 303–326

Goldberg IK: Internet addictive disorder: diagnostic criteria. Psycom.net. March 23, 2002. Available at: http://www.psycom.net/iadcriteria.html. Accessed May 28, 2009.

Goldsmith TD, Shapira NA: Problematic Internet use, in Clinical Manual of Impulse-Control Disorders. Edited by Hollander E, Stein DJ. Washington, DC, American Psychiatric Publishing, 2006, pp 291–308

Granacher RP Jr: Starting a forensic practice, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 55–74

Green A: More states use GPS to track abusers. The New York Times, May 9, 2009. Available at: http://www.nytimes.com/2009/05/09/us/09gps.html. Accessed June 9, 2009.

Griffiths EJ, Kampa R, Pearce C, et al: Munchausen's syndrome by Google. Ann R Coll Surg Engl 91:159–160, 2009

Hart A, Henwood F, Wyatt S: The role of the Internet in patient practitioner relationships: findings from a qualitative research study. Journal of Medical Internet Research 6(3):e36, 2004. Available at: http://www.jmir.org/2004/3/e36/HTML. Accessed May 29, 2009.

Hass N: In your Facebook.com. The New York Times, January 8, 2006. Available at: http://www.nytimes.com/2006/01/08/education/edlife/facebooks.html. Accessed April 24, 2009.

Ichimura A, Nakajima I, Juzoji H: Investigation and analysis of a reported incident resulting in an actual airline hijacking due to a fanatical and engrossed VR state. CyberPsychol Behav 4(3):355–363, 2001

Jameson S: Cyberharassment: striking a balance between free speech and privacy. 17 CommLaw Conspectus 231, 2008

Keelan J, Pavri-Garcia V, Tomlinson G, et al: YouTube as a source of information on immunization: a content analysis. JAMA 298:2482–2484, 2007

Klonoff RH, Herrmann M, Harrison BW: Making class actions work: the untapped potential of the Internet. University of Pittsburgh Law Review 69:727–768, 2008

Ko CH, Yen JH, Chen CS, et al: Psychiatric comorbidity of Internet addiction in college students: an interview study. CNS Spectr 13(2):147–153, 2008

Ko CH, Yen JY, Liu SC, et al: The associations between aggressive behaviors and Internet addiction and online activities in adolescents. J Adolesc Health 44(6):598–605, 2009

Kornblum J, Marklein MB: What you say online could haunt you. USA Today, March 9, 2006, A1

Kuszler PC: A question of duty: common law legal issues resulting from physician response to unsolicited patient email inquiries. J Med Internet Res 2(3):e17, 2000. Available at: http://www.jmir.org/2000/3/e17. Accessed May 15, 2009.

Labi N: An IM infatuation turned to romance; then the truth came out. Wired Magazine, 15(9), August 21, 2007. Available at: http://www.wired.com/politics/law/magazine/15-09/ff_internetlies. Accessed May 29, 2009.

Lidsky LB: Silencing John Doe: defamation and discourse in cyberspace. Duke Law Journal 49:855–946, 2000

Lustig A, Mackay S, Strauss J: Morgellons Disease as Internet meme. Psychosomatics 50:90, 2009

McGrath MG, Casey E: Forensic psychiatry and the Internet: practical perspectives on sexual predators and obsessional harassers in cyberspace. J Am Acad Psychiatry Law 30:81–94, 2002

Neimark G: Boundary violation. J Am Acad Psychiatry Law 37(1):95–97, 2009

Neimark G, Hurford MO, DiGiacomo J: The Internet as collateral informant (letter). Am J Psychiatry 163:1842, 2006

Pacenza v IBM Corp, No. 04 Civ. 5831 (PGG), 21 Am. Disabilities Cas. (BNA) 1260 (S.D.N.Y. 2009)

Quittner J: Divorce, Internet style. Time Magazine, April 14, 1997, p 72. Available at: http://www.time.com/time/magazine/article/0,9171,986178,00.html. Accessed April 21, 2009.

Recupero PR: E-mail and the psychiatrist-patient relationship. J Am Acad Psychiatry Law 33:465–475, 2005

Recupero PR: Legal concerns for psychiatrists who maintain web sites. Psychiatric Services 57:450–452, 2006

Recupero PR: Forensic evaluation of problematic Internet use. J Am Acad Psychiatry Law 36:505–514, 2008

Recupero PR, Rainey SE. Forensic aspects of e-therapy. Journal of Psychiatric Practice 11:405–410, 2005

Recupero PR, Harms SE, Noble JM: Googling suicide: surfing for suicide information on the Internet. J Clin Psychiatry 69:878–888, 2008

Reuters: Chinese Internet addict kills mother over money. Thompson Reuters news, June 14, 2007. Available at: http://www.reuters.com/article/InternetNews/idUSPEK20480120070614. Accessed June 16, 2009.

Schifano F, Leoni M, Martinotti G, et al: Importance of cyberspace for the assessment of the drug abuse market: preliminary results from the Psychonaut 2002 Project. CyberPsychol Behav 6:405–410, 2003

Shapira NA, Goldsmith TD, Keck Jr, PE, et al: Psychiatric features of individuals with problematic internet use. J Affect Disord 57(1–3):267–272, 2000

Siempos II, Spanos A, Issaris EA, et al: Non-physicians may reach correct diagnoses by using Google: a pilot study. Swiss Medical Weekly 138(49–50):741–745, 2008

Stein DJ, Black DW, Shapira NA, et al: Hypersexual disorder and preoccupation with internet pornography. Am J Psychiatry 158:1590–1594, 2001

Stelter B: Guilty verdict in cyberbullying case provokes many questions over online identity. The New York Times, November 28, 2008. Available at: http://www.nytimes.com/2008/11/28/us/28Internet.html. Accessed September 17, 2009.

Suler J: The online disinhibition effect. CyberPsychol Behav 7(3):321–326, 2004

Thanawala S: Students post videos of schoolyard brawls online. The Associated Press, via USA Today, March 6, 2009. Available at: http://www.usatoday.com/news/education/2009-03-06-schoolfights_N.htm. Accessed June 16, 2009.

Thompson JW Jr, LeBourgeois HW III, Black FW: Malingering, in The American Psychiatric Publishing Textbook of Forensic Psychiatry. Edited by Simon RI, Gold LH. Washington, DC, American Psychiatric Publishing, 2004, pp 427–448

Toronto E: Time out of mind: dissociation in the virtual world. Psychoanalytic Psychology 26:117–133, 2009

Tucker E: Facebook used as character evidence, lands some in jail. USA Today, July 16, 2008. Available at: http://www.usatoday.com/tech/webguide/Internetlife/2008-07-19-facebook-trials_N.htm. Accessed April 24, 2009.

Turkle S: Life on the Screen: Identity in the Age of the Internet. New York, Simon and Schuster, 1995

Turnage AK: Email flaming behaviors and organizational conflict. Journal of Computer-Mediated Communication 13:43–59, 2007

Van Gelder L: The strange case of the electronic lover, in Computerization and Controversy: Value Conflicts and Social Choices, 2nd Edition. Edited by Kling R. New York, Academic Press, 1996, pp 533–546

Vance K, Howe W, Dellavalle RP: Social Internet sites as a source of public health information. Dermatologic Clinics 27:133–136, 2009

Vazquez J: Gangs turn to social networking sites to recruit. CBS5 [CA] Web site, February 7, 2008. Available at: http://cbs5.com/local/Internet.gang.recruiting.2.648038.html. Accessed June 16, 2009.

Vennemann B, Pollak S: Death by hanging while watching violent pornographic videos on the Internet: suicide or accidental autoerotic death? Int J Legal Med 120(2):110–114, 2006

Vila-Rodriguez F, MacEwan BG: Delusional parasitosis facilitated by Web-based dissemination. Am J Psychiatry 165(12):1612, 2008

Wallis D: Just click no. The New Yorker Magazine, January 13, 1997, p 28

Wentz R: Use of Google as a diagnostic aid: is Google like 10,000 monkeys (letter)? Br Med J 333(7581):1270, 2006

White RW, Horvitz E: Cyberchondria: studies of the escalation of medical concerns in web search. Microsoft Research. November 2008. Available at: http://research.microsoft.com/apps/pubs/default.aspx?id=76529. Accessed September 17, 2009.

Whitty MT, Carr AN: New rules in the workplace: applying object-relations theory to explain problem Internet and email behaviour in the workplace. Comput Human Behav 22:235–250, 2006

Ybarra ML, Mitchell KJ: Youth engaging in online harassment: associations with caregiver-child relationships, Internet use, and personal characteristics. J Adolesc 27:319–336, 2004

Yen JY, Ko CH, Yen CF, et al: The comorbid psychiatric symptoms of Internet addiction: attention deficit and hyperactivity disorder (ADHD), depression, social phobia, and hostility. J Adolesc Health 41:93–98, 2007

Young KS, Cooper A, Griffiths-Shelley E, et al: Cybersex and infidelity online: implications for evaluation and treatment. Sexual Addiction and Compulsivity 7(10):59–74, 2000

Zimmerman RK, Wolfe RM, Fox DE, et al: Vaccine criticism on the World Wide Web. J Med Internet Res 7(2):e17, June 29, 2005. Available at: http://www.jmir.org/2005/2/e17/. Accessed May 29, 2009.

Suggested Readings and Relevant Web Sites

Barak A: Phantom emotions: psychological determinants of emotional experiences on the Internet, in The Oxford Handbook of Internet Psychology. Edited by Joinson A, McKenna K, Postmes T, et al. New York, Oxford University Press, 2007, pp 303–329

Bhuvaneswar CG, Gutheil TG: E-mail and psychiatry: some psychotherapeutic and psychoanalytic perspectives. Am J Psychother 62:241–261, 2008

Block JJ: Lessons from Columbine: virtual and real rage. Am J Forensic Psychiatry 28(2):5–34, 2007

Block JJ: Issues for DSM-V: Internet addiction. Am J Psychiatry 165:306–307, 2008

Douglas AC, Mills JE, Niang M, et al: Internet addiction: meta-synthesis of qualitative research for the decade 1996–2006. Comput Human Behav 24:3027–3044, 2008

Glancy GD, Newman AW, Potash MN, et al: Cyberstalking, in Stalking: Psychiatric Perspectives and Practical Approaches. Edited by Pinals DA. New York, Oxford University Press, 2007, pp 212–226

Guidelines for physician-patient electronic communications <www.ama-assn.org>. American Medical Association. Full Text available at: http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/guidelines-physician-patient-electronic-communications.shtml.

McGrath MG, Casey E: Forensic psychiatry and the Internet: practical perspectives on sexual predators and obsessional harassers in cyberspace. J Am Acad Psychiatry Law 30:81–94, 2002

Neimark G, Hurford MO, DiGiacomo J: The Internet as collateral informant [letter]. Am J Psychiatry 163:1842, 2006

Recupero PR: Forensic evaluation of problematic Internet use. J Am Acad Psychiatry Law 36:505–514, 2008

Shapira NA, Goldsmith TD, Keck PE Jr, et al: Psychiatric features of individuals with problematic Internet use. J Affect Disord 57(1–3):267–272, 2000

Stein DJ, Black DW, Shapira NA, et al: Hypersexual disorder and preoccupation with Internet pornography. Amer J Psychiatry 158:1590–1594, 2001

Suler J: The online disinhibition effect. CyberPsychol Behav 7:321–326, 2004

Turkle S: Life on the Screen: Identity in the Age of the Internet. New York, Simon & Schuster, 1995

http://www.ahima.org/ [American Health Information Management Association. Has some helpful guidelines on the use of technology in healthcare.]

http://www.cyberangels.org/

http://www.cyberbullying.us/

http://groups.google.com/group/Internet-addiction-support/

http://www.haltabuse.org/

http://www.netaddiction.com/

http://www.nlm.nih.gov/medlineplus/. [MedlinePlus contains numerous resources including medical/health news updates and links to additional resources on the Web.]

http://www.patientslikeme.com/

http://psychcentral.com/netaddiction/. [Internet Addiction Guide maintained by John M. Grohol, Psy.D. Part of PsychCentral's helpful and informative website, available at: http://psychcentral.com/. Contains links to additional resources and information.]

http://www.psych.org/ .[Home page for the American Psychiatric Association. Contains information on HIPAA and other legal/ethical issues.]

http://wiredsafety.org/

http://www.ismho.org/. [International Society for Mental Health Online. Includes ethical guidelines and a bibliography of research on the Internet and mental health.]

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Chapter 23

Psychological Testing in Forensic Psychiatry

Madelon V. Baranoski, Ph.D.

Psychological testing is the administration and interpretation of standardized tests with acceptable psychometric properties. The tests are selected based on the functional area in question, including cognition and intelligence, learning styles and disabilities, memory, personality structure, and assessment of brain injury sequelae. Psychological testing is an extensive and sophisticated mainstay of the discipline of psychology and informs educational, occupational, and clinical assessments. The application of psychological testing in forensic cases has been evolving since the 1970s. Unique aspects of psychological tests contribute to the utility of psychological assessments for the courts. The quasi-objective measure of personality, the standardized testing, and the specific measurement of function are some of the characteristics that create a place for psychological testing in forensic cases. For example, the United States Supreme Court decision in *Atkins v. Virginia* (2002), which prohibits the execution of persons with mental retar-

I would like to acknowledge Josephine Buchanan, B.A., for her editorial review.

dation (now called developmental deficit disorder), is a ruling that requires IQ assessment and an IQ score range to determine the legal exclusion.

Psychological testing has been used to answer every type of forensic question, including competency and state of mind in criminal cases and disability, custody, and other questions in civil cases (Melton et al. 2007). My purpose in this chapter is to present the role of psychological testing as an adjunctive tool in psychiatric forensic assessments and to examine the merits and limits of testing in formulating cases. It is written for the forensic psychiatrist as consumer of psychological testing conducted by a qualified psychologist. The chapter is organized into three sections that correspond to the incorporation of psychological testing in forensic formulations. I begin with the advantages of including psychological testing in forensic assessments and then describe the various categories of tests. The chapter concludes with consideration of the limits of psychological tests and caveats for their use.

