Psychiatry on Trial

Fact and Fantasy in the Courtroom

Ben Bursten, M.D.

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Acknowledgments

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Much of the material in this book is drawn from my experiences as I worked with attorneys. I especially appreciate those lawyers who have

stuck with me, even though they could not depend on me to support their position in some cases. Yes, there are some lawyers who really want to know the opinion of an independent psychiatrist. They are a credit to their profession.

One person must be singled out. My wife, Jocelyn, acted as my first editor. She read draft after draft of each chapter, and she pointed out where my rhetoric was too pedantic or my meaning too obscure. To the degree that this book is intelligible, the credit belongs to her. And her enthusiasm and encouragement for this project never faltered, even when I had to discard earlier attempts. She also gave me one of the most valuable gifts a writer can get—the gift of time. Time to think, time to write, time to go to the library. For all the gifts she has given me over the years, I am very grateful.

Preface

As in any profession, psychiatry has its warts and its beauty marks. And since we psychiatrists are human beings, we are subject to the same distortions, misunderstandings, ego trips, and temptations as others. At times we may pontificate, weaving theories unsupported by data, in order to impress others with our "knowledge." Sometimes we parrot our teachers without questioning whether what we (and they) believe is really accurate. We may use our professional platforms in the service of political or ideological ends. At times our eyes may wander from our science to the sources of our income. That's the bad news.

The good news is that our profession has been willing to reexamine old theories and to modify them as new evidence has emerged. With the

development of advanced research techniques, psychiatry is increasingly based on empirical studies. And the best in our profession use these data in their practices without losing their touch of humanity when they interact with patients. Respect for patients and concern for their welfare are the hallmarks of any good physician.

The warts and beauty marks come into bold relief when we psychiatrists enter the legal arena. Here, our pronouncements are on display, sometimes splattered all over the news media. Here we are beyond the doctor-patient dyad; we are working with society's rules, and society is quick to judge us.

There is no shortage of people ready to criticize psychiatric testimony. Some even suggest that psychiatrists should be barred from the courtroom. Unfortunately, the criticisms are not

always wide of the mark. There is improper testimony; sometimes there is outrageous testimony. But there can also be good testimony which can help the judge or jury reach a more well-informed decision. This book attempts to distinguish between the good and the improper testimony. It is not a source book on psychiatry; neither is it a source book on legal concepts. I have tried to give just enough information about psychiatry and law so that the issues can be understood by either profession. Rather than the academic prose style, I have opted for a more conversational rhetoric, hopefully understandable to nonprofessionals in either field. It is the language I use when I testify on the witness stand.

In this book I report many case examples to illustrate the points I am making. In order to protect the privacy of the people involved, I have changed their names. I have also altered some of

the details of the case histories to help preserve anonymity. However, none of the facts which are essential to the psychiatric or legal understanding of the case examples have been altered. All material in quotation marks is accurate, as copied from testimony, records I reviewed, or my extensive interview notes.

Some of the cases described have already received wide publicity. These contain correct names and incidents, and they will be noted as such in footnotes. Names and details of cases cited as court decisions are accurate. And of course, names cited as references are also correct.

In my forensic psychiatric practice, I have had the opportunity to review the records and conclusions of many of my colleagues. Sometimes I was impressed; sometimes I was disgusted. And sometimes I was taken aback with the realization

that during the course of my career, I, too, have purveyed misinformation because of naiveté or carelessness, or desire to please someone. I trust that as my career proceeded, I have been correcting these errors. It is in this spirit that I offer this book so that we, as professionals, may confront the problems. I have no illusions that we will solve them, but at least we can bring them out in the open. And I offer this book also to our critics who too often focus on the warts while neglecting the beauty marks. For psychiatrists will continue to play a role on the legal stage, and the real question is how society can be best served by our actions.

Chapter 1

Prostitutes and Junk Scientists

Jay Ziskin, psychologist and lawyer, didn't mince any words. He cited a long string of legal and mental health professionals who criticized the role of psychiatrists and psychologists as expert witnesses, and he concluded, "The continued participation of members of these professions in the legal process is a travesty and is well recognized as such by the public and the media. Hundreds of millions, if not billions of dollars of taxpayers' money goes down the drain in the continued imposition of this encumbrance on the legal process. I can only provide the relevant data. It is up to the legal and mental health professions to take steps to stop this travesty."[1] His attack on

psychiatric testimony has been echoed by countless professional and lay critics. Such testimony is useless, they say. Or worse, it is useless and biased. Or still worse, it is useless, biased, and fraudulent.

Of course not everyone agrees with this assertion. However, even judges who don't subscribe to such a sweeping condemnation sometimes have their strong doubts about what they hear from psychiatrists. In a recent case, the doubts reached the point where the judges on the Appeal Panel were either merely disgusted or downright exasperated with the psychiatrist's testimony. At the very least, they didn't trust him, and they let the whole world know. In a footnote, they wrote that Dr. Smith[2] left Michigan "under something of a cloud when his group was charged with bilking a federal program. He settled the government's claim against him... He 'went into

business for himself' by sending out 140 'marketing letters' to lawyers announcing that his services as an 'expert' psychiatrist were available." The footnote went on to state that Dr. Smith "evaluates between 48 and 70 cases yearly for the attorney in this case, and he charges substantial fees as a 'forensic psychiatrist.'"

The case was straightforward enough. A woman sustained minor back and hand injuries at work. She claimed these injuries caused her to be severely depressed. Dr. Smith agreed and testified that her depression would never get better. She was mentally crippled for life. Although the defendant company offered testimony from another psychiatrist who was much more optimistic about her recovery, the judge went with Dr. Smith. He awarded her $300,000. The defendant company appealed and the Appeal Panel reversed the lower court's judgment. They

noted that Dr. Smith contradicted himself in his testimony and that much of what he said was "opaque."

The judges could have stopped there, but something about Dr. Smith, or about the state of the art of psychiatric expert witnesses in general, pushed them to add this damning footnote. They just had no faith in this expert witness.

Unfortunately, this kind of accusation can be found in the written decisions of quite a few judges. Mossman has compiled a list of cases where the psychiatric or psychological witness is described as a prostitute, whore, or hired gun.[3]

Back in the Middle Ages, one didn't need expert witnesses, because there wasn't very much science around. Everyone knew there were witches who caused all sorts of bad things to happen.[4] No one was needed to explain to the court what witchcraft

was all about. If things went awry, put a woman on trial. The judges knew a witch when they saw one.

Things changed with the rise of science—the magic of alchemy gave way to the science of chemistry, physics and mathematics added complexity to engineering, and statistical methods enabled scientists to predict the likelihood of something happening. Medicine, too, was changing. Folk remedies gave way to treatment based on research. Superstition and myth were yielding to understanding. But this kind of understanding takes a great deal of study and experience. And you can't understand everything. People specialize.

The fruits of this knowledge explosion made the situation in the courtroom quite different. Now there were people who knew more about some things than judges and juries did. Ordinary

witnesses possessed *common* knowledge. In court, they could testify about what they had seen and heard (or what they thought they saw and heard, for perception and memory are easily distorted).[5] The juries knew what the witnesses were talking about. But expert witnesses possessed *uncommon* knowledge — things that had to be explained to juries. That's why expert witnesses are not restricted to giving only data; they must interpret the data to the jury. And since nothing is certain in this world, their interpretations can represent their opinions. Other experts, in good faith, can have different interpretations of the data.

When we get two experts, relying on their specialized knowledge and experience, who offer different opinions, who makes the decision? Why, the jury of course—or the judge, if it isn't a jury trial. And they are people who have no specialized knowledge. Sometimes, even when there is only

one expert, the judge or jury may not agree with the expert's opinion. More than once, I've heard one of my colleagues complain, "Of course he's insane. He has all the symptoms of schizophrenia. How can the jury, with no medical training, say he's not?"

The answer is really quite simple if you understand what a trial is all about. We tend to think of a trial as a search for truth. Did O.J. Simpson *really* kill his wife? Did tobacco companies *really* conspire to hide the addictive properties of tobacco? How is a judge or jury to know which side is correct? What they decide is not what is true, but what they believe—what the truth is as they see it. The courtroom is not a truth arena; it is a persuasion arena where the contestants try to make the judge or jury see it their way.

Wealthy litigants may spend thousands of dollars hiring jury consultants. Do these experts, armed with questionnaires for prospective jurors, look for people who are truth specialists? Of course not. They look for telltale signs which might predict how the jurors will decide the case. Each side wants to load the jury with those who are likely to be favorable to them—even before they hear the evidence.

No, the courtroom is not—and cannot be—a laboratory where truth is discovered. The purpose of the court is a very practical one: When a dispute arises in society, there must be a mechanism for deciding it.[6] We may hope the decision is correct, but our confidence in the truth is too often shaken by those convicts who have been found guilty, but who are ultimately released because of new evidence.

While the courtroom may be an arena of persuasion, there are limits to how the contestants can go about the business of persuading. Court rules define what kind of evidence is acceptable and what procedures the attorneys must follow. Witnesses are sworn to tell the truth (as they see it). Although each attorney tries to argue more convincingly than the other (the adversary system), these rules help the judge make the trial fair to each side.

Within these rules, the lawyer's job is to do his or her best to protect the interest of the client—in other words, to win. And if he or she can bring in some expert in a specialized field who can throw light on the issues in the case, so much the better—as long as the expert supports the client's case. As Huber pointed out, the expert who cannot be relied on will not be called again.[7] Telling the attorney something he or she doesn't want to hear

is no way for an expert to build up a forensic practice.

This book is about one kind of specialized knowledge—psychiatric testimony. As happens in every specialty, sometimes the psychiatric facts of the case run counter to what the lawyer is looking for. What then? Even though the lawyer may know the case is weak, he or she may engage the service of a "flexible" psychiatrist—one who will march to the attorney's tune. The witness needn't necessarily resort to outright lying. Sometimes the "expert" phrases the testimony in such a way that the jury doesn't realize it is getting a distorted impression of the facts. Sometimes he or she may present irrelevant facts in order to impress and persuade the jury. One such witness may have plied his trade in Bobby's case.

Bobby was on trial for murder. Both the

district attorney and Bobby's lawyer agreed to these facts: Bobby's drug use started with speed (amphetamines) when he injured his back in his late adolescence. His usage gradually escalated, and at the time of the killing, he used not only speed but also cocaine, Valium, and marijuana—and, of course, beer. He was living by himself in a small run-down house. He ran with a rough crowd and supported himself by selling drugs to others.

One evening, he came home to discover that someone had broken into his house. Several items were stolen—guns, tools, two television sets, and drugs. The house was a mess.

Several witnesses agreed about what happened after that. The gossip among his friends was that a young man with whom he was acquainted, Greg, had pawned the television sets in another city. The gossip flowed back and forth

and Greg learned he was suspected. Greg and his friends accosted Bobby in a bar and warned him not to report the crime. To emphasize the warning, they stole a scarecrow from a nearby cornfield, painted it with red splotches to simulate blood, and hung it in a tree near Bobby's house.

Bobby and his friends retaliated by shooting holes in Greg's car. By now, the lines were drawn. Bobby's group captured Greg and brought him to the house, where he was tied up in a back room. During the next few days, as usual, everyone was using drugs—"partying." Since they knew Greg's friends might attack and attempt to rescue him, they took turns outside the front door—gun ready to shoot any intruder.

During the next five days, from time to time Bobby went into the back room to tease and torture his victim. He shot at him, barely missing

his head. He and his friends kicked him mercilessly, but they made sure not to allow him to lose consciousness. They cut his arms and legs —small cuts which could fester and hurt, but which would not bleed excessively. Although Bobby demanded Greg tell him where the guns and tools were, Greg held firm. Finally, Bobby took him out of the back room, laid him on a blanket in the kitchen, and slowly inserted a knife through his chest wall and into his heart. Greg bled out internally and died. The captors cleaned the house thoroughly. Wrapping Greg in a blanket, they drove him to a river and pitched him in.