Role for Psychological Testing in Forensic Assessments

Psychological testing is not a required component of the forensic assessment. There are, however, cases in which testing can aid in the formulation of a case. The utility of testing arises from the nature of the standardized tests and their relevance to specific forensic questions that require psychiatric assessments. The psychiatrist's decision to include testing through a referral to a psychologist should be based on an understanding of what testing can offer and how it can contribute to the psychiatric formulation.

Characteristics of Psychological Testing

Psychological testing is a collection of standardized measures having established psychometric properties. These properties include reliability (the capacity of a test to measure the same variable over time and across situations), validity (the capacity of a test to measure what it is designed to measure), the error rate, and the limits to generalizability of the test. The tests assess behavior to determine level of capacity, function, and symptoms, compared with established norms. For all established tests, psychological testing answers the questions How does this person compare with the populations tested, and Where on the continuum or in which category does this person fall? The established continua and categories distinguish among relevant levels of function and characteristics, such as

IQ, levels of depression, personality characteristics, and memory capacity. Psychological tests are similar to other medical tests such as blood tests; there are established norms and cutoffs. The interpretation of psychological tests integrates specific results with data, including clinical evaluations, history, and collateral information, to determine the relative utility of the testing.

In contrast to clinical interviews, psychological tests are not individualized or specific to the person or the situation. That is, test questions do not vary from person to person and do not address specific symptoms or circumstances. Each test is administered according to a standard protocol; individual results are scored and interpreted according to a standard statistical profile. Although the administration of the tests is fixed, their selection and interpretation consider the person's history and the context in which the individual is involved. For example, personality tests include items that identify somatization as a diagnostic characteristic and personality trait. If, however, the person taking the test has a chronic disease, the interpretation of somatization requires caution and further validation.

The interpretation of psychological testing requires an individual assessment and collateral information that determine the applicability of the results of the testing. Is this profile (as determined by the testing) applicable to this individual? Is the testing result supported by other data? Just as with an aberrant blood test result that does not coincide with any clinical manifestation or history, aberrant testing results must not override what the history and individual assessment show.

Relevance of Psychological Testing to Forensic Assessments

Heilbrun (1992) identified relevance to the legal question as the primary criterion for including psychological testing in forensic cases. Although specific relevance must be assessed on a case-by-case basis, the nature of psychological testing makes it valuable in forensic work in general. Psychological tests augment the clinical evaluation in a number of ways: they offer a comparative and therefore objective measure of function; they evaluate function relevant to daily living, tapping into function beyond the scope of the clinical interview; they help to reconcile disparate historical and treatment data; and they identify fruitful areas for further assessment.

Objective Nature of the Testing

Because psychological tests are standardized, they offer an objective measure of function that allows comparison with measured populations. For exam-

ple, with cognitive tests, the determination of IQ is a standard measure that has been associated with other function in controlled studies. Although a clinical interview can give an estimate of an intellectual range, the testing can identify with more precision cognitive strengths and weaknesses, overall intellectual ability, and a foundation for analyzing a person's overall achievement. Standardized, the tests assess abilities and characteristics beyond the particular forensic matter and provide information about function beyond that which can be measured in a clinical psychiatric assessment.

Case Vignette 1

The court requested an evaluation of a 14-year-old girl arrested for arson after she helped her boyfriend retaliate against a store owner who had fired him. The evaluation was requested because the girl, stoic throughout the proceedings, expressed little remorse. Adjudicated as an adult, she was pegged as "antisocial, arrogant, cynical and criminal-minded." The purposes of the evaluation were to aid in sentencing and determine the need for supervision. The forensic psychiatrist administered the adolescent versions of the Minnesota Multiphasic Personality Inventory–2 (MMPI-2) and the Millon Clinical Multiaxial Inventory–III (MCMI-III). The results of the standardized personality measures aided the formulation. Scores indicated traits of significant anxiety, depression, dependency, and low self-esteem. Her profile indicated immaturity with no elevations on antisocial or conduct disorder scales. The adult court lacked a referent group with which to compare individual adolescents. The standardized tests provided a comparative backdrop of adolescents in general and thereby offered a context in which to understand this particular adolescent.

In forensic assessments, for which precision is required for legal purposes, psychological testing may be necessary. Consider, for example, a death penalty case in which developmental deficit disorder is at issue. Because that diagnosis requires an IQ of 70 or less, formal testing is necessary. Even in cases for which a clinical appraisal of intellectual capacity would be adequate for determining placement, supervision, and treatment options, formal testing may be required if funding for service is contingent on a specific IQ score cutoff.

Simulation of Relevant Situations

Psychological tests simulate real-life demands through sets of structured tasks that tap into different functional arenas. Their administration also provides an evaluation of function under conditions beyond those of a usual clinical interview through posing various tasks, questions, and challenges. For example, visual-spatial tests identify levels of function that correspond

to parking a car, sewing, eating, and organizing an apartment. In a disability case, the results of the tests can inform an assessment focused on the ability to return to work after a head injury. As another example, cognitive testing includes measures of concentration and attention that test capacity beyond that required in a structured forensic interview by a supportive and empathic psychiatrist.

Because tests vary in structure, type of simulation, and complexity of task, they test strengths, weaknesses, and limits of ability. The testing procedures create emotional tension and distractions and then measure their effects on function. The standard battery of psychological tests includes measures of cognitive capacity, memory, attention, and concentration, as well as standard tests of personality characteristics and projective measures to elicit the individual's worldview and organizational capacity. These tests provide a limited replica of daily experience. One way to appreciate the contribution of psychological tests is to consider the testing as a substitute for extensive observation of a person in real-life circumstances and varied social interactions. The tests provide the kind of information that psychiatrists glean through extended treatment of patients or after long hospitalizations.

Case Vignette 2

A 34-year-old woman was arrested for threatening her neighbor with a butcher knife after the neighbor accidentally ran over the woman's dog. Before the judge, as she was about to accept a plea deal, she had an outburst that prompted the judge to order a competency evaluation. In the evaluation, she demonstrated knowledge of her charges and of the proceedings. She spoke calmly about her case and expressed embarrassment over her behavior. The psychiatrist recommended to the court that she was competent, but at the hearing she was unable to answer the judge's questions. Subsequent cognitive testing of her intelligence produced results that confirmed the psychiatrist's assessment that she had adequate intelligence to understand courtroom proceedings as indicated by her general fund of information and vocabulary. However, on tests of concentration and those that involve novel stimuli, her function was on the borderline intellectual level, and she showed marked impairment in thinking when she was anxious. By simulating the conditions in the court (asking a series of unrelated and difficult questions without regard to context, presentation of novel stimuli, and timed activities), the testing evoked the emotional dyscontrol similar to that which she showed in court. The results led to further assessment, and she disclosed a traumatic frontal brain injury from a car accident 6 years prior that she had not reported in the clinical assessment. The information provided by the testing led to accommodation by the court to allow her to proceed through to disposition and to a referral for treatment.

Reconciling Disparate Data

Psychological testing can assist in formulating diagnoses when historical and treatment data do not converge or when competing clinical hypotheses lead to different treatment options. The most frequent referral assessments include a focus on psychotic thinking or a formal thought disorder and on the type and severity of characterological disorders.

Case Vignette 3

A 28-year-old woman was arrested after she shot and killed her sleeping 62-year-old mother, then shot herself, grazing her chest. Initially, she reported to the police that a burglar had done the shooting, but in the emergency room, she confessed to the shooting. She was referred for a forensic evaluation because her older siblings reported that she was mentally retarded and that she had once lost custody of her preschooler to her ex-husband when she was found to have been negligent. Her siblings also reported that she had never worked and that she was unreasonably distressed over her mother's rheumatoid arthritis. Various reports described her as psychotic, mentally retarded, and antisocial. In contrast, other records indicated that she had attended community college and graduated with an accounting degree; that she had married and divorced; that she held a seasonal job at H&R Block, where she was assigned as a tax reviewer; and that she had legally purchased the gun she used to kill her mother, correctly filing all of the required paperwork. The psychological battery included cognitive and personality tests. The results of the Wechsler Adult Intelligence Scale, 3rd Edition (WAIS-III) indicated a significantly higher verbal IQ (high-average range) than performance IQ (borderline range). The results supported by past school records identified a performance learning disorder. Through further assessment she was diagnosed with Asperger's syndrome. The diagnosis explained the initial contradiction between her college and employment success and her social awkwardness, failure in ordinary living situations, and the family's view of her as limited. The finding also helped formulate a motive by explaining her perception of the mother's illness as mortal suffering, from which she sought to rescue her.

Uncovering Issues for Assessment

Those who work in forensic psychiatry, in contrast to clinical psychiatry, usually do not have the luxury of extended time with clients. The knowledge of clients that unfolds through years, months, or weeks of therapy is unavailable in the truncated evaluations that are limited by the time frames of courts and the legal system in general. Psychological testing often evokes information through tests that are unrelated to the legal situation. In the course of testing, clients give answers or free associate on topics that may not have

been elicited in the structured clinical interview. These responses can direct the psychiatrist to fertile areas for exploration and assessment. Beyond the scores and standard interpretation, the testing relationship provides a different arena for exploring motive and perceptions. Working collaboratively, the psychiatrist and psychologist can exchange impressions that emerge from the different approaches.

Special Relevance to Forensic Psychiatry

The utility of psychological testing applies to clinical, educational, and employment assessments as well as to forensic cases. There are, however, additional reasons—reasons unique to forensic assessments—for including psychological testing in a forensic assessment. These include aid in formulating a case within the special conditions of forensic work, support for an opinion, and bolstering of credibility with the court through both substantive support and the perception of due diligence.

Unique Conditions of Forensic Work

Psychological testing is especially useful to forensic cases because of the nature of the work: the legal system raises critical questions that need to be answered in a specific (and usually short) time with certainty, albeit not absolute certainty. Forensic cases rarely afford the psychiatrist the luxury of time through which disorders, motives, and critical and explanatory issues can emerge. Confounding this issue even more is the standard of reasonable medical certainty, which presses for an opinion that foregoes the hunches, speculation, and clinical guesses that define an evolving therapy case. Forensic psychiatrists have to be more certain in less time than psychiatrists do in clinical practice. Stated another way, forensic psychiatrists have to explain with reasonable medical certainty a moment in time or a specific event, despite limited opportunity for evaluation. Psychological testing adds one other source of knowledge about the person.

Foundation for the Opinion

Although psychological tests themselves cannot explain an event, determine competence, or establish the cause of behavior, they can provide a context to support or refute a forensic opinion. For example, results of psychological testing that indicate a person has a thought disorder or psychotic disorder provide support for the opinion that at the time of a violent act, the person was psychotic. On the other hand, if testing results showed no disorder, an opinion

that the person was psychotic during a particular episode would require more explanation and collateral to support it. When psychological testing is completed early in the evaluation and the results are available to the psychiatrist, the integration of results into both the evaluation itself and the formulation creates a solid and defensible opinion. For the court, the inclusion of psychological testing also gives the perception of due diligence and a comprehensive evaluation. Even when psychological testing results in contrary findings and requires explanation, the credibility of the forensic expert is enhanced by the documentation that shows other opinions were considered and rejected.

Forewarning of Opposing Findings

Many forensic cases involve a "battle of the experts," and in difficult cases, differing opinions are not uncommon. Psychological testing helps the expert on either side to learn what the tests show and how those tests support or refute the opinion. Forewarned, the expert can decide how to address contrary findings. For example, defense attorneys of a 27-year-old man arrested for the severe beating of his 9-month-old son after an argument with his girlfriend, the baby's mother, proffered a diminished capacity defense based on the psychiatric opinion that the man had significant cognitive deficits and was using drugs and alcohol at the time and therefore could not appreciate the vulnerability of the child. Collateral data indicated that the man had received special education, had dropped out of school, still lived with family, and was mostly unemployed. The prosecution expert was a psychologist who conducted cognitive testing. The man scored in the low-average range of intelligence and on personality tests showed borderline and antisocial characteristics. Although these findings did not necessarily contradict the defense expert's opinion, they were data that did need to be accounted for and explained. Had the defense expert requested testing, the formulation could have integrated these findings and diluted their impact in court. Although psychological test results can never independently establish a forensic opinion, they may provide strong collateral data.

Categories of Tests and Testing Procedures

Psychological tests vary in form, purpose, and foundation. Established psychological tests, including those that would be acceptable in court and meet

a *Daubert* challenge, have several characteristics in common: established reliability and validity, a known standard error rate for tests that are scored, standard scoring instructions, criteria for taking the test (such as age, language, and reading ability), and limits of interpretation and generalizability. These characteristics define who can take the test, how to score the test, how it can be interpreted, and how confident one is in the results.

There are a number of different ways to categorize tests based on purpose and form. One system, based on the purpose of the testing and the human characteristics evaluated, is relevant to forensic work.

Cognitive/Functional Tests

Cognitive/functional tests measure specific capacities and behaviors that relate to everyday function. The scores reflect a person's ability relevant to established population norms. These tests have right and wrong answers and measure specific learning and reasoning capacities, such as verbal ability, abstract reasoning, pattern recognition, visual-motor integration, and tracking of visual cues. Cognitive tests include intelligence tests, achievement tests, and tests to assess specific cognitive areas and deficits, such as attention deficits and dyslexia. The tests are often used in educational assessments. Achievement tests, for example, track performance of students in different grades, as well as competitiveness for placement in higher education (e.g., college boards, Medical College Admission Test [MCAT], and Law School Admission Test [LSAT]).

Cognitive tests are included in a standard forensic battery of tests because of their diagnostic utility. They assess how a person thinks, as well as provide an estimate of intelligence. The tests identify disorders in thinking, including formal thought disorders, attention and concentration impairments, and variation in capacity that can be pathognomonic of autism and other developmental spectrum disorders. Performance on the cognitive tests can also detect problem-solving style and obsessive-compulsive and paranoid characteristics.

Intelligence Tests

In forensic assessments, the most common cognitive tests are intelligence tests. These measure past learning, verbal skills, abstract reasoning, processing speed (how fast a person can think through a problem), perceptual organization, and working memory (how well a person can hold and manipulate information in mind while solving a problem). Intelligence tests are regularly updated and are designed to reflect a normal or bell-shaped dis-

tribution of intellectual ability. The scores roughly correlate with general adaptation and level of education and employment. In forensic evaluations, cognitive tests also serve as diagnostic tools in identifying psychosis, paranoid ideation, attention deficits, and malingering relevant to specific cases.

The gold standards in IQ tests for forensic work are the Wechsler (Wechsler 1997) series and the Stanford-Binet (Roid 2002) tests. They have established psychometric properties, detailed scoring, procedural manuals, and norms. The Wechsler series includes tests for very young children, adolescents, and adults, as well as a short form for IQ assessment.

Through 2008, tests of adult intelligence have reported three IQ scores:

1. Verbal IQ: a measure of verbal facility, verbal reasoning (including vocabulary and abstract reasoning), and past learning, both formal and incidental
2. Performance IQ: a measure of active problem-solving with novel stimuli, perceptual organization, and pattern recognition
3. Full Scale IQ: a measure of overall intelligence derived from the subscores for verbal and performance IQs

The most recent edition of the Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV; Pearson Education 2008) was significantly revised to capture domains of intellectual capacity. The revision reflects the new research on the components of intelligence and what distinguishes different levels of ability. The WAIS-IV no longer reports verbal and performance categories. The new dimensions include the following domain scores:

1. Verbal Reasoning (vocabulary, abstract reasoning)
2. Perceptual Integration (pattern recognition, visual-motor integration)
3. Processing Speed (rate and accuracy of problem solving)
4. Working Memory (mental problem solving)
5. Full Scale IQ (derived from all subscales)
6. General Ability (blend of capacities)

Similar to past editions, the scoring distribution is normal with a mean of 100 and a standard deviation of 15. The new test format and scoring allow for more precise analysis of strengths and weaknesses in problem solving, intellectual ability, and psychological impairments.

Although actual IQ scores often have limited utility in a forensic evaluation, the performance characteristics can support diagnoses and demonstrate for the court examples of psychiatric categories. The following are responses that were included in reports as examples of common psychiatric symptoms:

- *Flight of ideas, racing thoughts* (from the vocabulary test). What does the word "assemble" mean? "That is an interesting word with ass right out front, which you could say is back-asswords [sic], pardon my French, which I did not major in [in a tone mimicking her mother], 'Take Spanish it will help you get a job.' Thanks, mom! She didn't give that advice to my sister, her favorite. What did you ask me?"
- *Tangential, neologistic, and disorganized* (from the similarities abstract reasoning test). How are a bird and a starfish alike? "Fission and fusion confused, conbirded [sic] and bridled in sky."
- *Paranoid ideation* (from a picture arrangement series in which the usual story is of a robber who steals an apple from a man eating lunch, then steals his money, and then returns the apple). Put the cards in the correct order to tell a story. "The man gives the other man an apple but it is spoiled, maybe poison, so he switches the apple around to trick him. These other cards do not fit in, unless you are trying to trick me. The color on the card is lighter than the others. Unless this is a trick to get me to make a mistake."

In these examples, the score of 0 on each one is less informative than the way in which the people were wrong and the opportunity their answers provide to demonstrate psychiatric symptoms with case-neutral material. The report of cognitive testing should include the scores and the person's characteristics and styles of thinking and problem solving, as well as relative strengths and weaknesses.

The Wechsler and Stanford-Binet tests have been translated into Spanish. There are also some French versions. With cognitive tests, the verbal subtests are more culture-bound, that is, affected by cultural differences, and thereby likely to produce falsely low scores. Nonverbal tests are less affected by culture and language. IQ test results are invalid when translated during the administration of the test. When language and culture are barriers, the appropriate test for estimating intelligence is the Test of Nonverbal Intelligence, 3rd Edition (Brown et al. 1997). The results give an estimate of intellectual ability, and the IQ score should be reported with the caution that the testing did not include a measure of language ability and verbal reasoning.

The Concept of "Scatter"

In IQ testing, most persons show relative strengths and weaknesses, indicated by higher and lower scores. However, in the absence of psychopathology, cognitive impairments, and learning disabilities, the difference in scores is generally not statistically significant. That is, the subtests do not vary by more than 3 points, and the differences across domains vary no more than

10 points. When the variation between scores is larger, the variation is referred to as "scatter." There are three sources of testing scatter:

1. Between the verbal and performance IQ, or among the domains
2. Between the subtests
3. Within the items in the subtests

Different types of scatter are associated with different psychiatric problems. For example, within subtests, scatter occurs when a person gets some easy items wrong and some hard items correct; that is, performance is irregular. That pattern can be a sign of attention deficit, distractibility related to anxiety, trauma, depression, and psychosis. Scatter between domains, in which the verbal domain is over 15 points higher than the perceptual and processing domains, is an indicator of a performance learning disability associated with Asperger's syndrome and autism. Here is an example of intratest scatter associated with psychosis from answers on the vocabulary test:

Define

Spring: "The season between winter and summer when things start to blossom"
Thief: "A robber"
Tomorrow: "Nebulous infinity"*
Question: "A statement of inquiry, to ask about"
Create: "A god-doing [*sic*] action"*
Polygamy: "A state of one man being legally or I mean officially when it is illegal or frowned upon by the ruling hierarchy. [pause] I was saying having more than one wife not lost through death divorce or tragic disappearance when proclaimed dead. More than one husband is polyandry, popular in poor societies."

As shown in the example, the definitions with the asterisks represent idiosyncratic thinking rather than simple ignorance. In everyday life, a formal thought disorder and psychotic process can manifest as inconsistent and variable interactions in which normal thinking is punctuated by disorganized, idiosyncratic, and loose associations. Scatter that is associated with other disorders, such as attention deficits, manifest as distractibility, confusion, or "going off track."

Achievement Tests

Achievement tests are a mainstay of educational assessments. They measure what has been learned against standard expectations of performance and are a good measure of educational benefit. Different from IQ tests, which measure learning ability, achievement tests are a measure of what has been learned

and retained. They are an indirect measure of the quality of the environment as well as the individual's ability to benefit from it. Combining IQ test and achievement test results can identify underachievers and overachievers; that is, those who work below and over their potential. Low achievement scores can be diagnostic (with collateral data, of course) of psychiatric disorders, attention and concentration disorders, poor attendance, substance and alcohol abuse, and poor education. Achievement tests can also point to interventions for mediation. The Wide Range Achievement Test–4 (Jastak and Wilkinson 1984; Wilkinson and Robertson 2006) and the Woodcock-Johnson III Tests of Achievement (Woodcock et al. 2001) are common achievement tests and tests of reading and reading comprehension.

Personality Tests

Personality tests are designed to measure the broadest definition of personality defined through the constructs of response to the social world and tolerance for and defense against anxiety, loss, isolation, intimacy, and change. There are two main forms of personality tests: standardized and projective tests. Unlike cognitive tests that use rate of accuracy to rank individuals against a population norm, personality tests result in "profiles" that describe strengths, vulnerabilities, patterns of adjustment, and, when scores are in the extreme, pathological conditions. Personality tests in forensic assessments must have established psychometric properties and well-defined criteria for administration and scoring in order to pass *Daubert* muster in court.

Standardized Self-Report Measures

Standardized personality tests produce normative scores that define a profile correlated with personality styles and disorders. The most frequently used standardized personality tests in forensic assessments are the Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2; Hathaway and McKinley 1989), the Millon Clinical Multiaxial Inventory–III (MCMI-III; Millon 1994), and the Personality Assessment Inventory (PAI; Morey 2007). All of these tests have subscales that produce a profile of personality and symptom characteristics.

The personality tests have validity scales built in to indicate the attitude toward test taking. These scales guide the interpretation of the test and confidence in the results. For example, the results of a person who answers defensively are likely to underestimate his or her level of psychological distress and difficulty. In contrast, the results of a person who obtains a marginally valid profile because of overendorsement of symptoms will have limited utility in assessment of personality structure. Standardized tests provide informa-

tion useful in formulating treatment recommendations as well as in describing strengths and vulnerabilities in adaptation.

The MMPI-2, MCMI-III, and PAI come with extensive manuals guiding administration and interpretation. The tests are computer-scored through packaged programs that provide periodic updates, norms, and interpretive narratives based on the profile of scores that augment the scores. Frequently, the MMPI-2 or PAI is administered with the MCMI-III to provide data on personality and adaptive characteristics along with a profile of personality pathology.

Of all the structured personality tests, the MMPI and MMPI-2 have been the most researched and have the most extensive norms. The tests have been used outside of psychiatry as measures that screen, for example, applicants to police forces, astronaut candidates, and student resident advisors in college. The basis for their extensive use is the empirical nature of the tests: items distinguish between groups—those who were successful and those who were not. In addition, the test is easy to administer (often in groups), computer-scored, and viewed as less subject to bias by inexperienced interviewers.

In 2008, a restructured version of the MMPI was published after years of reformulation and research. The revised edition—the Minnesota Multiphasic Personality Inventory–2—Restructured Form (MMPI-2-RF) (Tellegen and Ben-Porath 2008)—has updated national norms as well as construct-based Content Scales. The new edition is shorter, with 338 items, compared with 567 in the MMPI-2, and contains 50 scales: 8 validity scales (the addition of one), 3 specific diagnostic (Higher-Order) scales addressing thought, mood, and behavioral dysfunction, 9 revised symptoms clinical problem scales, 23 specific problem scales (including a focus on internalizing, externalizing, somatic and cognitive, and interpersonal difficulties), 5 personality psychopathology scales, and 2 interest scales. The new tests address some of the main criticisms of the MMPI-2—particularly the absence of a construct-based interpretation of the test and the underreporting of pathology based on the clinical scales and the method of scoring (Baer and Miller 2002; Bagby and Marshall 2004). As with the MMPI-2, the new edition comes with extensive manuals for scoring, interpretation, and reporting of results (Ben-Porath and Tellegen 2008a, 2008b).

Despite the structure and extensive research, the new scales (and for that matter, the initial MMPI-2) are not without controversy. One validity scale, in particular, has polarized the psychological and legal community. The FBS, or Faking Bad Scale, used to identify "non-credible somatic and cognitive complaints" (Ben-Porath and Tellegen 2008a, 2008b), has been critiqued as biased against women, trauma victims, and those with chronic illnesses (Arbisi and Butcher 2004; Arbisi et al. 2006; Butcher et al. 2003, 2008). Supporters cite the extensive research that supports its validity (Nelson et al. 2006). The controversy effectively illustrates the character of forensic assess-

ments. In a clinical matter, the academic battle would be waged in professional journals. However, because the scale has been recommended for use in civil injury litigation, the matter is no longer academic. The *Wall Street Journal* criticized the test and violated the test publisher's copyright by publishing some of the items on the test. Lawyers have also entered the argument and, mounting *Frye* and *Daubert* challenges, have kept the scale out of testimony in a number of states. The fury over the test is captured in an excerpt from the Web magazine *Lawyers USA*:

> Although plaintiffs' attorneys are unanimous in despising the Fake Bad Scale, there is a mini-debate about whether it is more effective to exclude the test before trial or allow it in and discredit it while cross-examining the defense expert. "It's a tough call, frankly," said Dorothy Clay Sims, a founding partner of Sims, McCarty, Amat and Stakenborg in Ocala, Fla., who has won three hearings over excluding the test. "*Frye* and *Daubert* hearings are tough, but courts don't seem to like this test, so it's difficult to give up a hearing that you have a good chance of winning," she said. "On the other hand, once the Fake Bad Scale is demystified for the jury, and you pierce through it, they look at the defense doctor and say 'Oh, come on.'" (Franklin 2009)

Controversy around that scale or any other increases the risk of challenge. Indeed, until the controversy has settled and a reasoned review of the research is presented, use of the scale in forensic cases should be done only after a critical appraisal of the most recent research, as well as the current legal decisions, is conducted.

Projective Tests

Projective tests are instruments that require the client to interpret and make sense of the task. The tests provide minimal direction, have no set form for the responses, and allow wide latitude in the way clients approach the task. The projective tests have been described as the "cocktail party" tests—in other words, how would a person respond in a complex and unstructured setting? Projective tests include verbal reports and drawings. Although projective tests primarily assess personality characteristics, they also can provide data on acute psychiatric disorders. The most common projective tests include the Rorschach Inkblot Test (Rapaport et al. 1945), the Thematic Apperception Test (Holmstrom et al. 1990), and drawings of human figures and family action.

Rorschach Inkblot Test

Description. The Rorschach Inkblot Test has a rich and controversial history in psychology and psychiatry. Rorschach developed the test during the early

heyday of psychoanalytic interest; but he stressed that he did not consider the test a way to access the unconscious or as a tool of free association. He viewed it more as stimuli to evoke attitudes and thought styles. Over time, complex scoring systems have been developed to standardize scoring for both research and clinical practice, but the original inkblot cards have not changed.

The test consists of ten 6- by 8-inch cards, each displaying an inkblot that is black, and on some cards red or multicolored inkblots. Cards are presented one at a time, and clients are asked to identify what the blot reminds them of and makes them think of. They are told there are no right or wrong answers.

The original cards have not been revised, although scoring and administration methods have varied over time. The most widely used scoring and interpretation system was developed by Exner (1995). The Exner system (like many other Rorschach scoring systems) evaluates the quality and determinants of the responses (called percepts). The score is based on the organization of the answers, the characteristics (such as form, color, and shading) of the card used in the response, and the content of the responses. One advantage of systemized scoring is that malingering or feigning on the Rorschach can be effectively identified. Responses arising from psychosis and a formal thought disorder are hard to mimic. Consider, for example, how difficult it is to repeat verbatim psychotic language, although we can recall and repeat the essence of very disturbed content. Thus, responses to the Rorschach that include evil and violent content but that are derived from good organization of form do not indicate psychosis.