Not having seen Greg for a few days, his girlfriend went to the sheriff and suggested that Bobby might be holding him. The deputy found Bobby's house to be neat and clean. He testified that Bobby did not appear intoxicated and that he was cooperative. There was nothing unusual about

him. However, one of Bobby's friends worried about the deputy's visit. He went to the sheriff and told him what happened. Bobby was arrested and charged with an unusually violent first-degree murder—the kind which could lead to the death penalty.

The evidence against Bobby was strong, but his attorney had two chances to save him from the electric chair. He might be able to convince the jury that Bobby was so out of his mind when he committed the offense that he didn't realize the significance of what he was doing. If that didn't work, he still might be able to persuade the jury to have pity on Bobby and sentence him to life in prison instead of death. He flew in Dr. Barker and explained what he needed.

Dr. Barker was no ordinary psychiatrist. He was trained in outstanding hospitals. He was on

the faculty of a major medical school. He was consultant to several important agencies. He was well versed in legal aspects of psychiatry, and he'd even taught in the Law School. He had testified "hundreds" of times. And he was on the ethics committee of the University. A saint! The attorney made sure the jury knew this man's pedigree. It is fair to say this doctor was knowledgeable about psychiatry. At the trial he was not likely to be confused or to be beset by thought-disrupting anxiety. Certainly he was not naive about what is expected in the courtroom.

In his testimony, Dr. Barker gave the jury a history of cocaine. The drug, he said, was used thousands of years ago by the Incas of South America. It gave them energy in the high mountains where the air is thinner. In the late 1800s, it was used as a stimulant by many physicians—here he dropped a few famous names.

It was an ingredient in Coca-Cola, until it was legally banned in the United States. All very interesting, but Bobby was Caucasian. He lived in southern Kentucky where the mountains are not as high as the Andes in Peru. And there was no evidence that Bobby was high on Coca-Cola. Perhaps Dr. Barker was trying to impress the jury with his vast knowledge. Perhaps they were impressed. But the testimony was irrelevant.

He recounted Bobby's life story for the jury, starting with an appendectomy when he was six. Dr. Barker described the surgery in some detail. As a child, Bobby struggled in school because he had a reading disability. Despite this fact, he managed to graduate from high school.

Bobby's life was a series of tragedies. He married at the age of 18, but his wife spent money excessively, and they went into debt. She started

to run around on him and finally left him for another man. Nonetheless, he continued to work very hard, trying to catch up on the debts incurred by his wife. Weighed down by all of this, Bobby began to drink.

Dr. Barker continued the tale of woe. Bobby did not come from a stable family. His father drank and occasionally used speed, and his mother was on tranquilizers for her nerves. After his parents divorced, Bobby shuttled between his parents, living a month or so with one and then moving to the other one's home.

While working on a construction job, Bobby injured his back. Seeing how Bobby was suffering, his father gave him some speed to perk up his mood. From that point on, Bobby's personality changed and he started using a variety of drugs. He lost his job and began running with a bad

crowd.

A pitiful story indeed, but not really expert psychiatric testimony. Dr. Barker never directly stated that these tragedies produced a disordered mental state at the time of the offense. His testimony was not the kind that needed a specialist to interpret. It did not rest on a body of knowledge acquired through years of study and experience. In fact, the same data could have been given by Bobby's mother or a close family friend with no psychiatric training whatsoever. But clothed in the mantel of psychiatric testimony, this history might take on special meaning. The jury might think Bobby did the deed because he was psychiatrically crippled by all these tragedies. Dr. Barker never actually said that; he never lied. He didn't have to.

Dr. Barker did provide some truly psychiatric

testimony—specialized knowledge which could help the jury understand. The use of amphetamines can make you psychotic. You can become paranoid and feel you are in danger. You may hallucinate and be convinced what you are seeing or hearing is real.[8] It's like a bad dream and you think people are after you. You may do anything to survive!

But there was a problem. Bobby *was* in danger. Greg and his friends *were* after him. "Ah," said Dr. Barker, "just because they're after you doesn't mean you're not also paranoid. It just makes the paranoia worse." He never explained how, if someone really threatens to kill you, it can get worse than that.

Bobby, of course, was "partying." He did do some foolish things during those five days. His judgment may well have been impaired from time

to time. But was it impaired at the time of the killing? “Yes,” said Dr. Barker, responding to the attorney’s question. “At that point, he was suffering from an amphetamine-induced psychosis —the effects of speed. It would focus his attention on the thought that Greg was out to kill him and he had to do something to survive.”

On cross examination, the district attorney specifically asked Dr. Barker if he meant that Bobby killed Gregory Stanton out of a misbelief that he was a threat to him.

Listen to the doctor’s response.

> Dr. Barker: “No, I’m describing the kind of thinking, the kind of focused thinking that takes place in individuals who have an amphetamine psychosis.”

Not the kind of thinking that *did,* to a reasonable degree of medical certainty, take place, but a generic *does* take place. If he were more accurate,

Dr. Barker should have said "that *could* take place." But accuracy was taking a back seat to persuasion. He failed to provide any sound data that Bobby even had an amphetamine-induced paranoid psychosis. Where were the delusions? Back to the fact that Greg really was a threat. And Dr. Barker testified that Bobby did not kill Greg out of a *misbelief* he was a threat to him. In fact, the doctor failed to inform the jury that a person with an amphetamine-induced paranoid psychosis is likely to be suspicious of everyone—including his cohorts with whom he was "partying" and whom he trusted to guard his house. The testimony was like a shell game, and it is doubtful the jury could detect under which shell the pellet ended up.

The jury didn't agree that Bobby suffered from a crippled mind when he killed Gregory Stanton. However, they did not sentence him to death; he got a life sentence. I don't know if this was because

they heard about the tragedies in his life, or because his life story painted him as a real human being. It's hard to sentence to death someone you've gotten to know. Or perhaps there were other reasons, not related to Dr. Barker's testimony at all.

However, the doctor's discussion, coming from a knowledgeable and experienced expert, at least raises the question of whether the testimony was bought and paid for by the attorney. I cannot answer this question. I have never met Dr. Barker and I don't know what was in his mind when he was testifying. Maybe he was confused—or misinformed—or something. But it is this kind of testimony which causes many people to label some psychiatrists who testify as prostitutes. And quite a few attorneys chuckle about the label, just before they pick up the phone to call them.

Some witnesses use junk science. Junk science, a term coined by Huber, has the trappings of science without the careful testing which gives science its substance. He noted that the research on which it is based "is a catalogue of every conceivable kind of error: data dredging, wishful thinking, truculent dogmatism, and, now and again, outright fraud."[9] In other words, the "research" is grossly faulty or absent altogether. Foster and Huber stress that to be truly scientific, a theory must be capable of being tested with the possibility that it might be proven incorrect.[10]

The witness who is an out-and-out prostitute knows when he or she is presenting conclusions which only pretend to rest on sound science. In fact, this "expert" may love junk science; he or she may even create some of it on the stand. However, there are others who truly believe what they are testifying about, but the theories on which they

base their reasoning are, perhaps unbeknownst to them, based on junk science. When they testify in good faith, they perpetuate a myth.

I encountered such a junk scientist several years ago when Attorney Roger Price asked me to evaluate his client. Jim and a friend had broken into a house one night. The next day, a woman was found in the house—raped and brutally murdered. The assailants were easily identified and charged with the crimes. The problem was that each defendant accused the other of being the perpetrator. Each claimed to have been only a frightened witness.

I evaluated Jim and talked with his parents. While I could not comment on the truth of what they told me, nothing either he or they said convinced me that Jim had a significant psychiatric condition which affected his judgment at the time

of the offense. Both men were found guilty by the jury. They were given the death penalty.

Several years later, an assistant district attorney called me. Jim had a new lawyer, and he was appealing his sentence. He claimed Roger Price had not given him an effective defense. He didn't dispute the finding of guilt. However, after the jury decides the defendant is guilty of first-degree murder, the trial moves to the sentencing phase. The lawyers may enter evidence to help the jury decide how severe the penalty should be. Jim argued that his former attorney (and I) failed to recognize how emotionally upset he was at the time of the offense. He should have another chance to present that point to a sentencing jury. If he were stressed out at the time, the jury could decide that the death penalty was too severe.

The new lawyer hired a psychologist to inquire

if Mr. Stone was, indeed, stressed out at the time. The psychologist's report was 20 single-spaced pages long. In addition to a three-hour interview, he administered 25 different psychological tests. They tapped Jim's intelligence, his memory, his ability to think. Special neuropsychological tests sought to uncover brain damage. Finally, the psychologist administered several personality tests to Jim. The psychologist may have thought he was being thorough; I think it was overkill.

The test results were striking. Jim's thinking ability was good to excellent, depending on the test. The neuropsychological tests revealed no brain pathology. But the personality tests revealed a host of problems. His tests fit the pattern of people who are immature and somewhat impulsive. Such people have a history of poor interpersonal relationships, and they tend to be rather passive. They have low self esteem and

little self confidence. Under stress, their attention turns to their bodies and the possibility of disease or injury. They come from troubled families and they may have long-standing problems of maladjustment.

The list of maladjustments went on and on. If something could go wrong in someone's makeup, it looked as if Jim was likely to have it. He was truly crippled. His diagnosis: mixed personality disorder.

In contrast to Dr. Barker's testimony about the history of cocaine and the tragedies in Bobby's life, the psychologist in this case stuck to specialized data—data which had to be interpreted in order for the jury to understand. What was needed at this point, however, was to link those test data with Jim's emotional state at the time of the offenses. The link was child abuse.

Jim told the psychologist he was virtually a captive of his predatory friend, the other assailant. He feared he would be harmed if he didn't participate. Emotional stress! What the psychologist did was to provide supporting evidence that this, indeed, was the case.

In the interview with the psychologist, Jim said he didn't remember anything about his childhood. According to the psychologist, people who don't remember anything about their childhood are victims of abuse; childhood memories are too painful to remember. Such victims often develop into people who are dependent and fear losing friends. Therefore, they are overly compliant. And Jim's tests showed he had passive trends. Further, such victims carry within them repressed memories of bodily threat and injury at the hands of the abuser—fear of injury, just like the tests confirmed. It all tied together, and science

supported what Jim said about his emotional state at the time of the offense.

When I read the report, I knew the science was weak. So was the logic. The test results were not surprising. Having worked in prisons, I have evaluated many convicted murderers and quite a few rapists. I have yet to find one whose character is without significant flaws. I doubt I ever will. Does your average well-adjusted person rape and murder? Give enough tests, and you are likely to find an array of problems which you can tie into the patient's history, whatever the history has been. You can pick and choose from among them and relate the findings to any number of histories. Not that tests are useless; they are just weak evidence if the other data aren't strong.

And what about the other data—Jim's history? Not remembering equals child abuse? At best, this

is a very controversial inference to make; the data to support this inference are weak and ambiguous. And, as it happened, in this case this inference was contradicted by other data. In my evaluation, a few years earlier, I asked Jim about child abuse, and he denied it. “Never happened,” he said. And his parents described a close and loving family. The only child they ever had any problems with was Jim’s younger brother—and these problems were not severe.

Of course, these people may have been covering up a family secret, even though in this legal situation it would have been to their advantage to portray Jim as a victim of family trouble. But at least this is a stronger piece of data than the inferences the psychologist made. And there was another piece of data. Jim didn’t tell me that, because he couldn’t remember his childhood, he didn’t know whether he was abused. He said he

knew he wasn't.

Junk science. I was asked to give my opinion about the psychologist's report. After outlining his series of inferences, I summed it all up by saying that he had built a rickety house on a foundation of sand. Apparently the judge agreed, and Jim's appeal was denied.

It is just such inferences and formulations which has led many writers to criticize psychiatric testimony and psychiatry, itself. The classic criticism came in the early 1960s from a psychiatrist—Dr. Thomas Szasz: "I submit that the traditional definition of psychiatry, which is still in vogue, places it alongside such things as alchemy and astrology, and commits it to the category of pseudo science."[11] Junk science!

Szasz was criticizing a "science" based on the psychiatry of the day— conclusions derived from

clinical practice—largely psychoanalytically oriented practice. Psychoanalysis was an easy target for ridicule. Our problems stem from infantile sexuality? Freud must have been a dirty old man. How do we know we are victims of repressed memories? Our analysts told us so. And how do they know? Their theories told them so. Not good science. Psychoanalysis does have its clinical uses, but court testimony is not one of them.[12]

However, even at the time Szasz was writing, psychiatry was changing. In the last few decades, there has been an explosion in sound, testable and tested theories. The theoretical basis of psychiatry is shifting from the clinic to the laboratory. But what do we find on the cover of a recent book attacking the use of psychiatric testimony? A psychoanalytic couch! And in this book by Dr. Margaret Hagen, we learn that Freud is still

considered psychiatry's "principle founding father."[13] She maintains that psychiatric testimony is based on pure fiction.

In my view, she paints with too broad a brush. There are problems with psychiatric testimony. There are prostitutes who will say anything for a referral and a fee. There are misguided practitioners purveying junk science. But Dr. Hagen throws the baby out with the bath water. We also have substantial information which can inform the judge or jury—information based on sound specialized knowledge and technique. The psychiatric expert does have a role in presenting and explaining this information in the courtroom. But he or she also has a role in rebutting the testimony of the prostitutes and junk scientists.

Notes

1 Ziskin J: Coping with psychological and psychiatric testimony (3rd ed.). Venice, Calif.: Law and Psychology

Press, 1991, p. 63

2 Even though the quotations are directly from the footnote of the court's decision, I have chosen to disguise the name of the psychiatrist and not to cite the case.

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Chapter 2

How Expert Is the Expert?

Just because you have an opinion doesn't mean you can testify as an expert witness. You must meet two requirements before the judge will let you speak to the jury: You must be qualified to speak about some issue in the case, and what you have to say must be helpful to the jury in reaching its verdict.[1]

The attorney who puts you on the stand is more than happy to question you about your qualifications. The better the qualifications, the more impressed the jury is likely to be. An unimpressive witness has little persuasive power. Where did you get your medical training? Your specialty training? Are you licensed to practice in

this state? How much experience have you had? Have you published in your field? Have you passed the Specialty Board exams in psychiatry? Like with the scarecrow in *The Wizard of Oz,* diplomas equal wisdom in the eyes of the jury. Your wisdom may increase with the number of diplomas you have.

Not that these questions are unimportant. They are necessary, but not sufficient. Remember Dr. Barker, the cocaine specialist? His wall was cluttered with diplomas, but his testimony was cluttered with nonsense. The bottom line is the testimony, not the credentials.

In addition to your qualifications is the matter of helpfulness. The testimony must be relevant to the case being tried. You must be able to help the jury by telling them something they ordinarily wouldn't know. As an expert witness, you are allowed to interpret data and give your opinion

because you have *specialized* knowledge and understanding—knowledge and understanding beyond that which the general public has.[2]

Some time ago, I was confronted with this question of helpfulness. The phone call came from an attorney in another state. He was defending the Applewood family. Bill Applewood was accused of sexually molesting Denise Sims, a nine-year-old friend of his daughter, Joan.

Bill's attorney had it all figured out, and he was hoping for confirmation from me. He told me Denise was confused because Bill Applewood had the same first name as a boy who had taken her into the basement of his house and engaged in sex play with her. I responded that I didn't think it likely that a nine-year-old would make that kind of error. I asked him for more details about the case.

It was a long and bizarre story. When Bill had

suggested to his daughter that they go to the circus on Saturday afternoon, Joan asked if her school friend, Denise, could join them. The following day, Joan told her folks that Denise had her mother's permission. On Saturday, Bill and Joan went to pick up Denise at her house. The child was waiting outside. Bill wanted to go in to meet Denise's parents, but the girl said they weren't home.

When they returned to Denise's house, they were met by a very angry and worried mother. Bill apologized and tried to explain that Denise had told them she had permission to go. The mother denied giving permission, and Denise told her mother it was Bill who said it would be all right. Once again, Bill apologized for the mix-up and said it wouldn't happen again.

Of course it wouldn't happen again, because

the Applewoods told their daughter Denise was not a very reliable playmate. Joan agreed. And that was that—well, almost.

When Denise told her parents Joan's father had taken them aside and fondled them, her parents were outraged. They contacted the police and it wasn't long before a Human Services worker came to talk with them. They told the social worker that when Bill came by with his daughter, he told Denise he had her mother's permission for her to go with them. The social worker said that was a bad sign. The parents readily agreed she could interview their daughter.

An hour into the interview, the story came tumbling out—a torrent of accusations which confirmed their worst suspicions. According to Denise, at the circus Bill took the two girls into a tent that wasn't occupied at the time, and he told

them to take their clothes off. Joan declined. Bill forcibly removed Denise's clothes and raped her vaginally, while Joan watched. Denise started to scream, but Bill covered her mouth with his hand. She fainted, but fortunately Joan breathed in her mouth and revived her.

Bill told her not to tell anyone or he would put her in the lion's cage. She promised, and Bill bought the girls ice cream and took them to an unoccupied house. Once again, he started to remove Denise's clothes, but she broke away and hid in a closet. She was shaking with fright as she heard Bill approach. When he opened the door, she slipped past him and ran down to the basement. Bill caught her and punched her in the stomach, threatening to kill her if she told anyone. Joan arrived just in time and pulled her father away.

When the social worker interviewed Joan's parents, Bill denied knowing anything about the molestation. He told her it was a perfectly ordinary afternoon at the circus until they brought Denise back to her house. It was then he realized Denise had lied about getting permission and was lying about Bill's willingness to take her without her mother's permission. The social worker asked to interview Joan. The interview would be in her bedroom and it would be videotaped. At first, Bill and his wife declined to involve their daughter in such an accusation. Of course, this didn't sit well with the social worker. What was this family trying to hide?

On the advice of their attorney, Joan's parents finally gave in. During the first two hours of the interview, Joan denied everything. Finally, on the promise that the interview would be over if Joan would just answer this one question—Did your

father have permission to take Denise?— Joan lowered her head and nodded. At least that's how the investigator saw it. The lawyer told me that when he reviewed the videotapes of the interview, it looked more like a sigh of frustration than a nod of agreement. Either way, it was a trick question, and Joan never had a chance to explain that her father thought he had permission.

I asked the attorney what the legal issue was. He replied that because the state felt Bill was a likely child molester, they had taken Joan away for her own protection. The Applewoods wanted their daughter back, and there would be a hearing. And Denise's parents were waiting in the wings, ready to prosecute Bill Applewood.

I asked how I could help him. Once again, the lawyer turned to his theory that there was confusion because of Denise's sex play with the

young boy whose name was also Bill.

I asked if that sex play actually happened. The attorney told me the boy had taken several girls to the basement when his parents weren't at home. Ultimately, a few girls, including Denise, told their parents. The parents confronted the boy's family, and the family moved away.

Again I doubted that a nine-year-old would make that kind of mistake. Besides, there were too many elements in Denise's story about Bill and Joan that had nothing to do with the sex play in the basement. "Frankly," I said, "Denise's story is bizarre."

He agreed and added that when you look at the taped interview with Joan, "Anyone can see how they try to put words in her mouth. And anyone can see how crazy Denise's story is."

"That's the point," I said. I told him it was obvious to me that Denise's story didn't make sense. The rape with Joan present to watch! Joan performing mouth to mouth resuscitation and Denise being able to jump right up and run away! The scene in the basement with Joan rescuing her again!

It sounded to me like a type of behavior we used to talk about years ago—pseudologia fantastica.[3] Some people make up fantastic lies, and sometimes they almost believe in them themselves. The stories are very dramatic and invite attention until they fall apart with their own weight.

The lies may have some references in reality. Most houses in that area had basements. Besides, Denise did have a sexual experience in a basement —yes, and with a Bill. The lion threat was another

obvious element; they did go to the circus. She probably pieced all this together with the social worker's interest in Bill Applewood. She performed brilliantly. She had already proven herself to be a facile storyteller with the change in her story when her mother denied giving permission.

The lawyer was enthusiastic and asked if I could testify about that.

I replied that I could, but for what purpose? All I would be doing is calling it a name. Aside from the bizarre story, I had no data to say the story was really a product of pseudologia fantastica—it just reminded me of it. If I said she had pseudologia fantastica, I'd be saying that I knew she was fabricating. I did know she was lying, not because I am a psychiatrist, but because of the nature of the story.

I asked the lawyer if he didn't think the judge would also see the implausibility of her story. He agreed that he would.

I said that in that case, the judge might not even allow my testimony because it didn't add anything except an impressive technical name—pseudologia fantastica. I really had nothing to add to what he could know by himself.

The lawyer still wanted me to testify, but financial considerations made the trip impossible. He went to the hearing without any psychiatric testimony. After the hearing he called me to say Joan had been returned to her family. The investigators had no proof, and the judge actually smiled when he heard Denise's story. I couldn't have been more helpful to the judge who had to make the decision than Denise, herself, was. Expert testimony would have been inappropriate.

But wait a minute! Experts are allowed to testify about things that the lay public may not know about. The lawyer said that anyone could see Denise's story didn't make sense. Does "anyone" mean "everyone?" Well, not exactly. Denise's parents couldn't see it. The social worker couldn't see it. If anyone/everyone could see it, Joan would never have been taken from her family and there would have been no hearing.

While I'll admit this case is so obvious that most people could see through the story, many situations call for testimony that isn't so apparent. Someone must decide if the testimony is something "most anyone" should know or if it requires an expert's help.

That someone is the judge, who has to pretend he or she knows what the general public is capable of understanding—the jury being representative

of the general public. Overtly biased jurors presumably have been screened out when the lawyers questioned the prospective jurors. Likewise, people who have obviously lived lives which were too sheltered to allow them to understand the issues in the case would not have been selected. Those making the cut and serving on the jury are assumed to be representative of the general public. And they are assumed to be reasonable.

In the law, the word, “reasonable” appears in many contexts. What does “reasonable” mean? One might say reasonable people are those whose thinking and actions are dictated by reason—they are rational.[4] You can see where this is going. Reasonable people are rational. Rational people are reasonable. Round and round. The idea of knowing what the reasonable person can understand is a legal fiction. Keeton devoted

twenty pages describing courtroom attempts to define the reasonable person, but he concluded that it is "a fictitious person who had never existed on land or sea."[5]

However, the court must rely on certain assumptions in order to proceed. Since there is no test of what the reasonable person knows or understands—we can't take a poll to find out about the average person (is the average person reasonable, anyhow?)—we must assume that a reasonable judge knows what a reasonable person understands. Without this legal fiction, we would have no basis for allowing expert witnesses to give interpretations while general witnesses cannot.

Because psychiatrists do have some specialized knowledge about human thinking and behavior, some people believe we are experts in all aspects of human activity—even who is a

reasonable person. Especially when they want us to confirm their own opinions.

Attorney Marie Foster wanted my professional opinion about reasonableness. When she called, she told me she was representing the insurers of a department store. Brenda had been stuck with a needle on the job in the alterations section. She thought she had AIDS and could no longer work. She was suing for workers' compensation.

Her doctor took a blood test, and he told her it came out negative. But she didn't believe her doctor. Ms. Foster wanted an expert opinion about whether that was reasonable.