Content is interpreted and scored as an indicator of attitude and perspective, but the way in which the person interprets the inkblot provides the diagnostic strength of the test. For example, persons with Asperger's syndrome usually offer no responses of human figures but may give a number of answers indicating human body parts. Hypomania and mania are indicated in an extraordinary number of responses with varying quality in organization. Persons with obsessive-compulsive disorders often focus on minute detail, with an absence of responses that integrate the whole blot.

Use of Rorschach in forensic evaluations. The Rorschach Inkblot Test is often included in a psychological test battery in forensic cases. The test has several strengths that make it a valuable tool. As a measure of psychosis, it is reliable and valid. When combined with structured tests, such as intelligence tests, it can identify borderline personality structure. The key characteristic in borderline pathology is the significantly stronger performance on structured tests than on projective or unstructured tests. For example, a person with borderline personality disorder will likely show no evidence of a thought

disorder on IQ testing but will give disorganized responses on the Rorschach that may reach the level indicative of a psychotic disorder. Because the inkblots evoke other-than-cognitive responses (similar to the response to color compared with written words), the test mimics interpersonal encounters that evoke emotional responses. The Rorschach as a projective test identifies fruitful areas for investigation that may not be provoked in a structured, goal-directed interview.

Despite these advantages, the Rorschach Inkblot Test has stirred much controversy that can limit its usefulness in forensics. Much of the controversy stems from the misuse and misinterpretation of the test. The most vocal opposition emerged after the test was used in custody disputes in civil matters. The use of the test to assess parenting skills, appropriateness of parenting, or any other function, for that matter, is inappropriate and a violation of a basic tenet of testing—avoidance of overinterpretation and inaccurate conclusions. The Rorschach was not designed to provide access to the unconscious. When it is used as one of a set of integrated tests, it can add a dimension that structured, self-report, and population-based tests cannot. Research on the validity and reliability of the Rorschach supports its use as a measure of psychotic illness and borderline disorders; it has never been established as a measure of function and, similar to all other psychological tests, cannot stand alone. Another criticism of the test concerns its interpretation, which is viewed as subjective and therefore subject to bias, a problem in all areas of psychiatry but fatal in forensics. Employment of a systematic validated scoring system increases objectivity and reduces bias. The Exner scoring system (Exner 1995) is particularly useful for forensic work. Another protection against bias, particularly on the projective tests, is the use of and supervision by colleagues.

Thematic Apperception Test

In 1935, at the Harvard Psychological Clinic, the Thematic Apperception Test (TAT) was developed by Henry Murray and Christina Morgan (Holmstrom et al. 1990). The underlying assumption was that universal human themes of attachment, belonging, and conflict are the basic frameworks for interpreting even neutral situations. The responses to neutral stimuli give an indication of the attitude or emotional set that one uses to interpret everyday life. The test is designed to reflect personality variation in a variety of social settings. The TAT comprises 20 cards that depict interpersonal and individual situations. The pictures, which resemble period art from the 1930s, are ambiguous in terms of the central figure or theme. Some cards are gender specific; most are gender neutral. About 10 pictures are selected for administration. The simple instructions request that the person tell a story about the

picture, including a beginning, middle, and end. When the person finishes, the examiner can ask questions about what the characters in the story are feeling and about their motivation. There is no standard scoring for the TAT; it is used primarily as a clinical tool to evoke motivations, emotions, conflicts, and expectations about treatment. The stories are often analyzed in terms of themes of helplessness, coping style, trust in others, defensiveness, and interpretation of emotion and conflict. Most cards evoke a popular or common story; deviation from the usual suggests different motivations, concerns, or conflicts.

For example, in one TAT picture of a room in a house, there is a close-up of a woman in profile holding onto a man, fully facing the viewer, who seems to be pulling away. In the background, in faded detail, a woman seated on a bed is viewed through the doorway. The usual stories involve some interaction between the man and woman in the foreground: either the man is angry at an outsider and the woman (often the wife) is trying to keep him from acting, or the man is leaving after an argument with the woman, and she is begging him to stay. In an evaluation regarding placement of an inmate who had committed a number of assaults on cellmates, the TAT was used to augment the structured tests on which the man had produced a defensive and "faking good" profile. He had no history of psychiatric treatment prior to incarceration for an assault in a bar. He was anxious and reported difficulty sleeping but had refused medication prescribed by the prison psychiatrist. For the picture described above, the man gave the following story: "Oh, this is a good one. The guy walks in on his girl screwing another woman. He says, 'I'm out of here. She's trying to lie her way out.'" He identified the other woman as the muted figure in the background, a figure most people ignore completely. When asked how he knew she was lying, he answered, "You can tell a homo by their look. I know what he means; there are homos all around here, and they try to trap you with their looks and mind games." His stories for other pictures had similar homophobic themes that were well out of the ordinary. The results of the testing did not define a diagnosis but opened an area for further assessment and informed a potential factor in his anxiety and problem behavior.

Because there is no standard scoring, the test should be used cautiously in forensic cases. It is useful in evaluations undertaken to recommend treatment or determine placements or supervision needs, and to identify strengths and vulnerabilities. When used in forensic cases, the limitations of the test should be described.

Projective Drawing Tests

Projective drawing tests requiring the respondent to make freehand drawings are most commonly included in child evaluations. For children, these

tests have standard scoring programs like that of the Goodenough scoring system for human figure drawings (Goodenough 1926; Harris 1963), which is based on empirical data to identify emotional indicators that appear more frequently in children with psychiatric diagnoses and impaired adjustment than in children without. The meticulous scoring program ignores content and relies instead on size of object, placement of parts, and inclusion of detail to score the drawings.

Compared with testing that involves children's drawings, projective drawings done by adults have less of an empirical base and are used more as projective measures, with specific guidelines for interpretation. Like the Rorschach, interpretation of drawings has been criticized as being too subjective and therefore biased. Studies have identified themes in drawings, such as transparencies (one body part or clothing drawn on top of another without proper shading) and lack of accentuated detail. These studies suggest that there is a role for projective techniques as long as the interpretation is limited to what has been researched. The tests should be used for noting areas for further investigation rather than for giving a definitive conclusion. The three most common projective drawing tests are Human Figure Drawing (Machover 1948), House-Tree-Person (Burns 1987), and Kinetic Family Drawing (Burns and Kaufman 1972).

Human Figure Drawing. The Human Figure Drawing test requires a person to draw a picture of a human being and then a second picture of the opposite sex. Although there are complex scoring systems that assess size and placement of body parts compared across the two drawings, the projective assessment simply assesses the inclusion of parts of the body and the presence of clothes, detail, and complexity of the picture. The comparison of the two drawings is also useful.

House-Tree-Person Test. Similar to the human figure drawings, the House-Tree-Person test is a projective drawing test with a complex scoring and interpretation system that was developed by John Buck in 1948 as a projective personality test. Revised in 1969, the test requires three drawings on separate sheets of white paper. After the drawings are done, the person is asked questions about the drawing. The interpretation is based on both the drawing characteristics and the responses to questions. Most of the literature on the House-Tree-Person comes from studies conducted prior to 2000, when developing validity and reliability of projective tests was a target of psychological research. One example of the kind of research done, as well as of the effectiveness of the projective test as a clinical tool, is the study by Meyer and colleagues (1955), who collected drawings from adults before and after they underwent major surgery. The postsurgical drawings showed fewer signs of

regression and anxiety. In another study by Lewis and colleagues (1988), drawings completed by adolescent boys detained in juvenile detention facilities were successfully used in identifying those who had been sexually abused.

Kinetic Family Drawing. The Kinetic Family Drawing test is used most often in child and family clinical assessments. The test requires the adult or child to draw a picture of his or her family "doing something." Its utility stems from the capacity of a drawing to capture a perception that verbal expression cannot. The pictures can reveal aspects of family dynamics and roles. Research has identified its usefulness as a clinical tool. Handler and Habenicht (1994), in a review of literature and research on the measure, cautioned that the validity of the tool requires an integrated approach that incorporates the results with other data. They also identified potential biases in interpretation related to gender, age, and ethnic and cultural factors.

Use of Projective Tests in Forensic Assessments

The advantage of projective tests (projectives) is their capacity to evoke responses that are missed on structured tests. Individuals interpret the ambiguous stimuli in terms of their own interests, motivations, and attitudes. Using an art analogy, the structured tests are a paint-by-numbers picture; the projectives are a blank canvas, a bowl of fruit, and a set of paints. Without overinterpreting the responses, the projectives offer an enhanced understanding of the examinee.

Beyond serving as a measurement of test results, projectives create a productive dynamic between the examiner and the examinee. The freedom of response produced by projectives often evokes information that is not provided on structured tests or in clinical interviews. If the responses are not overinterpreted, they can suggest areas for exploration and, sometimes, for further testing.

Projectives are most useful in neurotic organization, but they can also indicate the presence of psychotic disorders. Responses on the Rorschach can help to differentiate schizophrenia from other psychotic disorders and can help to distinguish borderline personality disorder. However, projective tests have no particular advantage over the structured personality and cognitive tests for Axis I disorders. The projective tests can identify areas of interest in Axis II disorders and can help the examiner understand personality factors that contribute to behavior.

Case Vignette 4

A 47-year-old Catholic nun, Sister B, presented with difficulty breathing and swallowing from chemical burns to her mouth, palate, and esophagus. She

was referred to psychiatry because she had swallowed liquid dishwasher detergent. She had a Master of Arts in literature and French and taught in a small Catholic college. An only child, she was reared by her mother, who had left her husband because he "had unnatural sexual tendencies." Sister B entered a convent at age 17 years. She had no psychiatric, drug, alcohol, or legal history. Her medical history was positive for a tonsillectomy at age 5 years, "urethral stretching procedures" from ages 12 through 17 years, and contractions of her left hand from a scalding water burn sustained in a "cleaning accident" at age 12 years. Her mother died in a psychiatric nursing home run by the daughter's convent 4 months before Sister B's hospitalization. A month earlier, Sister B had gone on her first-ever vacation with a fellow nun, who was a "close friend." During the psychiatric assessment, Sister B insisted that she was not depressed or suicidal and had confused the liquid soap for an herbal drink. She was eager to get back to the college to prepare for the upcoming semester. Others in her community expressed concern, noting that she seemed distraught in the days before the incident. On the Rorschach she was guarded, giving one response per card. They were the popular answers, except on one card. The usual responses for this card include perceptions of humans (two little girls with ponytails) or of animals (two rabbits). Sister B answered, "Okay, if you want me to say it, I will—a vagina, a putrid vagina." When asked what made it look like that, she noted, "You can see the fumes of the putrefaction, like clouds." Her response was of poor quality in contrast to her responses on the other cards. Notably, the particular card is called the "mother card" for the themes it elicits. After the testing, Sister B was asked more about her mother. Emotionally, she described her mother as a "saint" and herself as a "sinner who nearly killed her mother." Sister B described her mother tucking her in at night and smelling her fingers to be certain her daughter was not "in the devil's box (masturbating)." When Sister B was age 12 years, her mother caught her talking to a neighbor boy and pulled her away, identifying the "putrid odor of sin." The mother took an overdose of her medication and nearly died. While praying for her mother to recover, she had a vision of the "Virgin, who told me to cleanse myself." She scrubbed her vaginal area with harsh laundry soap, (causing strictures of the urethra), then boiled water to pour over her vaginal area, burning her hand. Now, as a 47-year-old woman on vacation, Sister B and the other woman kissed. The evaluators concluded that Sister B had not made a suicide attempt but had had a brief psychotic episode (within a schizotypal personality structure) shaped by her early development and adult isolation and triggered by the intimate encounter.

The Rorschach test, by itself, does not establish a diagnosis but can reveal areas of neurotic conflict. Other projective tests work in the same way, opening avenues for exploration. But overinterpretation of projective test results erodes the accuracy and credibility of the evaluator's opinion, especially in forensic work. Projective testing experts who have great success in clinical arenas face different challenges in forensic assessments, where the *Daubert* standard does not recognize lone practitioners who have unique mastery of a test. The requirements of peer agreement and specified error

rates preclude acceptance of projective tests as the primary source of a psychological opinion. The tests are more effective in a supportive role, directing further exploration or offering clarifying anecdotes.

Neuropsychological Tests

In the period from the 1940s through the 1980s, projective testing and research flourished. But, currently, interest has shifted to the study and assessment of the human brain. Corresponding to neuroimaging studies, neuropsychological testing has grown in sophistication and popularity. It is a subspecialty that requires postdoctoral specialization. The focus of neuropsychological testing is assessment of brain and nerve impairment identified through behavioral assessment as well as the provision of prognostic and practical information about recovery.

Neuropsychological tests identify specific brain dysfunctions and allow the examiner to analyze the factors that result in disruptive behaviors such as impulsivity, concentration deficits, and aggression. In forensic assessments, neuropsychological tests are most frequently employed in disability assessments after head trauma. The specialized testing can also complement cognitive and personality assessments in criminal cases that include an unexpected decline in function, chronic drug or alcohol use, or a history of head trauma.

Neuropsychological testing requires a battery of tests that includes cognitive testing. The most common are the Halstead-Reitan Battery (Broshek and Barth 2000; Reitan and Wolfson 1993) and the Luria-Nebraska Neuropsychological Battery (Golden et al. 1982, 2000; see also Golden and Freshwater 2001), which are made up of individual tests to measure systematically discrete brain function. Eight tests comprise the Halstead-Reitan Battery, which assesses the severity of general brain damage, as well as specific brain areas of dysfunction (Broshek and Barth 2000). Complete neuropsychological batteries include cognitive and memory testing in addition to specific brain function tests.

Independent tests of brain function can be combined into different batteries based on the type of injury and the problems that are presented. In *A Compendium of Neuropsychological Tests,* Strauss and colleagues (2006) present a comprehensive description of various tests and highlight their uses, psychometric properties, and strengths and limitations. A common test employed in screening for neuropsychological deficits is the Categories Test (in the Halstead-Reitan Battery), which is used to evaluate general brain dysfunction (Broshek and Barth 2000; Strauss et al. 2006). The Stroop Test, which has been popularized as a game for brain development, was developed

by John Ridley Stroop to assess interference in verbal processing (Golden and Freshwater 2002). It involves three tasks: naming the color of dashes that appear in only three colors, reading the repeated list of the names of those colors printed in black ink, and, finally, naming the color of ink in which the list of the three color words is printed. The scoring is the differential in performance across the three tasks. The test is used in conjunction with other screening tests and shows potential for assessing the role of impulsivity versus distraction in adults with attention deficit disorder.