I responded that I couldn't answer that question any better than she could. I had my own opinion as a layperson, but psychiatry doesn't teach us what's reasonable and what isn't. Her client may have had a false belief, or maybe not.

But even if she had a false belief, it might be a reasonable mistake. I didn't consider this a psychiatric question.

Nonetheless, Ms. Foster proceeded to tell me about the case. Brenda was a seamstress. She had worked in the alteration room of the department store for more than thirty years. Over a year ago, she scratched her forearm with a needle and some blood appeared. She was convinced she had AIDS from the needle scratch, despite the fact that her family doctor, Dr. Rogers, tried to convince her the AIDS test was negative. Unfortunately, she became depressed because of her "affliction," and she spent an inordinate amount of time worrying. She dropped out of work and social activities because of her fear of spreading this dread disease in crowded places. She even stopped going to church, although she remained devoutly religious.

The attorney challenged me by asking if I was still going to tell her this was all reasonable behavior.

I replied that it didn't sound reasonable to me. I reiterated that this was not a psychiatric opinion. I was just using the same criteria she was—it just didn't sound reasonable. I added that from a psychiatric point of view, Brenda might have a problem.

At that point she told me Brenda had been in psychiatric treatment with doctor Franklin for several months now. The picture became clearer. The needle scratch was healed. Brenda wouldn't get much workers' compensation for that. But if the scratch caused her to have a psychiatric problem, the compensation award could go way up. Ms. Foster was hoping I'd find that Brenda had no psychiatric problem—hoping I'd say she was

just unreasonable. She wanted me to rebut Dr. Franklin. I replied that I could certainly comment about whether and to what extent Brenda had a psychiatric problem, but I wouldn't comment on the question of reasonableness.

Ms. Foster agreed to send me all the medical records, after which I would arrange an independent evaluation of Brenda. The records from Dr. Rogers, Brenda's family practitioner, revealed that Brenda had a pattern of overreacting to stresses of any kind. Prior to the needle incident, she had multiple minor medical complaints accompanied by anxiety, nausea, and sometimes sleep problems. Formerly, these symptoms could be easily treated by a day off from work, perhaps a minor antianxiety pill, often just a placebo and reassurance. But this one was different. It didn't respond to the usual simple measures.

The doctor's records also revealed what happened after she got the needle scratch. Her employer sent her to an ambulatory care clinic where she received a tetanus toxoid shot. That night, her arm started to swell and hurt from the injection, and she went to Dr. Rogers the next day. According to his subsequent notes, she misheard him when he commented about the toxoid shot she'd received at the ambulatory clinic; she thought he'd said the arm was toxic. Although the swelling went down, Brenda was sure it was a sign AIDS was spreading throughout her body. When a few months passed with no improvement in her outlook, Dr. Rogers recommended a psychiatrist, but Brenda was indignant; she wasn't crazy, she had AIDS.

Dr. Franklin's records picked up the story. Brenda had gone to the lawyer at the urging of her daughter-in-law. She accepted the psychiatric

referral from him because he agreed she might possibly have AIDS, but that whatever it was, it was making her nervous and the psychiatrist could help with that. Besides (she told Dr. Franklin), the attorney said this would help her get the money the company owed her because she was injured on the job.

Dr. Franklin diagnosed Brenda as having hypochondriasis—an unshakable preoccupation with the idea that she suffered from a disease (in this case, AIDS) despite medical evidence to the contrary. He ruled out psychosis by giving her an adequate trial on antipsychotic medication with no change in her symptoms. In fact, when she developed a mild tremor as a side effect of the medicine, she felt she'd developed another symptom of AIDS. The medicine was discontinued.

She was depressed and anxious. Sometimes

her sleep was disrupted by a nightmare that the Devil was watching her. She was terribly ashamed about her disease. Dr. Franklin started psychotherapy and put her on an antianxiety medication and an antidepressant. While these measures took the edge off some of the worry, her basic concern about AIDS was as firm as ever. Like many people with hypochondriasis, her condition had become chronic and the outlook for recovery was poor.

When I saw her, she was pleasant and soft-spoken at first, although she kept her arms pulled in as if she wanted to wrap herself up. She recounted the events I had read in the records. She told me she'd gotten AIDS from a needle carelessly left on a table by a young coworker. Then she launched into a tight-lipped diatribe about the young girls she'd been forced to work with in the crowded alteration room. They had no values.

They were poor workers. They swore and took the Lord's name in vain. Most of them never even went to church. Many lasted no more that a month or so at work. Some of them were fired within a week. Just the kind of loose girls who could have AIDS. One of them must have contaminated the needle.

I probed for psychosis by asking her how she could be so sure she had AIDS.

"What else could it be," she asked.

"Even though you tested negative?"

"But what if the tests are wrong? I keep having these symptoms. Look, Doctor, I'd be the happiest person in the world if they could prove I don't have AIDS. Once in a while, I think, maybe they're right, but then I get a boil or something. It must be AIDS."

Dr. Franklin was right. Brenda wasn't delusional. People with delusions won't even admit to the possibility they might be wrong, and they often get angry when challenged. This was hypochondriasis. And she was incapacitated. Her mind was so often on AIDS, she found it difficult to concentrate; She hesitated to visit her grandchildren for fear of contaminating them. The only high points in her life were listening to religious programs on television and talking to Johnny on the phone. And these points weren't very high.

"Who is Johnny?" I asked.

She told me Johnny was a very good friend she'd met after her husband passed away. He had lost his wife a long time ago. They used to go out to dinner together, but now, once in a while, they go driving in the country—when she feels up to it.

“Have you two had a romantic relationship?” I inquired.

“Not really.” She looked away and I waited. “Well, sort of.”

“Sexual?”

“Yes. To be perfectly honest with you, Doctor, we did it a few times. But then, we got to thinking. It’s not right to have sex without you’re married. So we stopped. Now, we’re just friends.”

“Do you miss it?”

“Sometimes, yes. But that’s not the way I was raised up.” She told me about her strict Christian upbringing. “I know what’s right and what’s wrong.”

“Do you feel guilty about having had sex with Johnny?” I asked.

"Not really," she answered. "We shouldn't have done it, of course. But we did it and it's over with. I don't think about it; it don't bother me."

I wasn't so sure about that. Could it be that somewhere in Brenda's mind, without realizing it, she felt God was punishing her for her sexual transgression? Did she feel that she was just like those loose girls in the alteration room? What more appropriate punishment than AIDS? Maybe so, maybe not. That wasn't the kind of thing I could testify about. It was a hunch. Perhaps later in psychotherapy, Dr. Franklin might find out. But the data weren't firm enough to present as expert opinion in court.

I had to agree with Dr. Franklin. Brenda was suffering from hypochondriasis and it was chronic. Associated with it was the anxiety and a mild depression. If what she told me about her

symptoms was true, it was unlikely she could return to work. The needle scratch did not trigger AIDS; it triggered hypochondriasis. Hypochondriasis and its outlook could be explained to the judge to help him decide on the matter of workers' compensation—expert testimony.

Ms. Foster was not happy with my findings. She refused to believe Brenda couldn't work because of the fear of AIDS. "Even if that fear was unreasonable?"

I ignored the part about unreasonableness and told her I couldn't rebut Dr. Franklin's conclusions. Actually, I thought he was doing a good job.

"Well, damn!" she barked. She hung up and I never heard from her again.

Why could I testify about the diagnosis of

hypochondriasis and its outlook, but not about the formulation I'd made regarding guilt? Both of these items required specialized knowledge; indeed, some in my field would say that the formulation required even more skill than the diagnosis. The difference between them lies in yet another aspect of evidence which can be admitted in court—the matter of degree of certainty. How sure can we be that what we are saying is accurate?

Although the lawyer who puts you on the stand tries to build you up, the opposing lawyer tries to shoot you down. One way of doing this is to demean your field of specialization. "Psychiatry isn't an exact science, is it, Doctor?" The lawyer wants a yes-or-no answer, but the question doesn't lend itself to a simple response. What is an exact science? One with all the answers? One with 100 percent predictability? One that is infallible?

And what distinguishes the “exact science” from junk science?

At first, it might seem odd that the courtroom, which operates on persuasion because it can never be certain of the truth, allows a question about “exact” anything. But among the rules governing which kinds of evidence can be presented when the lawyers try to persuade the jury, are standards of how likely the opinion presented will turn out to be correct. The testimony must have some substance behind it; it can’t be pulled out of thin air.

Unfortunately there is plenty of room to maneuver between “exact science” and make-believe. And, while “exact science” might be an ideal, it is only approachable—never attainable. As Kuhn has described, scientific points of view change from time to time.[6] Today’s “exact science”

may become tomorrow's historical oddity. This is true of the biological sciences underlying much of medicine, and the psychobiological sciences underlying the psychiatric branch of medicine. At the time of Brenda's hearing, people who had hypochondriasis had a poor prognosis. Since then our view—theory, if you will—of hypochondriasis has changed, and newer medications are being tried with some success.[7] Nowadays, I would have to check to see if Dr. Franklin had tried the newer medical regimens before concluding Brenda was unlikely to recover. But you can only testify about the knowledge available at the time of the trial. There is always the possibility that newer theories or newer data will change the picture. Medicine, like all of science, is continually evolving. No science is an exact science. The "wisdom" of one era may be deleted from the textbooks of another.

A side-by-side pair of articles in the *Journal of*

the American Medical Association[8] points this out with great clarity. In 1897, Dr. W.J.K. Kline, A.M., M.D., stated that chemistry is the bedrock of medicine. All we need is to expand the number of chemical laboratories and *voila!,* "Medicine will be an exact science." We will know exactly what is needed to maintain health.

The companion article, written 100 years later by Robert L. Martensen, M.D., Ph.D., stated that "Nowadays, many doctors believe that 'molecular medicine' will satisfy the yearning for medicine to be an 'exact science.'" Medicine an exact science? Dr. Martensen doubted it, and he noted that since as far back as 1647, that claim has been made.

If you still believe medicine is an exact science, go to any convention of doctors. You will hear debates and skeptical questions. Or go to a hotly contested trial with experts testifying for each

side. You may hear different interpretations of the same data—from reputable and well-meaning physicians.

If medicine is not an exact science, how does the court decide which evidence is firmly based enough to be admitted? The traditional method of discerning if expert testimony (including medical opinion) was firm enough was the Frye[9] test. The data and the opinion drawn from them must have "general acceptance" in the field of the expert. Does that mean that an astrologer can testify so long as what he or she deduces from the stars meets with general acceptance among other astrologers? What about purveyors of nutritional supplements who agree with other such purveyors? Creation Scientists?

Clearly more was needed, and the more recent Daubert[10] standard provides the following more

specific guidelines. (1) The theory or technique can be (and has been) tested. This doesn't mean it has been proven, but it must be susceptible to being disproven. Any theory which has an answer to fit any result you might get is not scientific. (2) It must have been published in a peer-reviewed journal. (3) There is a known or potential rate of error. There are too many unknown variables in life for 100 percent results in most cases. (4) There must be certain accepted standards controlling how you get the data. (5) The technique should have wide acceptance by others in the field. These guidelines tell the judge what he or she should consider in deciding whether the offered evidence should be admitted. These guidelines apply to the Federal Courts; state courts are not obligated to follow them. But Guideline 3 is of particular interest here. The "rate of error" indicates how nearly certain the expert can be that

the testimony represents firmly based opinion. If the theory has been tested and reported, but the test results hardly ever support the theory, it is of little use.

In 1971, Pollack put it very well: "In the physical sciences, judgments can be offered with a high level of mathematical probability (although still not with certainty); but judgments in the biological field, and especially in medicine, hold a much higher risk of error and are generally offered with a lower level of confidence. . . . Judgments in psychiatry are made with a still greater risk of error and with an even lower level of conviction than obtains in most other branches of medicine."[11]

Since 1971, psychiatry has been closing the gap, but we still have a way to go. There has been a substantial increase in empirically based and

tested data. There is also much speculation and untested theory in psychiatric practice—theory which may be helpful in certain therapeutic situations but which should be treated with great caution in the legal arena. My formulation that Brenda's hypochondriasis resulted in part from sexual guilt was such a speculation. I could not testify to that. On the other hand, at the time of the consultation, there was evidence that hypochondriasis tended to be chronic; I could have testified to that.

How nearly certain does a doctor have to be in order to testify? I have found no hard and fast rule, but the general requirement seems to be that we must testify to a reasonable (there's that word again) degree of medical certainty. In legalese, this means the opinion must be more probable than not—a 51 percent degree of certainty. Mere speculation (stating that something is possible) is

not admissible.[12] If the doctor's testimony is that the opinion is the mostly likely among the possible explanations, it is admissible.[13] That is why psychoanalytic formulations and therapeutic hunches which may well change as therapy goes on does not make good testimony.

If, indeed, the level of certainty in psychiatric testimony is lower than that of other medical specialties, it may come as a surprise that, according to Wecht, psychiatry and pathology are the only specialties that are "consistently and uniformly accorded professional recognition by the courts."[14] The demand for psychiatric testimony is understandable if we remember that the court is an arena for resolving disputes. Disputes very often involve the issues of how people think and how their mental state determines what they do. This is the area of psychiatry.

I shall discuss the variety of these issues in subsequent chapters. Some of our data and explanations are reasonably firm; these should be presented to the court. Some are only speculation; these should be kept out. Presenting the data from which the opinions are drawn may help the judge and jury evaluate the testimony. Often, the testimony of another psychiatrist can help the judge and jury distinguish which is which.

Notes

1 Fed. Rules Evidence: 28 USCA Rule 702

2 U.S. v. Carr. 965 F.2d 408, 412 (1992)

3 Kolb LC and Brodie HKH: Modern clinical psychiatry (10th ed.). Philadelphia: W.B. Saunders Co., 1982, p. 609

4 Cass v. State, 61 S.W.2d 500, 504 (1933)

5 Keeton WP: Prosser and Keeton on the law of torts. St. Paul, Minn.: West Publishing Co, 1984, p. 174

6 Kuhn TS: The structure of scientific revolutions. Chicago: Univ. of Chicago Press, 1970

7 Fallon BA et al.: The psychopharmachology of

hypochondriasis. Psychopharm. Bull. *32:* 607-611,1996

8 Medicine as an exact science. Journ. Amer. Med. Assoc. *278:* 608-609,1997

9 Frye v. U.S., 293 F. 1013,1014 (1923)

10 Daubert v. Merrill Dow Pharmaceuticals, Inc. 509 U.S. 579, 592-595 (1993)

11 Pollack S: Principles of forensic psychiatry for psychiatric-legal opinion-making. (In) Wecht CH (ed.): Legal medicine annual. New York: Appleton Century Crofts, 1971, pp. 261-295

12 Lindsey v. Miami Development Corp. 689 S.W.2d 856, 861 (1985)

13 Norland v. Washington General Hospital 461 F.2d 694, 695 (1972)

14 Wecht CH: Legal medicine and jurisprudence. (In) Eckert WG (ed.): Introduction to forensic sciences (2nd. ed.) Boca Raton, Fla.: CRC Press, 1997, pp. 81-92

Chapter 3

Searching for Causes

A black cat crosses your path, and later that day you get hit by a car. Does that prove black cats bring bad luck, and the cat caused the accident to happen? Of course, some people think like that, but most of us don't. You'll never get a lawyer to take the case against the owner of the cat. Even if the lawyer believes in the black cat superstition, he or she knows no judge or jury will allow you to win the case.

Just because one thing happened after the other doesn't mean there is a causal relationship. Yet that kind of thinking is so common philosophers who analyze logical errors even have a Latin name for that kind of misguided reasoning:

post hoc, ergo propter hoc—after this, therefore because of this.

While you'll never hear of any actual black cat lawsuits, some attorneys will file suits for huge amounts of money based on the same illogical principle. The factory belched smoke—therefore, the illnesses the citizens suffered must have been caused by the toxins in the smoke. Maybe so, but maybe not. There must be more than the mere connection over time. There must be some data to show that this kind of smoke causes that kind of illness. There must be evidence that the fumes reached the plaintiffs. Experts must testify about the causal relationships. And there may be experts who testify on opposite sides of the issue.

The lawyer might take the case even if the proof is weak and the causal connection is very tenuous, because he or she counts on the fact that

the jury may have enough sympathy for the sick people to decide in their favor. Or the jury may have such a negative attitude about big factories and pollution that they see a causal connection despite what the experts say. The company may choose to settle out of court rather than run the risk of a trial. An adverse verdict from a jury might cost them even more money.

Causal relationships are at the heart of many lawsuits. Some of them are obvious. If the car carelessly swerves and knocks you down, it is apparent the driver caused your injuries. You don't have to have an expert witness to establish who was responsible for your problem. However, sometimes what seems to be the cause of the injury may turn out not to be the cause after all. Expert opinion may be needed to sort things out. Frequently this is the case when a psychiatric injury is involved.[1] Betty's injury was such a

situation.

At first glance, Betty's case seemed straightforward enough. She was a stocker in a discount department store. One day, she picked up a container of chocolates. Placing it on the pail shelf of the ladder, she climbed up to the third step. The next thing anybody knew, there was a thump as the ladder tipped over. Another stocker rushed to the candy aisle and found Betty on the floor. According to her coworker, Betty was not responding. The coworker shouted at her, but Betty did not move. The coworker summoned the manager who called for an ambulance.

Betty remained unresponsive until she arrived at the emergency room. There, she cleared quickly. An X-ray of her skull revealed no fractures or any other abnormalities. Nonetheless, as a cautionary procedure, the doctor hospitalized her for

observation overnight. She was released the next morning.

Betty said her life had gone downhill ever since the accident. Her memory was spotty and she couldn't concentrate. She suffered from intermittent headaches. She was constantly fatigued and depressed. Occasionally her mood was so bad she thought of killing herself. Her doctor diagnosed her as having a major depression, and he put her on medication. In her condition, she was no longer able to work.

Since the accident happened while she was working, Betty was suing for workers' compensation. Her symptoms appeared to be consistent with a person who suffered a concussion—a brain which has been shaken up by some kind of blow to the head. There were other problems also. Betty had intermittent pains in

various parts of her body—pains which defied medical diagnosis. Everything seemed clear enough: The fall at work caused the concussion which resulted in her psychiatric symptoms.

In fact, when her attorney sent her to a psychiatrist and a neuropsychologist, they agreed with the diagnosis—post-concussive syndrome. When they reviewed the hospital records, they were not surprised at the normal X-ray. It is not unusual to find nothing on the X-ray when someone has a concussion. On the other hand, when these doctors took her electroencephalograph, it was abnormal. Further, some of the psychological tests given by the neuropsychologist confirmed that Betty had problems concentrating and remembering. And she was depressed. The pains and fatigue could be a result of her depression.

Even though Betty had a history of mysterious aches and pains long before the incident in the store, she deteriorated after the incident. In the consultants' opinion, "The fall caused the concussion which exacerbated Betty's pre-existing condition." Because her condition was made worse — to the point where she could no longer work— she sued for $500,000 plus money for the continued medical treatment she would probably need for the rest of her life.

Of course, the lawyer for the insurance company saw it differently. Just because Betty's complaints happened following an incident at work, that doesn't mean they were caused by the work situation. He believed she was malingering. In his opinion, Betty's extensive medical problems which defied diagnosis in the past showed that she'd faked illnesses all her life. And now she saw a chance to collect money.

Did she really have a concussion? Her medical records revealed several problems with that diagnosis. The doctors in the emergency room had written that she had a “possible concussion.” They had not witnessed her loss of consciousness; they were going on the basis of the information they were given. I wondered how a fall from three feet up could do such damage. There were no marks or bruises anywhere on her body. Absolutely none on her head. Even if she did fall, it’s unlikely she’d sustain a serious injury to her head. Certainly, there was not enough distance for her to somersault in midair and land head first.

There were other problems, also. Betty clearly remembered what the doctors did in the emergency room from the moment she came to, and she knew what occurred during her overnight stay. People with serious concussions don’t usually remember events just after they wake up;

the damaged brain cannot immediately lay down memory traces.

But what about the abnormal electroencephalograph? What struck me about the EEG report was that the abnormal patterns were those often seen in patients who are on medications. Betty was on an endless list of medicines. As I reread the psychiatrist's report, I realized he did not even mention the medications she was taking. Perhaps he had failed to ask her about them. Perhaps he didn't think they were important enough to report. Or perhaps, he preferred to reach a diagnosis in Betty's favor.

I am not an expert in interpreting brain wave patterns; that skill is properly the province of a neurologist. I showed the EEG report and the list of Betty's medicines to a neurologist colleague. He agreed that some of the medications could well

have produced these results.

If she did not have a concussion, what was going on? Was the attorney correct? Was she a faker? Of course, this was always a possibility, but perhaps there was another explanation. While it was true that having a concussion would yield rich monetary rewards, this had not been the case in her many past unexplained illnesses. In fact she had several previous "falls" without bruising in situations where there was no chance of financial compensation.

The account of events given by her coworker furthered my doubt Betty was faking. When she arrived at work, she didn't punch the time clock. Instead, she went directly to the back room, and she picked up the container of chocolates. When the coworker went to the scene of the "fall," she saw there was more than an adequate supply of

chocolate already on the shelf. The contents of the container were all spilled out on the floor. And the chocolate shelf was low enough that Betty needn't have used the ladder. Any stocker who was a competent faker would have chosen an item which needed restocking and a shelf which required using the ladder. And even if the fall was genuine, how can we explain that Betty, an experienced stocker, climbed a ladder to restock a low shelf that didn't need it?

If not faking or a concussion, what was going on? I spent many hours poring over countless medical reports both before and after the incident in the store. There was doctor visit after doctor visit, going back 23 years to the age of 17. She was marching through life in an endless parade of every type of complaint imaginable. It seemed to me Betty had a somatization disorder.[2] People with this problem have many different types of

medical complaints which drive their physicians to distraction because they can't pin down any diagnosis.

Betty's history more than fit this disorder. When she divorced her first husband, she suddenly developed a paralysis of her right arm. The neurologist could find no cause, and she cleared up a day later. Betty maintained she'd had a stroke. Some time later, her gynecologist performed a hysterectomy because her pelvic pains defied more conservative treatment. The pathologist reported that her uterus was perfectly normal, but Betty was convinced she'd had cancer. There were many stomach and digestive complaints, none of which could be diagnosed after extensive evaluations. There were a variety of mysterious aches and pains. And there were several falls without bruising which she attributed to fainting. One physician's note said, "Doesn't

remember falling, but found herself on the floor."

Often she was treated with reassurance and tranquilizers. Now, of course, she added concussion to her list of medical tragedies.

Somatization disorder was the more likely explanation for her symptoms, but what about the strange behavior preceding her "fall"? Frequently people with somatization disorders have associated episodes of dissociation.[3] This is a process wherein the person's memory, perceptions, or actions appear to have "broken off" from his or her usual state of awareness—sort of like when you tip over a vase and a piece breaks free. It's still part of the vase, but it's separated from the rest. Amnesias and fugue states, where someone travels to a strange place but doesn't know who he or she is, are examples of dissociation. The widely known cases of multiple

personality where different personalities take over from time to time are dissociative reactions. It's like being on automatic pilot.

Indeed, during her interview with me, there were two brief episodes where she tuned out of our conversation and moved her hands in a strange repetitive manner. When I asked her what was going on, she didn't recall doing it.