The Rey-Osterrieth Complex Figure Test (Meyers and Meyers 1995) and the Draw-a-Clock Test (Freedman et al. 1994) are other screening tests that identify general brain dysfunction. Abnormal findings on either of these tests should be followed by a neurological examination and a full neuropsychological battery to determine the extent and severity of the disorder. These tests can also help to distinguish among diagnoses of cognitive deficiency, dementias, and psychoses.

Memory Assessments

Tests for memory are included as part of neuropsychological batteries and cognitive batteries. In forensic psychiatry, assessment of memory and of feigned memory impairments are required in both civil and criminal cases. For example, when a defendant reports no recollection of an alleged criminal behavior, a referral to assess memory is often the primary request. Memory assessments include a standard battery of discrete tests to assess verbal, figural, and association memory as well as immediate and intermediate memory. The most common memory battery is the Wechsler Memory Scale—4th Edition (Pearson Education 2008). The Rey-Osterrieth Complex Test is also commonly included. The distinction between immediate and intermediate memory is important in understanding memory deficit etiology and treatment. Immediate memory is a loose term for the incorporation of information into awareness. In a mental status examination, immediate memory is also termed "registration," referring to the client's ability to repeat words when they are spoken. Intermediate memory is the capacity to retrieve stored material. Long-term memory is hard to assess in a testing session, because insufficient time has passed; usually, long-term memory is assessed, crudely, through the report of past history.

Memory assessments cannot measure the effects of past interference on either short-term or intermediate memory. For example, in one case, a college student who had been drinking heavily got into a fist fight at a bar and

severely beat another patron. He had spotty recollections of the evening, but no organized recall of the fight and no recall of why he was fighting or what he thought at the time. Memory testing on the young man revealed above-average recollection on both immediate and intermediate memory. The results of the testing had limited bearing on the psychiatrist's report except to determine that the student did not have a primary memory deficit and did not malinger memory deficits. The normal memory did not preclude a blackout (Hartzler and Fromme 2003), and the lack of malingering did not ensure he was truthful about his lack of recall.

In a general way, memory assessments show effects of attention and concentration deficits, obsessive intrusions, psychosis, dementia, and brain dysfunction. The tests are most helpful in determining differential impairments between verbal and figural memory and in making recommendations for improving recall. In forensic work, memory assessments could be useful in designing restoration-to-competency curricula for those with memory loss.

Psychological Assessment of Malingering

Assessment of malingering is a frequent referral question for psychological testing. Unfortunately, malingering has become a shorthand term for willful falsification of physical or psychological information about the self. One result is confusion in referral questions to the forensic expert and in reports by the experts when the examinee has presented invalid information. For example, immigration clients seeking asylum have been referred for a "malingering assessment" when, in an asylum interview, they report "more trauma than their demeanor shows." In another example, a candidate for a government position was turned down because the client "had malingered by faking good on the psychological testing."

The arena of false representation is complicated with overlapping categories. Rogers (2008) and Rogers and Resnick (2001) provide practical and theoretical frameworks for assessing false reporting. Figure 23–1 contrasts different categories of false presentations in relationship to the dimensions of willfulness (conscious to unconscious) and source of motivation (extrinsic to intrapsychic). On one end of these continua are willful feigning of psychotic symptoms for secondary gain (e.g., to avoid prosecution) and willful faking-good on psychological testing for obvious gain (e.g., acceptance to a

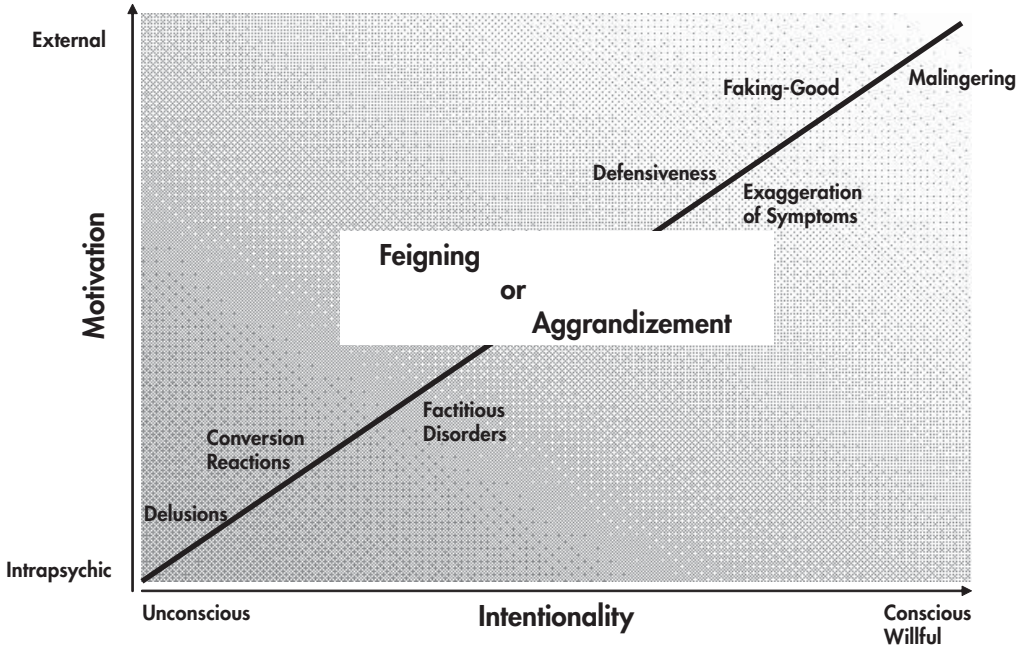

FIGURE 23–1. Intentional and motivational factors in relation to false reporting.
Shading indicates severity of psychopathology.

police academy). Both are conscious lying to gain obvious external benefit, but only the first is malingering. On the other end of the continua are conversion reactions, factitious disorders, delusions, and defensiveness, in all of which misrepresentation is unconscious, motivated by internal and often unrecognized gains. Psychiatric disorders contribute to this type of misrepresentation.

In forensic work, the identification of malingering has particular significance. The *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition, Text Revision (DSM-IV-TR; American Psychiatric Association 2000), advises that malingering be "strongly suspected" (p. 739) if any combination of four conditions is present. The first is an examination in the medicolegal context, thus covering nearly all forensic evaluations. The others—a notable discrepancy between the person's report of symptoms and impairment and the objective facts, lack of cooperation in the evaluation and noncompliance with treatment, and presence of antisocial personality disorder—are also found frequently in forensic evaluations.

The importance of the evaluation of malingering notwithstanding, its assessment is complicated and requires the triangulation of data from a comprehensive clinical assessment, psychological testing, and reliable collateral information. Indeed, even the definition of malingering contributes to controversy. DSM-IV-TR identifies the two essential components of malingering as first, the "intentional production of false or grossly exaggerated physical or psychological symptoms" (p. 739), and second, the goal to achieve "external incentives, such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (p. 739). Where factitious disorders are motivated by intrapsychic dynamics (e.g., maintaining the sick role, gaining acceptance through sympathy), the secondary gain in malingering is obvious to the lay observer. However, these criteria do not clarify complex cases in which idiosyncratic presentations and extreme situations confound the categories. In many of these cases, psychological testing can establish feigning (reporting symptoms not present or grossly exaggerating them), the first prong of malingering, but cannot establish the motivation without the contextual analysis.

For example, a 22-year-old man was incarcerated, pretrial, on assault charges for beating two men during a drug deal. A competency-to-stand-trial evaluation was ordered after the young man reported to the jail clinician that he was going to kill himself because voices were telling him to "see God." He would not discuss his case with his attorney, who reported that "the man is talking to himself and laughing." The psychiatrist evaluated the man and found his report of symptoms not credible. Although he had attended some special education classes in high school, he had no psychiatric history and no evidence of a psychiatric disorder at the time of his arrest. Psychological

testing indicated that the young man was of low-average intelligence and was feigning psychosis. However, establishing that he was feigning, even malingering, did not answer the competency questions regarding appreciation of the nature of the proceedings and capacity to assist in his defense. When asked what the best outcome for his case would be, the defendant identified assignment to the "mental health prison" and indicated that he would plead guilty if he could stay in the mental health jail and/or segregation. Confronted with the suspicion that he was feigning symptoms and therefore uncooperative, he became genuinely distraught, explaining that he feared for his life in jail. He believed that rival gang members would retaliate against him for the assault on their members. The forensic psychiatrist concluded that his feigning of symptoms was protective and not malingered. She decided that because the defendant had demonstrated the capacity to learn and was inclined to accept the deal that his attorney recommended, any reference to malingering would be unnecessarily pejorative and unwarranted. Although other experts may have decided differently, the case demonstrates that in forensic evaluations the finding of malingering requires more than the determination of the validity of symptoms.

Psychological Tests for Malingering

Malingering tests, more properly termed *feigning tests* (Table 23–1), are specific psychological tests used to assess the credibility of symptoms and disabilities. There is no psychological test for global malingering; tests are designed to assess the quality and the nature of symptoms in reference to usual manifestations of illness. They are designed around the assumptions that each major mental disorder has common presentations of major signs and symptoms and that the severity of the illness will have concomitant manifestations in function. Tests for feigning target specific areas that correlate with the presented symptoms. The following table presents tests frequently used in forensic evaluations.

In addition to the specific tests for malingering, all psychological tests require some way to determine the validity of the test results. The assessment of feigning, cooperation and effort, and social desirability (on personality tests) is built into testing protocols. Indeed, cognitive and neuropsychological tests are in themselves effective tests of feigning. For example, the Wechsler series of cognitive tests provide information on effort and on faking deficits (Pope 2009a, 2009b), particularly when test results are compared to collateral data, such as school performance and employment history. Even

TABLE 23–1. Common tests for feigning psychiatric impairments

Test	Target	Procedure	Advantages	Limitations
Miller Forensic Assessment of Symptoms (M-FAST; Miller 2001)	General malingering	Face-to-face mental-status format	Short Easily administered and incorporated in clinical exam	Requires cooperation Risk of false positives in unusual or guarded presentation
Structured Interview of Reported Symptoms (SIRS; Rogers 1992; Rogers et al. 2002)	Feigned psychosis	Face-to-face structured interview	Strong psychometric properties Score includes assessment of quality of symptoms Useful in identifying cultural differences in psychosis Established as a court-accepted test	Lengthy assessment Training for administration preferred Complex scoring Most reliable in English or Spanish
Test of Memory Malingering (TOMM; Tombaugh 2009)	Feigned memory deficit	Face-to-face administration with booklets of simple line drawings	Strong psychometric properties No language or literacy requirement Useful in cross-cultural work	Overestimates feigning in ADD No norms established for those with PTSD

TABLE 23–1. Common tests for feigning psychiatric impairments *(continued)*

Test	Target	Procedure	Advantages	Limitations
Validity Indicator Profile (VIP; Frederick 1997)	Lack of effort Feigned cognitive deficit	Pencil-and-paper test Vocabulary and geometric subtests	Computer scoring Strong psychometric properties Report includes estimate of range of IQ Literacy and language requirement for only one subtest Distinguishes between deception and careless responding	Limited usefulness with developmentally disabled Lengthy test Modest refusal rate

Note. ADD = attention-deficit disorder; PTSD = posttraumatic stress disorder.

without collateral data, the presentation of the person offers data with which to compare the test results.

On cognitive and neuropsychological tests, faking-good is not possible. Because the tests are objectively scored, a person cannot perform beyond the limits of his or her own ability. On personality assessments, however, faking-good and feigning symptoms are both threats to the validity of the results. Personality tests have built-in scales for assessing defensiveness and social desirability, as well as the exaggeration and feigning of symptoms. These scales are used to determine the validity of the tests and represent a measure of confidence the examiner has in the results. For example, when the validity scales on the MMPI-2 indicate a defensive response pattern, the results suggest that the client denied the distress and difficulty that most people often have. Perhaps the client answered "false" to the statement: "I sometimes get angry enough to say something I would regret." A defensive profile weakens the reliability of those scales that measure depression, anxiety, and psychosis, and so test results are likely not an accurate representation of the personality structure. Similarly, if someone exaggerates symptoms or reports many unusual ones, the validity of the test is undermined.

The validity scales of the structured personality tests (e.g., MMPI-2, MCMI-III, PAI) cannot by score alone identify feigning or faking-good. The scores require interpretation by the examiner with knowledge of the context and testing situation. The standard computer scoring programs, accepted by the courts, identify invalid testing results but do not give a reason for them. Tests can be invalid for a number of reasons not related to faking. Low reading ability, frank psychosis, and cultural barriers are the most common reasons for invalid results. Another major source of error comes from inaccurately filling in the computer answer sheet. Of course, these sources (low reading ability, psychosis) of inaccurate results should be addressed before the test is administered, but they are not always considered. In no case should malingering or faking-good be considered the default interpretation.

Clarifying and Reporting Malingering in Testing Results

In psychological assessments, invalid test results do not constitute a useful finding and often could be unduly prejudicial. Knowing, for example, that someone faked cognitive impairment does not provide information about true cognitive ability. Unless the faking is markedly masterful or markedly

clumsy, the results have little to offer. Although psychologists differ in opinion on how to address and report invalid results, the approach most useful and ethical in forensic evaluations is one that provides feedback to the client. Through gentle confrontation, the questionable results should be described along with supporting data and an offer "to start again" with different equivalent tests. Confrontation is easier with psychological test results than within a clinical interview. In such instances, the scores are removed from the interaction: a computer or manual declares the test invalid—the psychologist is just the messenger. When feigning is identified on psychological tests, the etiology must be identified. With collaborative data and other testing, the likelihood of each explanation should be considered. Explicating the reasoning provides the foundation for an opinion of feigned symptoms but cannot establish malingering, which requires a contextual analysis that establishes willful manipulation toward an extrinsic goal.