Putting this all together, it was my opinion that in her lengthy course of a somatization disorder, Betty had a dissociative episode during which she came into the store without punching in, got the container with chocolates, climbed the ladder and spilled the chocolates, then lowered herself to the floor without actual injury, tipped the ladder over and remained unresponsive until she got to the hospital—all on automatic pilot. Afterward, she had no recollection of it, not even the part about

coming in and climbing the ladder. Not even the ambulance ride. Nothing, until she abruptly "woke up" in the emergency room. It wasn't a concussion, and it most probably wasn't faking.

Dissociation and somatization was the most likely explanation, and as I explained in the previous chapter, the most likely explanation meets the criterion of reasonable degree of medical certainty. The obvious cause which was first presented (fall and concussion) had to yield to a more complicated explanation. This information could help the judge decide the nature of the cause as well as the nature of the apparent injury. However, I never had the opportunity to see how this diagnosis played out in court, because, as often happens, the attorneys settled the case. Instead of the $500,000 and more at risk, the insurance company agreed to pay $50,000. My report was a factor in getting the plaintiff to accept

this offer.

Betty's case, then, shows how psychiatric opinion, based not on speculation but on diagnosis and data, can be of help in resolving the question of cause in legal situations. Searching for possible causes is an important part of the work of a forensic psychiatrist.

Often, the cause of the psychiatric problem is more complicated than factor A producing factor B. Like a falling row of dominos, there can be a sequence of events,[4] a causal chain where one event causes another which causes still another. The sequence can involve (say) an accident which causes injury to an arm or leg, which causes the victim to react with emotional distress. In such cases, those responsible for the accident may be held responsible for the whole string of consequences.[5]

Most injuries in the workplace involve damage to parts of the body: fractures, problems with displacement of spinal discs, burns, etc. Generally, it is not difficult to determine the cause. Then, if the damage leads to psychiatric dysfunction, the causal chain can be examined and evaluated. But what if there is no bodily injury? A person can develop psychiatric dysfunction because of stresses at work. Can that person sue for workers' compensation?

A problem arises: Stresses frequently occur in the usual course of work. Production quotas must be met, schedules must be kept, unforeseen problems may arise. Sometimes a boss or coworker speaks sharply because he or she is having a bad day. Even at the highest corporate level, managers must worry about the bottom line and the stockholders. It's not only lonely, it may be risky at the top.

Particularly if an employee is psychiatrically vulnerable—say, an anxious person or one who is prone to develop depressions—he or she may be unable to withstand the usual business stresses. We might understand why someone whose leg was broken when a pile of cases fell against him would want to be compensated, but a person who fell apart psychiatrically because he or she was frequently criticized or was asked to put in a large amount of overtime? Should that person be allowed to sue?

Actually, the answer depends on where you work. In some states, if you suffer from a psychiatric dysfunction because you couldn't stand the usual work stresses, you can sue for workers' compensation.[6] Other states require workers' compensation to be paid only if the dysfunction arises because of a single unusually stressful incident. Even then, often the courts in

some of those states stretch the law and award compensation when the dysfunction has been caused by the more usual work stresses.[7]

Nonetheless, in some jurisdictions, both the law and the courts adhere to the standard which requires that there must have been an unusually stressful occurrence in order to qualify for workers' compensation. As one court put it, "...a mental stimulus, such as fright, shock or even excessive unexpected anxiety could amount to an 'accident' sufficient to justify an award for a resulting mental or nervous disorder."[8] The court went on to distinguish that sort of "accident" from "every stress and strain of daily living or every undesirable experience encountered in carrying out one's duties under a contract of employment." These stresses and strains are not compensable in that jurisdiction.

In such a jurisdiction, it is up to the judge to decide whether that kind of stressful event the plaintiff experienced was usual or unusual. We psychiatrists are not experts in what is unusual or outrageous in the workplace. However, if the stressful event does qualify, we may help in evaluating whether that stressful event is the cause of the psychiatric dysfunction.

Janet had worked her way to the top. Starting as a secretary in an office pool, she progressed step by step up the secretarial ladder, and now she was the executive secretary of a company vice president. Each promotion came with added responsibilities, and Janet, eager to please, met them all.

Of course, she paid a price: longer and longer hours, work to take home at night, telephone interruptions when she was engrossed in

document preparation. And Janet was the worrying type. At night, she would lie awake, going back over the day and wondering if she got this letter off or set up that appointment. The next morning, she went in early to check, and of course she had done everything.

Actually, she liked working for Mr. Jenkins. While not lavish with compliments, once in a while he did tell her that she did a good job. And he was a pleasant man. You don't always find that in a workaholic. He often stayed late in the office, and he needed her to stay with him. Things were always happening in Mr. Jenkins's domain—interesting things, even if it was a high-pressure office. And Janet did like to keep busy.

One afternoon, she was on the telephone checking the airline schedule for her boss when the intruder appeared. He brushed right past her

desk and entered Mr. Jenkins's office before Janet even had a chance to ask who he was. The door slammed and Janet heard loud, angry voices. Then a shot rang out. The intruder reappeared and ran for the elevator.

A minute or two later, Mr. Jenkins came out. He was pale and shaking. He told Janet the office was a mess and he was going home. He said that she should take care of things. After he left, she went into his office and picked up the papers that were scattered all over his floor. She straightened out his desk. She saw the hole in the wall where the bullet struck. Immediately she knew what to do. She called security. They informed her that she should leave everything untouched; the police were already here. They had apprehended the intruder who was a disgruntled ex-employee.

It took a little over two years before Tom

Browning called me. He was the lawyer for the insurance company which carried the workers' compensation coverage for Janet's company. He told me the story briefly, and then he informed me that Janet had reported for work for the next few days, but after a few hours, she left, claiming illness. The following week, she had a doctor's excuse to stay off work for two weeks. After that, she went back to work on a full-time schedule, but her performance deteriorated. Two months later, she got another doctor's excuse and never returned to work after that.

Janet was suing for workers' compensation and her lawyer sent her to a psychiatrist, Dr. Embry, who found she was significantly impaired because of the intruder incident and was unlikely to recover. Tom wanted another opinion. Was Janet psychiatrically impaired? If so, was it due to the incident, or was it due to her general inability to

keep up with the high-pressure work schedule? If it was the former, it might well qualify as a consequence of an unusually severe stressful event. But she did go back to work. And her medical records showed she was beginning to crumble even before the incident. Could she have recovered from the stress of the incident during her two weeks off and now was reacting to the usual business stresses?

I examined the medical records Tom sent over. Apparently, Janet had been struggling emotionally for several years. Her family practitioner's notes reported intermittent visits for "stress at work." He had often advised her to take more time off or to seek a different job. He prescribed sleeping pills and antianxiety medications. These helped for a while, and then she came back with the same problems. On several occasions he suggested psychiatric help, but she always declined.

The doctor's notes revealed that Janet came in a few days after the incident. He agreed to give her medication and an excuse for two weeks' leave of absence, but he insisted that she see a psychiatrist. He put it this way in his note: "Once again, I told her she needs psychiatric help and I wouldn't give her a back-to-work slip unless she goes." Janet agreed to see Dr. Embry.

Dr. Embry wrote very clear notes. He saw Janet frequently and tried a variety of medications and psychotherapeutic techniques. He was aware that her need to do a good job—to work harder and harder—was based on her insecurity. She needed frequent reminders of success. Work had been a struggle for her for a long time. He documented her periods of anxiety and her need to check and recheck her work. She told him she couldn't look for another job because that would mean she failed at this one.

However, the incident with the intruder precipitated different symptoms. She began to have nightmares about the event. Sudden loud noises startled her and could even bring on sweating and nausea. She couldn't concentrate, and she dreaded going back to that office. When she did go back for two months, she felt like a robot, doing things she'd done for years while trying not to realize where she was. Obviously, it didn't work.

Despite the psychiatrist's best efforts, Janet did not improve very much. Every day was a struggle against memories. She blamed herself for not being able to work. Without being able to prove herself, her selfesteem plummeted. She even had thoughts of suicide.

I told the attorney that Dr. Embry documented a very significant impairment. Janet had post-

traumatic stress disorder. She had panics. She was depressed. And, if the doctor's notes were accurate, these problems were brought on by the incident with the intruder.

Although I felt I could add nothing, the attorney wanted me to evaluate Janet. If both psychiatrists agreed, it would strengthen his report to his client. I set up an appointment with her.

Indeed, there was nothing I could add to Dr. Embry's opinion. I was curious about one thing, however. I wondered why Janet, who was so familiar with protocol, cleaned up the papers before calling security. Truly she must have been aware the police would want the scene untouched.

"I couldn't think straight," she replied. "When I heard the shot, I knew Mr. Jenkins was dead. I was afraid I'd be next." She shuddered and her face

flushed. She paused to compose herself, and then she went on. “After the man left, all I could think about was that I’d have to go in there and see blood all over the place. I still dream about that. Then, when Mr. Jenkins came out and told me to take care of things, I had this thought, you know—this thought that if I did what he said and cleaned up, maybe it would all go away. But it didn’t.” She sobbed. It was clear Janet was suffering from the unusual event.

I sent the lawyer my report and the insurance company settled the case.

Causal chains are not always exactly like a row of dominos—one cause “falling” and producing the next cause. Life doesn’t travel in a single straight line. In the course of an emotional disturbance, other things happen—death of a close relative, breakup of a romantic relationship, etc. These are

intervening causes.[9] There may be several causes of the condition we observe—some lying within the apparent causal chain and some outside the chain. Sometimes, those lying outside the causal chain are more relevant to a persons psychiatric state than those within the causal chain.

Sam sustained a low back injury from a fall at work. The consensus among the orthopedists was that he could do only light duty work. His 10 percent impairment would be permanent. This would entitle him to a very modest compensation.

However, the pain did interfere somewhat with his sleep. And since he always was a hard worker, the restrictions on his activities bothered him. He seemed to be sitting around the house and brooding. His lawyer sent him to a psychiatrist who diagnosed a significant depression—a depression caused by his pain. According to the

psychiatrist, despite adequate treatment, the depression had hung on so stubbornly for so long, it was unlikely to improve.

The causal chain seemed simple enough: incident at work—back injury—significant depression. It was a causal chain which would greatly increase Sam's compensation.

The insurance company asked me to evaluate him. Sam told me there were good days and bad days, depending on the amount of pain. When the pain was controlled, he woke up refreshed from a good night's sleep. He was eating well and his weight was stable. He tried to help his wife around the house, until his back started to hurt. He was able to take his own meals when his wife was at work. On a bad day, the pain was worse and his activities were more curtailed. "Not much of a life," he said. Friends used to visit, but they gradually

dropped off. “I guess I wasn’t very good company.”

In response to my question, he was able to tell me what was going on in the news. He watched television quite a bit—liked war movies. “But when I get to thinking, I can’t concentrate.” All in all, I felt he did not have a major depression, but then, he was on medication. He might have been sicker without it.

That phrase, “I get to thinking,” came up again and again in the interview. Of course his back condition bothered him, “but what really gets to me is the way the company treated me.” When he applied for permanent workers’ compensation, the company did not immediately grant it. He felt they forced him to sue, and now they were asking their doctors to evaluate him. To him, this was a great indignity. “I gave them my best for 25 years, and they treat me like a second-class citizen.” His face

flushed as he said this. This is the theme that he thought about—brooded about—when he got to thinking. “On a bad day, when I hurt, I sit around and think, ‘Why did the company do this to me? It’s not fair.’” At another point in the interview, he said, “It’s always on my mind; why did they do me this way?”

At one point, I tried to get him away from this line of thinking. “Suppose the company had given you permanent workers’ compensation. How would this affect you?”