A caveat concerns the relationship between the validity of psychological testing results and the forensic question. Valid test results do not establish truth about the incident, just as malingered test results do not establish lying. The validity of testing results informs the interpretation of the tests. If the tests are valid, the conclusions are reliable; if the tests are invalid, conclusions based on them are suspect. There is, of course, some overlap; a person who feigns psychotic symptoms on the Structured Interview of Reported Symptoms may be likely to fake symptoms in a clinical interview. But the Structured Interview of Reported Symptoms cannot reliably establish the person as a liar. Similarly, valid psychological tests cannot confirm the person as a truth teller.

Testing Procedures

Psychological tests have specific administration and scoring procedures, and in forensic assessments adherence to the standard methods is paramount. General procedural requirements apply across all tests:

1. *All tests are administered face-to-face; no tests go home; all self-report questionnaires are completed under observation.* The integrity and interpretation of psychological tests depend on the novelty to and the independent answers of the test taker. Psychologists are required to protect the tests. In forensic assessments, the chain of custody of the tests is critical to the validity of the report. For example, if the examinee takes the test home, the expert cannot be certain that the answers are from the examinee. Even if the examinee is left in a separate room to take the test, there can be contamination of the results unless the examiner makes certain that

the person answers all questions unaided. With current technology, direct observation is even more important. In one case, a psychiatrist administered the MMPI-2 to the client who, alone in the room, used his cell phone to ask for help with the questions from his brother.

2. *Tests are scored according to protocol and standard computer scoring, not homemade computer programs.* Standard psychological tests have detailed scoring rules, and conversion of raw scores has been computerized for many tests. The computer scoring program is usually available at extra cost from the vendor authorized to sell the test. These programs are considered standard and, therefore, are the easiest to defend in court. Nonstandard computer scoring programs should not be used in forensic assessments; their reliability and validity have usually not been established and peer reviewed.
3. *Tests are administered in a battery, never alone—especially in forensic cases.* Because no one test can explain behavior or the complex questions raised in forensic matters, testing always revolves around the functional question. Two examples: an assessment of cognitive function includes more than the IQ test and will also assess effort and perhaps achievement. The administration of the MMPI-2 or MMPI-2-RF will produce a score, but in the absence of a clinical interview and history, the interpretation of the test will be uncertain. No opinion can be justified on the basis of one test.

Psychiatric-Psychological Collaboration

The forensic psychiatrist-psychologist team can be an effective unit for forensic assessments. Choosing a psychologist is similar to choosing any other specialist in circumstances for which qualifications, collegiality, and appreciation of forensic issues are desired. Minimally, the psychologist must be licensed in the state where the evaluation will be conducted and, preferably, have diplomate status granted by the American Board of Professional Psychology. The diplomate in psychology is not the same as someone who has a board qualification in medicine; licensure is sufficient to practice, but diplomate status is afforded only after expertise is demonstrated. An effective collaboration between psychiatrist and psychologist depends on the appreciation of forensic work, particularly on the understanding that results of the testing must be relevant and understandable in a legal arena. The psychia-

trist can ask for past (redacted) reports by the psychologist to get an idea of what to expect. Recommendations from other experts are also helpful.

A framework to build effective collaboration includes ongoing communication, as seen in these six steps (Campbell and Baranoski 2008):

1. *Formulation of the referral question.* Why is testing requested? What are the areas that raise evaluation issues: cognition, psychosis, malingering?
2. *A review of what testing can offer and possible results.* This step is critical. Unless the psychiatrist is already familiar with the psychologist's work and reports, an early discussion about how the psychiatrist works, the fee schedule, and the organization of the report will avoid later conflict and confusion. The two-way consultation can also reframe the pertinent question. For example, in the case of a drug deal in which the buyer shot the seller and claimed that the seller was out to get him (despite witnesses to the contrary), the psychiatrist asked for psychological testing "to show that the man was lying." Because psychological tests cannot explain one moment in the past, the request was reframed through consultation: does the man have any disturbance in thinking; does he feign on psychological testing? How might those findings be related to the alleged criminal behavior? The psychiatrist decides how to incorporate the psychological testing results into the formulation.
3. *Provision of collateral data and clinical impressions to the psychologist.* Some psychologists review data before meeting the client; others prefer a meeting first. The psychologist must know the legal parameters of the case (e.g., is the testing at the behest of the defense or prosecution?) to determine how to introduce the testing and whether it is confidential or not. In order to complete a psychological assessment, the psychologist must conduct a clinical interview, collecting history of early development, education and employment, and head trauma and physical illness that may impact test results, as well as medication, social circumstances, and current function. Tests can be administered in a vacuum, but they cannot be interpreted without background data.
4. *Choice of tests made by the psychologist.* When psychiatrists or attorneys dictate to the psychologist what tests to perform, they hobble the usefulness and credibility of the evaluation. The referrer asks the question; the psychologist chooses and then defends the methods to answer it. In one case, a psychiatrist asked a psychologist to administer the MMPI-2 in a criminal defense case, "just to show he is not psychotic." The psychologist summarized the computerized report, which indicated the defendant was defensive, with paranoid and antisocial characteristics. Without further testing and a clinical evaluation, the validity of the results was indeterminable, complicating rather than clarifying the psychiatric assessment. The

psychologist erred by not clarifying the risk of a one-test assessment. Another common example concerns death penalty cases in which defense attorneys at sentencing request an assessment for mitigation. A practice growing in frequency is to instruct the psychologist not to administer the MMPI-2 because of the risk that it will show antisocial characteristics. The psychologist in that situation has the obligation to identify the risk of excluding a particular test at the attorney's request.

5. *Discussion of results before writing a report*. The psychologist usually writes an independent report, but a discussion of the results with the psychiatrist, who has additional clinical and forensic data, will help the psychologist frame the validity and applicability of the results. In some cases, the discussion will result in further testing.
6. *Reconciling of discrepancies*. When results of psychological testing conflict with the psychiatric formulation, the psychiatrist and psychologist work together to explain the discrepancy. Valid results cannot be ignored out of hand. Such an approach will leave the psychiatrist vulnerable on cross-examination. A discussion in both reports concerning the discrepancy is more effective.

The more explicit the communication about the role of the psychologist in the case, the smoother the collaboration will be. A contract in the form of a letter can clarify the question, method of payment, expectations about the report (separate reports or the psychological testing report included in the psychiatric report), and expectations about testimony. If the psychiatrist writes the letter and does the hiring, then contact between the attorney and psychologist may be minimal. However, if the psychologist is hired by the attorney as a second or adjunct expert, then communication between the attorney and psychologist will occur. In that case, three-way meetings (psychiatrist, psychologist, and attorney) can reduce confusion and conflict.

Psychologists practice under ethical and practice guidelines that address assessments, reporting, testifying, remuneration, and collaboration. These guidelines are available through the American Psychological Association.

Common Pitfalls in Psychological Testing

As useful as psychological testing can be in case formulations, the testing can create substantial difficulties when misapplied, especially in forensic sit-

uations. Three of the most common errors in forensic psychological assessments are a lack of testing coherence, overtesting, and novel testing.

Lack of Coherence

There is a routine to assessments in the order and type of tests administered. When followed, that routine can help to ensure a coherent and meaningful report. A lack of coherence occurs when the report presents the result of one test as contrary to the result of another without reconciliation. Consider this example: in a presentence evaluation, the psychologist described a 24-year-old man in federal court on charges of participating in narcotics distribution as "extremely low in cognitive function with an IQ of 65" and as "faking symptoms on the MMPI-2." These findings are contradictory and uninformative—either the man had feigned cognitive deficits or he should not have been administered the MMPI-2, which requires a level of reading comprehension precluded by such a low IQ. The report, as it stands, is useless to the psychiatrist and to the court. Although conflicting results do occur in the testing, further testing, more collateral data, and colleague consultation can resolve the dilemma. If not, the conflict must be acknowledged and discussed.

Overtesting

Overtesting occurs in two ways: 1) through administration of redundant tests and 2) by testing when there is no question being raised. An example of the first is administration of tests that address the same question in different ways—for example, administering two different IQ tests when the first was seen as valid. More common is the administration of two similar standard tests, such as the MMPI-2 and the PAI. Although the tests are similar, they provide different narrative and scales. If the goal is to raise clinical hypotheses, fishing for different perspectives can be productive. But in forensics, varying results muddy opinions and erode credibility. Even when differences across tests are not clinically relevant, variation in wording can distract attention from the conclusion.

The second form of overtesting is more problematic. When there is no question for psychological testing to answer, testing should not be done. Testing conducted to demonstrate the lack of a disorder is particularly risky. If the psychiatrist asks for testing so that he or she can be certain that nothing is missed, then the testing is appropriate. But if the psychiatrist is comfortable with the finding of no diagnosis, administering tests raises the possibility of a finding that will complicate the forensic work.

Case Vignette 5

Ms. M, 28 years old, diagnosed with borderline personality disorder, shot and killed her boss and his wife, then hanged herself. She was rescued and on a respirator in a vegetative state for over a year. After 5 years, she was quadriplegic and her speech was slurred. Despite her impairments, she volunteered to work with people with disabilities. She got a scholarship to attend a community college where she was studying social work aided by a voice-activated computer system. The prosecutor, who had lost track of her after caregivers assured him she would never recover, reopened the double murder case after she appeared on a television news story that highlighted her perseverance. Ms. M had an understandable amnesia for the homicides but was also unexpectedly unable to learn about her charges or the proceedings against her. The court ordered a competency-to-stand-trial evaluation. The psychiatrist assessed her as malingering her current deficits and then ordered psychological testing. Not surprisingly, the neuropsychological battery showed significant bilateral deficits. Because psychological testing identifies strengths and specific deficits, it is designed not to show accommodation. Despite her brain trauma, she showed collective functioning that surpassed the specific impairments. In this case, testing complicated the conclusion. The collateral data—her attendance at school, her mastery of subject matter, and her recall of material to pass tests—was directly relevant to the tasks of competency. She was found incompetent, but when committed to a psychiatric hospital for restoration, she quickly informed her attorney that she would accept the plea offer. The psychiatrist's opinion had been validated. The psychological testing had obfuscated the functional capacity that was directly relevant to competency.

Novel Testing

Post-*Daubert*, the use of new tests or new twists on old tests has diminished but still occurs. Novel testing is not erroneous per se, even when the new tests have not successfully met a *Daubert* examination. Over time, new tests establish precedent of use that makes them part of standard testing. New tests do run the risk, if *Daubert* is raised, of being rejected (*State of Connecticut v. Cyrus Griffin* 2005). So many factors influence the decision to grant a *Daubert* hearing that even meritorious and reasonable tests can be scrutinized. Deciding to use a new test requires a cost-benefit analysis: what will the test add against the cost of a *Daubert* challenge defeat?

Case Vignette 6

In a civil suit against a dental clinic, a 37-year-old woman maintained that she had posttraumatic stress disorder secondary to an event 5 years earlier when, 8 weeks pregnant, she contracted hepatitis C during a tooth extraction. Earlier that day, she and her husband had seen the first ultrasound of

the fetus. In the dental office, her husband overheard a commotion about a broken sterilizer. Titers showed that she converted from negative to positive. Four years later, she presented with psychiatric symptoms of panic attacks. She sued the dental clinic. The psychiatrist hired by the couple's attorney viewed her reaction as posttraumatic stress disorder, even though it did not meet the stringent DSM-IV-TR criteria—she did not witness or experience a near-death experience. Her husband had withheld information about the contamination for over a week. She had no flashbacks but had experienced a strong sense of doom. The defense argued that she had always had adjustment problems, based on a history of depression after a previous miscarriage.

On structured inventories in psychological testing, she obtained a profile of posttraumatic stress disorder, depression, and obsessive-compulsive and avoidant traits. In order to substantiate his opinion that the dental event changed her sense of competency and safety in the world, the psychiatrist administered the Attributional Style Questionnaire, developed by Peterson and colleagues (1982), and the World Assumptions Scale by Janoff-Bulman (1992). The results supported his opinion that the exposure to hepatitis from contaminated instruments created a shift in the woman's worldview: on a happy day in her life, when she finally had a healthy pregnancy, she contracted a life-threatening disease at a dentist's office; if a dentist's office is that dangerous, then the rest of the world can never be safe. In a *Daubert* hearing, the defense challenged the use of the two scales as research tools, standardized on college students and not used in posttraumatic stress disorder litigation. The judge ruled for the defense and rejected all of the testing, concluding that the two scales were central to the conclusion. However, the plaintiff's attorney used the psychologist's narrative in closing arguments. The jury found for the plaintiff. The common-sense presentation, that is, the "folk tale" (Morris) that resonated with the jury, succeeded where the formal testing had failed.

Conclusion

Psychological testing is a valuable adjunct to forensic psychiatric assessments. Standard tests, through research, have established psychometric properties that can meet a *Daubert* challenge. Offering an objective source of data, testing can aid in diagnostic and functional assessments for all phases of criminal and civil proceedings. Testing is a specialty of the field of psychology, supported by science. Clear formulation of the forensic question, careful selection of the tests, strict adherence to administration, scoring, and

ethics, and research-backed interpretation maximize the applicability and success of psychological testing in the courts. A successful collaboration between the forensic psychiatrist and psychologist offers a convergence of expertise in analysis and formulation of complex cases. As long as the limitations of testing are recognized, psychological testing has a place in the legal arena.

Key Points

- Valid psychological tests have psychometric properties determined by research, including reliability, validity, and generalizability.
- Testing aids in formulation of cases and supports the psychiatric opinion.
- Psychological assessments involve batteries of tests; no opinion can be based on a single test.
- On its own, psychological testing can never explain a single episode of behavior.
- Collaboration between the psychiatrist and psychologist maximizes the benefits of psychological testing in forensic cases.

Practice Guidelines

1. Identify the need for psychological testing based on inconsistency in data, testing by the opposing side, and diagnosis of cognitive deficiency or malingering.
2. Choose a licensed psychologist with forensic expertise based on colleague recommendations and a review of testing reports.
3. Review forensic and diagnostic questions with the psychologist, and in collaboration conduct a cost-benefit analysis of testing.
4. Establish a contract that clarifies expectations for the report, consultation with the attorney, testimony, and reimbursement.
5. Provide collateral data and clinical information to the psychologist.
6. Review testing results with the psychologist before a report is written.
7. Reconcile inconsistencies between the psychological and psychiatric opinions.

8. Meet with legal client and psychologist together to discuss the results and opinions before the final report is submitted.
9. In using tests, adhere to rules for administration, scoring, and interpretation. Use only standard computer scoring packages, available through authorized vendors.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000

Arbisi PA, Butcher JN: Failure of the FBS to predict malingering of somatic symptoms: response to critiques by Greve and Bianchini and Lees-Haley and Fox. Arch Clin Neuropsychol 19:341–345, 2004

Arbisi PA, Ben-Porath YS, McNulty J: The ability of the MMPI-2 to detect feigned PTSD within the context of compensation seeking. Psychol Serv 3:249–261, 2006

Atkins v Virginia, 536 U.S. 304 (2002)

Baer RA, Miller J: Underreporting of psychopathology on the MMPI-2: a meta-analytic review. Psychol Assess 14:16–26, 2002

Bagby RM, Marshall MB: Assessing underreporting bias on the MMPI-2. Assessment 11:115–126, 2004

Ben-Porath YS, Tellegen A: Minnesota Multiphasic Personality Inventory–2—Restructured Form: Manual for Administration, Scoring, and Interpretation. Minneapolis, University of Minnesota Press, 2008a

Ben-Porath YS, Tellegen A: Minnesota Multiphasic Personality Inventory-2 Restructured Form: User's Guide for Reports. Minneapolis, University of Minnesota Press, 2008b

Broshek DK, Barth JT: The Halstead-Reitan Neuropsychological Test Battery, in Neuropsychological Assessment in Clinical Practice: A Guide to Test Interpretation and Integration. Edited by Groth-Marnat G. New York, Wiley, 2000

Brown L, Sherbenou RJ, Johnsen SK: Test of Nonverbal Intelligence, 3rd Edition. San Antonio, TX, Pearson, 1997

Burns RC: Kinetic-House-Tree-Person Drawings (K-H-T-P): An Interpretive Manual. New York, Brunner/Mazel, 1987

Burns RC, Kaufman SH: Actions, Styles and Symbols in Kinetic Family Drawings (K-F-D): An Interpretive Manual. New York, Brunner-Routledge, 1972

Butcher JN, Arbisi PA, Atlis MM: The construct validity of the Lees-Haley Fake Bad Scale: does this measure somatic malingering and feigned emotional distress? Arch Clin Neuropsychol 18:473–485, 2003

Butcher JN, Gass CS, Cumella E, et al: Potential for bias in MMPI-2 assessments using the Fake Bad Scale (FBS). Psychological Injury and the Law 1:191–209, 2008

Campbell WH, Baranoski MVB: Psychological testing for forensic psychiatrists. Presented at the 39th annual meeting of the American Academy of Law and Psychiatry (AAPL), Seattle WA, October 2008

Daubert v Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993)

Exner JE: The Rorschach: A Comprehensive System, Vol 1: Basic Foundations. New York, Wiley, 1995

Franklin K: In the News, 2009. Available at: http://forensicpsychologist.blogspot. com/.

Frederick RI: Validity Indicator Profile Manual. Minneapolis, MN, National Computer Services, 1997

Freedman M, Leach L, Kaplan E, et al: Clock Drawing: A Neuropsychological Analysis. New York, Oxford University Press, 1994

Frye v United States, 293 F. 1013 (D.C. Cir. 1923)

Golden CJ, Freshwater SM: Luria-Nebraska Neuropsychological Battery, in Understanding Psychological Assessment: Perspectives on Individual Differences. Edited by Dorfman WI, Hersen M. New York, Klewer Academic/Plenum, 2001

Golden CJ, Freshwater SM: The Stroop Color and Word Test: A Manual for Clinical and Experimental Uses. Wood Dale, IL, Stoelting, 2002

Golden CJ, Hammeke TA, Purisch AD, et al: Item Interpretation of the Luria-Nebraska Neuropsychological Battery. Lincoln, University of Nebraska Press, 1982

Golden CJ, Freshwater SM, Vayalakkara J: The Luria-Nebraska Neuropsychological Battery, in Neuropsychological Assessment in Clinical Practice: A Guide to Test Interpretation and Integration. Edited by Groth-Marnat G. New York, Wiley, 2000

Goodenough F: A new approach to the measurement of intelligence of young children. J Genet Psychol 33:185–211, 1926

Handler L, Habenicht D: The Kinetic Family Drawing technique: a review of the literature. J Pers Assess 62:440–464, 1994

Harris DB: Children's Drawings as Measures of Intellectual Maturity: A Revision and Extension of the Goodenough Draw-a-Man Test. New York, Harcourt Brace & World, 1963

Hartzler B, Fromme K: Fragmentary and en bloc blackouts: similarity and distinction among episodes of alcohol-induced memory loss. J Studies on Alcohol 64:547–550, 2003

Hathaway SR, McKinley JC: Minnesota Multiphasic Personality Inventory, 2nd Edition. Minneapolis, University of Minnesota Press, 1989

Heilbrun K: The role of psychological testing in forensic assessment. Law Hum Behav 16:252–272, 1992

Holmstrom RW, Silber DE, Karp SA: Development of the Apperceptive Personality Test. J Pers Assess 54:252–264, 1990

Janoff-Bulman R: Shattered Assumptions: Toward a New Psychology of Trauma. New York, Free Press, 1992

Jastak J, Wilkinson G: Wide Range Achievement Test—Revised. Wilmington, DE, Jastak Associates, 1984

Lewis DO, Pincus JH, Bard B, et al: Neuropsychiatric, psychoeducational, and family characteristics of 14 juveniles condemned to death in the United States. Am J Psychiatry 145:584–589, 1988

Machover K: Personality Projection in the Drawing of the Human Figure: A Method of Personality Investigation (1948). Springfield, IL, Charles C Thomas, 1980

Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007

Meyer BC, Brown F, Levine A: Observations on the House-Tree-Person drawing test before and after surgery. Psychosom Med 17:428–454, 1955

Meyers JE, Meyers KR: Rey Complex Figure Test and Recognition Trial. Lutz, FL, PAR, 1995

Miller HA: Miller Forensic Assessment of Symptoms Test (M-FAST): Professional Manual. Odessa, FL, Psychological Assessment Resources, 2001

Millon T: Millon Clinical Multiaxial Inventory–III. Minneapolis, MN, National Computer Systems, 1994

Morey LC: The Personality Assessment Inventory Professional Manual. Lutz, FL, Psychological Assessment Resources, 2007

Nelson NW, Sweet JJ, Demarkis GJ: Meta-analysis of the MMPI-2 Fake Bad Scale: utility in forensic practice. Clin Neuropsychol 20:39–58, 2006

Pearson Education: Wechsler Memory Scale, 4th Edition. San Antonio, TX, Pearson Education, 2008

Peterson C, Semmel A, Von Baeyer C, et al: The Attributional Style Questionnaire. Cognit Ther Res 6:287–300, 1982

Pope K: Malingering research update. Available at: http://kspope.assess/malinger.php. Accessed September 2, 2009a.

Pope K: Malingering research update—part 2. Available at: http://kspope/assess/malinger-2.php. Accessed September 2, 2009b.

Rapaport D, Gill M, Schafer R: Diagnostic Psychological Testing, Vol 1. Chicago, IL, Year Book Publishers, 1945

Reitan RM, Wolfson D: The Halstead-Reitan Neurological Test Battery: Theory and Clinical Interpretation, 2nd Edition. Tucson, AZ, Neuropsychology Press, 1993

Rogers R: Structured Interview of Reported Symptoms. Odessa, FL, Psychological Assessment Resources, 1992

Rogers R: Clinical Assessments of Malingering and Deception. New York, Guilford, 2008

Rogers R, Resnick PJ: Malingering and Deception: The Clinical Interview. New York, Guilford, 2001

Rogers R, Bagby M, Dickens SE: Structured Interview of Reported Symptoms. Lutz, FL, Psychological Assessment Resources, 2002

Roid GH: Stanford-Binet Intelligence Scale, 5th Edition. Rolling Meadows, IL, Riverside, 2002

State of Connecticut v Cyrus Griffin, 869 A.2d 640 (Conn. 2005)

Strauss E, Sherman EMS, Spreen O: A Compendium of Neuropsychological Tests. New York, Oxford University Press, 2006

Tellegen A, Ben-Porath YS: Minnesota Multiphasic Personality Inventory–2—Restructured Form Technical Manual. Minneapolis, University of Minnesota Press, 2008

Tombaugh TN: Test of Memory Malingering. Princeton, NJ, Pearson Education, 2009

Wechsler D: Wechsler Memory Scale, 3rd Edition. Princeton, NJ, Pearson Education, 1997

Wilkinson GS, Robertson G J: Wide Range Achievement Test 4: Professional Manual. Lutz, FL, Psychological Assessment Resources, 2006

Woodcock RW, McGrew KS, Mather N: Woodcock-Johnson Tests of Achievement–III. Published electronically, Riverside Publishing, 2001

Suggested Readings

Ben-Porath YS, Tellegen A: Minnesota Multiphasic Personality Inventory–2—Restructured Form User's Guide for Reports. Minneapolis, University of Minnesota Press, 2008

Heilbrun K: The role of psychological testing in forensic assessment. Law Hum Behav 16:252–272, 1992

Larabee GJ: Detection of symptom exaggeration with the MMPI-2 in litigants with malingered neurocognitive dysfunction. Clin Neuropsychol 17:54–68, 2003

Markon KE, Krueger RF, Watson D: Delineating the structure of normal and abnormal personality: an integrative hierarchical approach. J Pers Soc Psychol 88:139–157, 2005

Melton GB, Petrila J, Poythress NG, et al: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd Edition. New York, Guilford, 2007

Pope K: Malingering research update. Available at: http://kspope.com/index.php. Accessed September 9, 2009.

Pope K: Malingering research update—part 2. Available at: http://kspope.com/index.php. Accessed September 9, 2009.

Rogers R: Clinical Assessments of Malingering and Deception. New York, Guilford, 2008

Rogers R, Dolmetsch R, Wasyliw OE, et al: Scientific inquiry in forensic psychiatry. Int J Law Psychiatry 5:187–203, 1982

Strauss E, Sherman EMS, Spreen O: A Compendium of Neuropsychological Tests. New York, Oxford University Press, 2006

Appendix

Glossary of Legal Terms

action A civil or criminal judicial proceeding. See CIVIL ACTION.

actus reus The wrongful deed that comprises the physical components of a crime and that generally must be coupled with MENS REA to establish criminal LIABILITY.

adjudication The formal pronouncement of a JUDGMENT or decree in a CAUSE OF ACTION.

administrative law The law governing the organization and operation of the executive branch of government (including independent agencies) and the relations of the executive with the legislature, the judiciary, and the public.

advance directive A method for individuals while competent to appoint PROXY health care decision-makers in the event of future incompetency. See DURABLE POWER OF ATTORNEY; HEALTH CARE PROXY; LIVING WILL.

adversary system A procedural system involving active and unhindered parties contesting with each other to put forth a case before an independent decision-maker.

affidavit A voluntary declaration of facts written down and sworn to by the declarant before an officer authorized to administer oaths.

appeal The submission of a lower court's or agency's decision to a higher court for review and possible reversal.

assault Any willful attempt or threat to inflict injury.

battery Intentional and wrongful physical contact with an individual without consent that causes some injury or offensive touching.

best interests of the child General standard applied by courts to determine the "care and custody of minor children." Different states consider dif-

ferent factors relevant in defining what constitutes a "child's best interests." Some of the more common factors include the mental and physical health of all individuals involved (e.g., child, parents); the wishes of the child as to his or her choice of custodian; and the interaction and degree of "psychological connectedness" between the child and the proposed custodian.

beyond a reasonable doubt The level of proof required to convict a person in a criminal trial. Of the three legal standards of proof, this is the highest level (90%–95% range of certainty) and the one required to establish the guilt of someone accused of a crime. See also CLEAR AND CONVINCING EVIDENCE; PREPONDERANCE OF THE EVIDENCE.

breach of contract A violation of or failure to perform any or all of the terms of an agreement.

brief A written statement prepared by legal counsel arguing a case.

burden of proof The legal obligation to prove affirmatively a disputed fact related to an issue that is raised by the parties in a case.

capacity The status or attributes necessary for a person so that his or her acts may be legally allowed and recognized.

case law The aggregate of reported cases as forming a body of law on a particular subject.

cause of action The grounds of an ACTION; that is, those facts that, if alleged and proved in a suit, would enable the PLAINTIFF to attain a JUDGMENT.

civil action A lawsuit brought by a private individual or group to recover money or property, to enforce or protect a civil RIGHT, or to prevent or redress a civil wrong.

clear and convincing evidence The second-highest standard applied to determining whether alleged facts have been proven (75% range of certainty). This is the standard applied to civil commitment matters and similar circumstances in which there is the chance that valued civil liberty interests and freedoms are at stake. See also BEYOND A REASONABLE DOUBT; PREPONDERANCE OF THE EVIDENCE.

commitment A legal process for admitting, usually involuntarily, a mentally ill person to a psychiatric treatment program. Although the legal definition and procedure vary from state to state, commitment usually requires a court or judicial procedure. Commitment also may be voluntary.

common law A system of law based on customs, traditional usage, and prior CASE LAW rather than on codified written laws (STATUTES).

compensatory damages DAMAGES awarded to a person as compensation, indemnity, or restitution for harm sustained.

competency Having the mental CAPACITY to understand the nature of an act. See also COMPETENCY TO STAND TRIAL; INFORMED CONSENT; TESTAMENTARY CAPACITY.

competency to stand trial Legal test applied to all criminal DEFENDANTS regarding their cognitive ability at the time of trial to participate in the proceedings against them. As held in *Dusky v. United States* (1960), a defendant is competent to stand trial if 1) he or she possesses a factual understanding of the proceedings against him or her, and 2) he or she has sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding.

complaint The initial pleading that starts a civil action and states the basis for the court's jurisdiction, the basis for the plaintiff's claim, and the demand for relief.

confidentiality The situation in which certain communications between persons who are in a FIDUCIARY or trust relationship to each other (e.g., physician-patient) are generally not legally permitted to be disclosed and are not admissible as evidence in court during a trial. See also PRIVILEGED COMMUNICATION.

conflict of interest A real or seeming incompatibility between one's private interests and one's public or fiduciary duties.

consent decree Agreement by a DEFENDANT to cease activities asserted as illegal by the government.

conservatorship The appointment of a person to manage and make decisions on behalf of an incompetent person regarding the latter's estate (e.g., authority to make CONTRACTS or sell property). See also GUARDIANSHIP; INCOMPETENCE.

consortium The RIGHT of a husband or wife to the care, affection, company, and cooperation of the other spouse in every aspect of the marital relationship.

contingent fee A fee charged for services only if the lawsuit is successful or is favorably settled out of court.

contract A legally enforceable agreement between two or more parties to do or not do a particular thing on sufficient consideration.

criminal law The branch of the law that defines crimes and provides for their punishment. Unlike civil law, penalties include imprisonment.

damages A sum of money awarded to a person injured by the unlawful act or NEGLIGENCE of another.