He didn’t say the family would be better off financially. He didn’t say that he’d still be depressed because of the incapacity from his injury. He couldn’t even break away from the thought that plagued him. “But they didn’t,” he replied. “They tried to screw me.” I wasn’t surprised his friends dropped off, if this was all he

wanted to talk about.

The company, of course, was following a reasonable course. They were giving him temporary financial help, but they had to be sure before handing out the large amount of money permanent disability would cost. It was Sam's feelings of entitlement and betrayal, not the company's action, which could be blamed for the bitterness which Sam made the center of his life. The cause of this distress was not something the company was legally responsible for.

Since I couldn't nudge him much from his recurrent complaint, I could not rule in or out some direct depression as a result of the injury. However, I testified that the bulk of his emotional reaction seemed to be the feeling of having been treated wrongly after years of faithful service.

The judge awarded him nothing for the

emotional component of his complaint. In my view, that may have been a bit harsh. I had said "the bulk," not "the entirety." But as a witness, I am not expert in fairness; that's for the judge or jury to decide. My job is only to provide a psychiatric opinion of what is going on with the person I evaluate and to give the data on which I base my opinion.

How much information do you need before you can be reasonably certain about the events causing a psychiatric condition? This question came up when Attorney Henry Bradley called me. He asked me to examine the medical records of Jim Thornton, who had been injured when a new stepladder collapsed. Jim was suing the manufacturer because of bodily injuries and depression.

Mr. Bradley represented the manufacturer's

insurance company. While he could acknowledge the bodily injuries, he was not ready to accept that they led to psychiatric dysfunction. According to him, Jim's psychiatrist did not perform a good evaluation, and therefore he had no basis for coming up with a diagnosis of depression.

I told him that in addition to the records, I'd need to see the patient in order to decide if I agreed with the diagnosis. He didn't want me to see the patient, because he wasn't sure he'd use me, and he would have to get the permission of Jim's lawyer to set up an evaluation. In essence, he didn't want to play his legal hand until he was more certain of the outcome.

Although I declined to make a diagnosis without an evaluation, I said I could look over the other psychiatrist's office notes and see if they supported the diagnosis he came up with. The

attorney told me about the case and said he'd send me the plaintiff's deposition and his psychiatric records.

Jim's psychiatrist was Dr. Higgins. The doctor's office notes revealed that he had performed quite an adequate evaluation, the results of which did support the diagnosis of a major depression. The diagnosis was consistent with the data he had recorded. In his opinion, the injuries due to the accident caused the depression. I reported this to Mr. Bradley.

The attorney was not happy with my opinion. He couldn't understand how the psychiatrist could say the injuries caused the depression without having had any of Jim's previous medical records. He hadn't talked to Jim's friends or relatives to see if anything else was going on. He ignored the fact that Jim's mother had some sort of mental

problem years ago.

I replied that he was now making a different point. I told him the diagnosis was consistent with data from Dr. Higgins's evaluation. I suggested to Mr. Bradley that the problem was that he didn't agree with the doctor's opinion about what caused the mental condition.

I reiterated that the diagnosis was consistent with data the psychiatrist had documented. I then focused on the nature of examinations. I explained that a clinical exam is different from a forensic exam. I proceeded to point out the differences with regard to the question of causation.

When a patient consults a psychiatrist clinically, we generally rely on the history he or she gives unless it is glaringly inconsistent with his or her complaints. We may supplement our history-taking when we feel laboratory or other

medical reports are necessary to bolster our diagnosis. When the patient is unable to give a coherent account, or is a child, the story must be rounded out by interviewing others. However, confidentiality may limit this kind of investigation. Actually, in our initial clinical evaluation, we are not so interested in causes as in diagnosis and response to previous treatments.

In the forensic situation, the issue of causation may be more important. Because the psychiatric problem has been raised in the legal arena, the issue of confidentiality may be automatically waived. In my forensic practice, in addition to examining if the symptoms are consistent with the alleged cause, I ask to examine preexisting medical records, witness reports, depositions, and sometimes employment and school records. I review the statements of others who know the plaintiff or defendant, if they are available. I may

well find causes other than the one which is alleged. Can you imagine what would happen to doctor-patient rapport if all these things were requested in the usual clinical situation? The patient would storm out, saying, “If you don’t trust me, doctor, how can I trust you?”

How much information I get in the legal situation is dependent on the attorney with whom I am working; it is the lawyer who must negotiate with the other attorney to get the material. Sometimes, the attorney doesn’t want to give me “too much,” because it might prejudice my opinion. I tell the lawyer I am capable of withstanding such prejudice. Besides, if I testify and am confronted with new data on cross examination, I might have to change my opinion on the stand, and the case may be blown apart.

When I pointed out these differences between

the two types of evaluations, Mr. Bradley shifted his focus. He would not risk having me evaluate Jim; I might agree with Dr. Higgins. Instead, he asked me to testify about the two types of evaluations. The jury might then agree that Dr. Higgins could not testify with any assurance about what caused the depression.

I told him I could testify about the different types of examination, but I could say nothing about Dr. Higgins's evaluation. I added that Dr. Higgins could testify on what caused the depression on the basis of the facts he had.

Mr. Bradley was not one to give up easily. He said that at the trial, he might ask Dr. Higgins if he was certain there were no other causative facts.

I pointed out Dr. Higgins might reply that if there were any other facts he'd be willing to reconsider his opinion. Any witness must be open

to receiving and considering new facts.

And while we were talking about what might happen at the trial, I added that the other attorney might ask me on cross examination if a doctor can form an opinion about a diagnosis to a reasonable degree of medical certainty based on a clinical examination. I'd have to say that the doctor can. We always practice on that basis; if we couldn't, how could we prescribe treatment?

The attorney sighed. He said that he would have to take the chance that the opposing lawyer wouldn't ask me that question, because he had nothing else with which to rebut Dr. Higgins's opinion.

We never had the opportunity to find out if the attorney's gamble would have worked at trial, because the case was settled out of court.

Hunting down causes is one of the most fascinating aspects of my work as a forensic psychiatrist. Often it is painstaking work, but when I can identify a cause (or the absence of a cause in the chain) and I have data to back up my opinion, I may well be in a position to tell the judge or jury something they would not have ordinarily known from common knowledge—to a reasonable degree of medical certainty.

Notes

1 Bushman v. Hahn, 748 F.2d 651, 659-660 (1986)

2 Cloninger CR: Somatiform and dissociative disorders. (In) Winokur G and Clayton PJ (eds.): The Medical basis of psychiatry (2nd. ed.). Philadelphia: W.B. Saunders Co., 1994, pp. 169-192

3 Spiegel D and Montenaldo JR: Dissociative disorders. (In) Hales RE et al. (eds.): The American Psychiatric Association textbook of psychiatry (3rd ed.). Washington: American Psychiatric Press, 1999, pp. 711-737

4 Rothstein MA et al.: Employment law (2nd ed.). St. Paul, Minn.: West Group, 1997, p. 596

5 Dobbs DB: The law of torts. St. Paul, Minn.: West Group, 2000, pp. 1050-1051

6 Carter v. General Motors Corp. 106 N.W.2d 105,109-113 (1960)

7 Rothstein: Employment law, p. 597

8 Jose v. Equifax 556 S.W.2d 82, 84 (1977)

9 Johnson v. City of East Moline 91 N.E.2d 401, 403 (1950)

Chapter 4

Psychiatric Impairments

Remember the medieval judges who knew a witch when they saw one? So, how do modern-day doctors know a sick person when they see one? They take a history from the patient and they use physical examination, laboratory tests and MRIs—they gather all sorts of data. And then they know a sick person when they see one, right? Well, mostly, but not always. Think back to the woman with the somatization disorder (unexplained symptoms all over her body) who complained of pelvic pain. Her doctor performed a hysterectomy—not an inconsequential procedure. But the uterus wasn't sick. Neither was the woman, at least in the way the doctor saw it. The problem is you can't see

pain, either with your eyes or with complicated imaging equipment. And even if you could, you wouldn't be able to tell if it is coming from the uterus or from the person's imagination.

Putting aside somatization disorder, there are people who appear at emergency rooms with a variety of faked symptoms you can't see, and they get "treated." Others actually produce pathology, or they secretly manipulate thermometers or other diagnostic instruments to produce the illusion of illness.[1] No, even doctors don't always know a sick person when they see one.

In the legal setting, instead of "sick" the word "impairment" is often used, although "disease," "defect," "disorder," or "illness" can also be found. For our purposes, all of these terms may be considered as synonyms of "sick." We'll stick with "impairments." According to the World Health

Organization, an impairment is “any loss or abnormality of psychological, physiological, or anatomic structure or function.”[2] Quite a mouthful! In common terms, you’re impaired if you’ve lost some of your health and/or you’re not normal (whatever that means), and it negatively affects the way you or part of your body does things.

Now, when it comes to faked impairments, psychiatry has more than its share of special problems, because there are hardly any tests, X-rays, etc. that allow us to be sure that there is, indeed, an impairment. We listen to what the patient tells us, but you can’t measure a patient’s hallucination; you can’t even hear it. We pay attention to how the patient acts and talks when we evaluate him or her, but it’s not hard to act depressed. Even asking relatives may not help, if they are in on the fraud.

In the clinical situation, this is usually not a problem, although it does occur with people who seek drugs, or those who pretend to seek help in order to satisfy a spouse who threatens divorce. When there is a legal issue at stake, however, the payoff for successful faking can be considerable: more compensatory money, avoiding prison, etc. The courts have recognized that sometimes mental problems can be "too easily feigned."[3]

As Rogers and Mitchell have stated, the question is not whether psychiatric impairment can be faked (it can), but whether we can detect the faker—and separate him or her from the truly impaired.[4] Sometimes psychological tests can be helpful; you can suspect faking if the test questions have been answered in such a way that the test cannot be scored and defies interpretation. The most widely used and respected personality test—the MMPI-2—has scales which can indicate if the

test can be scored, or if it was taken in such a way that no valid conclusions can be drawn. These scales can suggest that the person may have taken the test with the aim of impressing the examiner with his or her high moral standards or if the person may have exaggerated the degree of his or her impairment. The person may give inconsistent answers to pairs of questions which ask substantially the same thing but are phrased differently. There are several scales which can strongly suggest malingering.[5] However, the test must be interpreted with caution, because it may not "fit" this *particular* test-taker. It is one piece of data, which must be combined with other data about the individual. Even tests which have been constructed specifically to detect malingerers are subject to errors. They may accuse someone who is genuinely impaired.[6] Testing can be helpful, but it is not definitive.

Tests were helpful in the evaluation of Fred Baker, a 34-year-old man who was knocked to the floor by a heavy piece of lumber in the lumber yard where he worked. There was a bruise on his lower back but no other findings except for complaints of back pain. The bruise went away, but the pain persisted. Several doctors agreed his description of the pain did not fit any neurological syndrome. He was either faking or psychiatrically disturbed. He was referred to Dr. Gibbons, a psychiatrist.

Dr. Gibbons took a careful history. Several years earlier, Fred was injured at home. Although the injury was not particularly impressive, Fred responded with excessive pain and a mild depression. He was treated with antidepressants and his condition cleared up after a few months. The present problem seemed to be a repeat of the previous causal chain— relatively small,

somewhat painful injury inducing a psychiatric reaction. Only this time, more than a few months had passed without significant progress.

Dr. Gibbons treated him for well over a year. Apparently, Fred had a serious depression—low energy, sad mood, loss of interest in anything. He felt guilty because pain prevented him from working to support his family. His memory was faulty and he couldn't concentrate. And he was beginning to hear occasional voices. The diagnosis was major depression with psychosis. The psychiatrist tried various medications in adequate dosage. Sometimes, it looked as if Fred were improving, but inevitably there was a relapse. When the doctor was contacted by Fred's attorney, he gave him the sad news: Fred was too sick to work, and the outlook for a complete recovery was not good. Sad news for Fred, but at least it would help the lawsuit.