***Daubert* hearing** A hearing conducted by federal district courts, usually before trial, to determine whether proposed expert TESTIMONY meets the federal requirements for relevance and reliability as clarified by the Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993).

***Daubert* test** A method that federal district courts use to determine whether expert testimony is admissible under Federal Rule of Evidence 702, which generally requires that expert testimony consists of scientific, technical, or other specialized knowledge that will assist the fact-finder in understanding the evidence or determining a fact in issue. Suggested criteria for admissibility were set forth in the Supreme Court decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993).

de facto Something that is in fact, in deed, or actually in effect, especially without authority of law. Compare with DE JURE.

defendant A person or legal entity against whom a claim or charge is brought.

de jure Something that is considered "lawful," "rightful," "legitimate," or "just." Compare with DE FACTO.

diminished capacity Refers to insufficient cognitive ability to achieve the state of mind (MENS REA) requisite for the commission of a crime. Sometimes referred to as "partial INSANITY," this doctrine permits a court to consider the impaired mental state of the DEFENDANT for purposes of reducing punishment or lowering the degree of the offense being charged.

due process (of law) The constitutional guarantee protecting individuals from arbitrary and unreasonable actions by the government that would deprive them of their basic RIGHTS to life, liberty, or property.

durable power of attorney A person designated by another to act as his or her attorney-in-fact regardless of whether the principal eventually becomes incompetent. This is prescribed statutorily in all 50 states. See also ADVANCE DIRECTIVE; HEALTH CARE PROXY; LIVING WILL.

duress Compulsion or constraint, as by force or threat, exercised to make a person do or say something against his or her will.

duty Legal obligation that one person owes another. Whenever one person has a RIGHT, another person has a corresponding duty to preserve or not interfere with that right.

eggshell skull rule In tort law, the principle that a defendant is liable for a plaintiff's unforeseeable and uncommon reactions to the defendant's negligent or intentional act.

emancipated minor A person younger than 18 years who is considered totally self-supporting. Legal RIGHTS afforded at adulthood are typically extended to an emancipated minor.

entitlement program In health law, legislatively defined rights to health care, such as Medicare and Medicaid programs.

expert witness One who by reason of specialized education, experience, and/or training possesses superior knowledge about a subject that is beyond the understanding of an average or ordinary layperson. Expert witnesses are permitted to offer opinions about matters relevant to their expertise that will assist a jury in comprehending evidence that they would otherwise not understand or fully appreciate.

false imprisonment The unlawful restraint or detention of one person by another.

felony A serious crime, such as murder, rape, arson, or burglary, usually punishable by imprisonment for more than 1 year or by death.

fiduciary A person who acts for another in a capacity that involves a confidence or trust.

fiduciary relationship A relationship in which one person is under a duty to act for the benefit of the other on matters within the scope of the relationship

forensic psychiatry A subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional, or legislative matters.

fraud Any act of trickery, deceit, or misrepresentation designed to deprive someone of property or to do harm.

***Frye* test** The former federal common-law rule of evidence on the admissibility of scientific evidence that required that the tests or procedures must have gained general acceptance in their particular field.

***Gault* decision** A landmark Supreme Court decision in 1967 that found that juveniles were entitled to the same DUE PROCESS RIGHTS as adults—that is, the right to counsel, the right to notice of specific charges of the offense, the right to confront and cross-examine a witness, the right to remain silent, and the right to SUBPOENA witnesses in defense. The right to trial by jury was not included.

guardian *ad litem* A guardian, usually a lawyer, appointed by the court to appear in a lawsuit on behalf of an incompetent or minor party.

guardianship The delegation, by the state, of authority over an individual's person or estate to another party. For example, a personal guardian for a mentally ill patient would have the legal RIGHT to make medical decisions on behalf of the patient.

habeas corpus (Latin, "you have the body") An order to bring a party before a judge or court; specifically, in regard to a person who is being retained within a hospital, to give the court the opportunity to examine that person and decide on the appropriateness of such retention.

health care proxy A legal instrument akin to the DURABLE POWER OF ATTORNEY but specifically created for health care decision making. See also ADVANCE DIRECTIVE; LIVING WILL.

immunity Freedom from DUTY or penalty.

incompetence A lack of ability or fitness for some legal qualification necessary for the performance of an act (e.g., by being a minor, or by mental incompetence).

informed consent A competent person's voluntary agreement to allow something to happen that is based on full disclosure of facts needed to make a knowing decision.

injury Harm or damage, or the violation of another's legal right, for which the law provides a remedy.

insanity In law, the term denotes that degree of mental illness that negates an individual's legal responsibility or CAPACITY.

insanity defense A legal concept that holds that a person cannot be held criminally responsible for his or her actions when, due to a mental illness, the person was unable to form the requisite intent for the crime he or she is charged with at the time the crime was committed. Historically, several standards or tests have been devised to define criminal INSANITY. Some of these include the following:

American Law Institute (ALI)/Model Penal Code test A DEFENDANT would not be responsible for his or her criminal conduct if, as a result of mental disease or defect, he or she "lacked substantial CAPACITY either to appreciate the criminality of his or her conduct or to conform his or her conduct to the requirements of law."

Comprehensive Crime Control Act (CCCA) of 1984 standard In 1984, as part of sweeping federal legislation, the CCCA altered the test for INSANITY in federal courts by holding that it was an affirmative defense to all federal crimes that at the time of the offense, "the DEFENDANT, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense."

***Durham* rule** A ruling by the U.S. Court of Appeals for the District of Columbia Circuit in 1954 that held that an accused person is not criminally responsible if his or her "unlawful act was the product of mental disease or mental defect." This decision was quite controversial, and within several years it was modified and then replaced altogether by the same court that originally formulated it.

irresistible impulse test Acquittal of criminal responsibility is allowed if a DEFENDANT'S mental disorder caused him or her to experience an "irresistible and uncontrollable impulse to commit the offense, even if he remained able to understand the nature of the offense and its wrongfulness."

***M'Naghten* rule** In 1843, the English House of Lords ruled that a person was not responsible for a crime if the accused "was laboring under such a defect of reason from a disease of mind as not to know the nature and quality of the act; or, if he knew it, that he did not know he was doing what was wrong." This rule, or some derivation of it, is still applied in many states today.

intentional tort A TORT in which the actor is expressly or implicitly judged to have possessed an intent or a purpose to cause INJURY.

judgment The final determination or ADJUDICATION by a court of the claims of parties in an ACTION.

jurisdiction Widely used to denote the legal RIGHT by which courts or judicial officers exercise their authority.

liability The quality or state of being legally obligated or accountable, or legally responsible to another or to society, enforceable by civil remedy or criminal punishment.

- **strict liability** Liability that does not depend on actual negligence or intent to harm but that is based on the breach of an absolute duty to make something safely.
- **vicarious liability** Indirect legal responsibility for the actions or conduct of those over whom the principal has control. For example, a private physician is generally vicariously liable for the negligence of any assisting employees.

lien A legal right or interest that a creditor has in another's property, usually lasting until a debt that it secures has been satisfied.

living will Procedure by which competent persons can, under certain situations, direct their doctors to treat them in a prescribed way if they become incompetent (e.g., withdraw lifesaving medical care if in a vegetative state). See also ADVANCE DIRECTIVE; DURABLE POWER OF ATTORNEY; HEALTH CARE PROXY.

medical malpractice Generally defined as "the failure to exercise the degree of skill in diagnosis or treatment that reasonably can be expected from one licensed and holding oneself out as a physician under the circumstances of a particular case" that directly causes harm to a patient. See also NEGLIGENCE; STANDARD OF CARE; TORT.

mens rea Literally, "guilty mind." One of two fundamental aspects of any crime. The other aspect is the act, or ACTUS REUS.

***Miranda* warning** Refers to the *Miranda v. Arizona* decision (1966) that requires a four-part warning to be given prior to any custodial interrogation.

misdemeanor A crime that is less serious than a FELONY and is usually punishable by fine, penalty, forfeiture, or confinement, usually for a brief term, in a place other than a prison, such as a county jail.

motion A written or oral application requesting a court to make a specified ruling or order.

negligence In MEDICAL MALPRACTICE law, generally described as the failure to do something that a reasonable practitioner would have done (omission) or as doing something that a reasonable practitioner would not have done (commission) under particular circumstances. See also STANDARD OF CARE; TORT.

nominal damages Generally, DAMAGES of a small monetary amount indicating a violation of a legal RIGHT without any important loss or damage to the PLAINTIFF.

parens patriae The authority of the state to exercise sovereignty and GUARDIANSHIP of a person of legal disability so as to act on his or her behalf in protecting health, comfort, and welfare interests.

plaintiff The complaining party in an ACTION; the person who brings a CAUSE OF ACTION.

police power The power of government to make and enforce all laws and regulations necessary for the welfare of the state and its citizens.

preponderance of the evidence The lowest of three levels or standards applied to determining whether alleged facts have been proven (51% range of certainty); more likely than not. This is the standard applied to civil lawsuits.

privilege A statutorily based RIGHT of the patient to restrict or bar the disclosure of confidential information in a court of law in most circumstances. See also CONFIDENTIALITY.

privileged communication Those statements made by certain persons within a protected relationship (e.g., doctor-patient) that the law protects from forced disclosure. See also CONFIDENTIALITY.

proximate cause The direct, immediate cause to which an injury or loss can be attributed and without which the injury or loss would not have occurred.

proxy A person empowered by another to represent, act, or vote for him or her.

punitive damages DAMAGES awarded over and above those to which the PLAINTIFF is entitled, generally given to punish or make an example of the DEFENDANT.

reasonable medical certainty In proving the cause of an injury, a standard requiring a showing that the injury was more likely than not caused by a particular stimulus, based on the general consensus of recognized medical thought.

reasonable person A hypothetical person used as a legal standard to determine whether someone acted with negligence.

respondeat superior The doctrine whereby the master (i.e., the employer) is liable in certain cases for the wrongful acts of his or her servants (i.e., the employees).

right A power, privilege, demand, or claim possessed by a particular person by virtue of law. Every legal right that one person has imposes corresponding legal DUTIES on other persons.

sovereign immunity The IMMUNITY of a government from being sued in court except with its consent.

standard of care In the law of medical negligence, that degree of care that a reasonably prudent medical practitioner having ordinary skill, training, and learning would exercise under the same or similar circumstances. Unless the practitioner is considered an expert or a specialist, the requisite degree of care is held to be only "ordinary" and "reasonable" care. If a physician's conduct falls below the standard of care, he or she may be liable in DAMAGES for any injuries resulting from such conduct.

standard of proof The degree or level of proof demanded in a specific case, such as "beyond a reasonable doubt" or "by a preponderance of evidence."

stare decisis To adhere to precedents and not to unsettle principles of law that are established.

statute An act of the legislature declaring, commanding, or prohibiting something.

strict liability See LIABILITY.

subpoena A command, typically at the request of a litigating party, to appear at a certain time and place to give TESTIMONY on a certain matter. Unless signed by a judge, a subpoena is not a court order compelling testimony but merely a court-issued order to show up.

subpoena ad testificandum A writ commanding a person to appear in court to give TESTIMONY.

subpoena duces tecum A writ commanding a person to produce specified records or documents at a certain time and place at trial.

***Tarasoff* rule** Based on the 1976 California decision *Tarasoff v. the Regents of the University of California*, this landmark opinion held that when a patient presents a serious, imminent danger of violence to a foreseeable victim, the

psychotherapist of that patient has a DUTY to use reasonable care to protect the intended victim against such danger. A number of JURISDICTIONS have issued a ruling or STATUTE involving some variation of the *Tarasoff* "duty to protect" doctrine.

testamentary capacity Pertains to the state of mind of an individual at the time he or she writes or executes his or her will. Generally, to have sufficient testamentary capacity, testators must possess a certain level of understanding of the nature and extent of their property, of the persons who are the natural objects of their bounty, and of the disposition that they are making of their property and must appreciate these elements in relation to one another and form an orderly desire as to the disposition of their property.

testimony Evidence that a competent witness under oath or affirmation gives at trial or in an AFFIDAVIT or deposition.

Title VII of the Civil Rights Act of 1964 A law that prohibits employment discrimination on the basis of race, sex, pregnancy, religion, and national origin, often referred to simply as Title VII.

tort A civil wrong subject to lawsuit by private individuals, as distinguished from a criminal offense, which is only brought or prosecuted by the state on behalf of its citizens. See also CIVIL ACTION.

tortfeasor One who commits a tort; a wrongdoer.

United States Code (U.S.C.) The compilation of laws derived from federal legislation.

vicarious liability See LIABILITY.

voir dire A preliminary examination by a judge or lawyer to test the competence of a witness.

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