After reviewing the records, I interviewed both Fred and his wife. Fred looked dejected and his speech was slow—as if it was an effort to produce sentences. The only time he showed any measure of enthusiasm (and it wasn't much) was when he talked about his back pain. His day was "pure shit. I sit at home and wait for another day." He said he was making no real progress with Dr. Gibbons. "He's a nice guy, but he doesn't seem concerned about my pain."

There did seem to be some psychotic features. He told me he sometimes heard voices when he was home alone, although he could not make out what they were saying—"Like someone's playing tricks on me." Sometimes he saw snakes. They seemed to appear when he was hearing the voices.

Fred's wife confirmed that her husband had gone downhill. When he heard the voices, he asked

her whether she could hear them. He did virtually nothing all day and she couldn't motivate him. He preferred to be alone. His sleep was poor.

On the surface, Fred did seem to be suffering with a psychotic depression, but there were a few puzzles. It would be very unusual to encounter a depressed person who experiences such simultaneous auditory and visual hallucinations as voices and snakes. And why would he ask his wife if she heard the voices when they came to him while nobody was home? He had told one doctor the accident knocked him out; he told another he had not been unconscious. With me, he split the difference—"I was kind of in a daze." Then, there was his gait. One orthopedist noted he had changed the leg on which he limped. And sure enough, when he came in to see me, he was limping on his right leg, but when he departed, the left leg had the limp.

In order to look further into the question of faking, I gave him the Rey Test. This is a brief memory test of fifteen items so arranged that even mildly mentally defective people can remember nine of them. Fred reported remembering only seven. While I didn't know his exact I.Q., his vocabulary and sentence structure was such that it was unlikely he was retarded. Another piece of data.

I next administered the MMPI-2. This was a laborious process because the test consists of 567 true-false items, and Fred had already told me he had a reading problem. I read the items to him. This turned out to be a bit of luck. When I received the computer-generated report, it was apparent the test was not able to be scored. Fred had endorsed so many problems which rarely occur that the invalidity scale was not only high; it was off the chart. In addition, almost all the problem

scales were extremely high. This kind of problem exaggeration could result from low reading level, severe psychiatric confusion, a plea for help, or falsely claiming problems. Because I read the items to him, poor reading ability was ruled out. The conduct of our interview made it clear he wasn't severely confused. While I couldn't really rule out the plea for help, his presentation to me in the interview gave me no data to support it. And I already had the other data supporting falsification of reported symptoms.

I tend to be conservative about testimony regarding malingering. I feel it is up to the judge or jury to decide whether the person is being truthful. When there is a conflict in testimony, they are the ones who decide whom to believe. In this case, I presented the data and said I could not make psychiatric sense out of all these findings; they didn't all fit together. The judge asked me if

Dr. Gibbons, who had seen him for over a year, was wrong. I replied that the clinician tends to believe the story, unless something doesn't fit. The forensic evaluator has a higher index of suspicion. Dr. Gibbons did a competent job with the data he had, but the deposition he gave indicated he did not have all the medical records I had. And he didn't administer the tests; he had no reason to. The judge ruled against Fred Baker.

I witnessed a funny coda to this evaluation. Several months later, I was in the courtroom waiting for my case to come up. Another case was being argued, and lo and behold! There was Fred going up to the witness stand without a limp. He was testifying on behalf of a friend. His speech was enthusiastic, and his memory and concentration were fine. Do you believe in miracle cures like that? I don't.

Psychological tests are only one type of strategy for attempting to detect faking.[7] We look for inconsistencies, overuse of rare symptom combinations, or observing differences in what is reported and what is seen. These kind of discrepancies led me to wonder about Frank Conway.

Frank, a factory worker, slipped on a wet floor in a convenience store. The emergency room doctor said he'd strained his back. Unfortunately, the pain persisted and was severe enough to interfere with his ability to continue working in the factory. He consulted several orthopedists, and there was general agreement that Frank's spine had been slowly degenerating prior to the accident. However, his problem was aggravated by the fall. While he had more pain than one would expect from this kind of condition, the doctors agreed he did have an injury. Frank was optimistic

about his chances for recovery. The doctors were less sure, but they were impressed with Frank's spirit. One note read, "He refuses to believe I can't restore his back to what it was before."

According to those records, Frank finally did believe he would be handicapped for life, and his optimistic bubble burst. His status had changed from a productive wage earner to a relatively sedentary person, from an athletic handball player to someone incapable of physical exercise. He became despondent, and his doctor referred him to a psychiatrist.

According to the psychiatrist's deposition, Frank had lost his selfesteem, he felt hopeless, and he could not do much around the house because of his depression. He was irritable and had withdrawn from friends. Although he responded somewhat to antidepressant medications, he had

settled on a plateau—moderate depression—and was unlikely to improve further.

Since Frank was suing the convenience store, his attorney sent him to another psychiatrist for a further opinion. This doctor was more robust in his appraisal. First of all, the doctor reported there was no doubt this was a man of "the utmost veracity." He then proceeded to describe symptom after depressive symptom—almost a textbook case. The diagnosis was major depression, severe. The prognosis was grim. In essence, Frank was a basket case.

After I evaluated Frank at the request of the attorney for the insurance company, I was not so sure he was a man of "the utmost veracity."

However, I was quite certain the doctor who wrote that report was not a psychiatrist of the utmost veracity. When Frank came for the

appointment, there was no basket case at my door. Frank arrived, sipping a large coke. He was pleasant and voluble. True, when he described his many depressive symptoms, his expression was downcast. “I don’t have any motivation. I have no desire to get out. I try to read the paper, but I can’t concentrate much. Nothing interests me.” However, when I asked him what was going on in the world, he began to wind up. He knew about the presidential campaigns—“that rich guy” (he named a candidate) trying to buy the election. “They all promise so much. If they kept half their promises, this would be a great place. They think they can tell us anything and we’ll believe it. There’s an old saying, ‘Not every closed eye is asleep.’ I’m not blind.” Well, Frank’s self-esteem hadn’t decayed.

He really took off when I asked if he watched TV. “Only ESPN- sports, that’s my thing. You better

believe I used to be a sports man. Basketball, football, baseball, tennis, handball. There's an NCAA tournament going on right now. Yesterday I had to switch back and forth between the basketball and the tennis at Forest Lawn." Not bad for a man who lost all interest and motivation.

He leaned forward for emphasis (apparently that position didn't bother his back). "My son's just like me. I talk to him. I told him he has to concentrate on just one or two sports. I was pushing basketball. When I watch him in a game, I'm his number one fan. It's a big thrill." Yes, indeed, a big thrill for a man who is severely depressed.

I decided the attorney's psychiatrist was either totally inept or a hired gun. I opted for the latter. I had to give more thought to the report of Frank's treating psychiatrist. I could not go along with a

diagnosis of moderate depression, but perhaps there were some mild depressive symptoms. Maybe the antidepressants had done a fair, but not complete, job. Alternatively, maybe the man was faking. Perhaps an MMPI-2 could shed some light.

Frank's MMPI-2 was easily scored. There were no suggestions of faking or even exaggeration. There were signs of anxiety and depression. The report seemed to go along with one of the two possibilities I had considered—depression, largely in remission.

I called the attorney with whom I was consulting, and I told him about my findings and the two possible conclusions—mild depression made better by treatment or faking. He responded with laughter as he said he was just about to call me. He'd hired an investigator who got an interesting video. The attorney scheduled a

meeting with Frank and his wife together with their lawyer. The tape was shown. There was Frank in great form on the handball court. His attorney was furious at him, but nothing like his wife. She was livid. He'd even fooled her!

I was left with several questions. Why didn't Frank's treating psychiatrist see the enthusiastic behavior I saw? I can only guess. Possibly it was because of the way clinical psychiatrists tend to see patients during this era of managed care. The visits are short and symptom-focused. There is little time for broader discussions about daily life or about sports. When he described his symptoms to me, Frank's demeanor was also downcast.

And why was Frank's wife livid? Was she really fooled, or was she angry because she may have let him persuade her to go along with the false story? Or was she angry because he was "foolish enough"

to get caught? Human behavior has many twists and turns, and we psychiatrists don't have all the answers. We shouldn't pretend that we do.

There is no sure way to diagnose psychiatric malingering. The strategies can sometimes point in that direction, but unless there is actual direct evidence (such as the videotape), you are left to wonder. In my view, a psychiatrist can testify to a reasonable degree of medical certainty that the data we have does or does not fit someone who has a psychiatric disorder,[8] but we are on shakier ground when we try to do the judge's or jury's job of calling someone a liar. That is why I present the data and my opinion, and I let others decide.

When you encounter obvious cases of malingering, it is easy to believe that everyone who is in a legal situation is lying. Most of the people I see give no evidence of faking. The data I

gather from them indicates there is a reasonable causal chain leading to a bona fide psychiatric impairment. Then I must reach the next question: How badly is the plaintiff impaired? In workplace accident and personal injury cases (such as auto accidents) the more severe the impairment, the greater the compensation. (In other types of cases, such as criminal insanity pleas or psychiatric hospital commitment, the issues of impairment severity are handled differently, but are no less important. These issues will be discussed in subsequent chapters.)

The American Medical Association has published the *Guides*,[9] now in its fourth edition, to enable physicians of every specialty to evaluate the degree of impairment. By fitting the person's symptoms with the descriptions in the book, doctors can arrive at a reasonable estimate of how impaired he or she is—an estimate which is

expressed numerically.

There is a curious thing about the *Guides.* You may remember the Frye and Daubert standards described in Chapter 2. The Supreme Court rejected opinions based only on consensus of people in the field; opinions must be based on data which can be tested. Yet we read in the *Guides* that the degrees of impairment have been decided by consensus of authorities in each specialty.[10] And how could it be otherwise? In many cases—and especially in psychiatry—there is no scientific way of determining whether one person is more impaired than another, or more specifically that one is impaired twice as much as another. Once again, the courts must rely on estimates that are reasonable (that word again) in order to proceed with their decision-making.

The *Guides* is used in most states in the United

States. In every specialty except psychiatry, the book gives criteria which translate into a number or range of numbers. For example, amputation of the thumb equals 40 percent impairment of the hand; amputation of the little finger equals 10 percent of the hand. Unfortunately the psychiatrists who designed the psychiatric section of the *Guides* balked at using numbers; they separated the degrees of impairment into five levels: none, mild, moderate, marked, and extreme. While they given cogent reasons for not using numbers, in my view this system is not very practical, because judges sometimes need numbers to put into the complicated mathematical formulae used to determine the level of compensation they will award to the plaintiff.

I prefer to use the Global Assessment of Functioning (GAF) described in the psychiatric diagnostic manual.[11] The group of psychiatrists

who worked out this system did not shy away from the use of numbers, and they linked various specific symptoms and activities to numerical levels of functioning. The scale goes from zero to 100, divided into ten levels. For example, a person who is acting on the basis of delusions and hallucinations or stays in bed day in and day out with no real communication is functioning somewhere in the 21-30 range. The rater can fine tune within this range. By contrast, the person who may overreact a bit after a family argument or has minor difficulties on the job or in school is put in the 71-80 level. The person who has no more than everyday problems with which he or she can cope well falls in the 81-90 level—that's where most people without any significant psychiatric problems fall. The top level is reserved for super-people who are sought out by others because of their many positive qualities and

whose life never seems to wobble. I haven't met any of them.

The GAF is an adaptation of a previous scale of functioning, which has proven to be reliable—that is, several unbiased raters with no ax to grind will come up with similar ratings.[12] Additionally, a person's score changes over time if there are changes in the person's condition.

Many people who suffer injuries had psychiatric problems before the injury being litigated. Suppose they were on a mild-symptom level (say, 65) before the event. Because of the recent injury, they may be now rated on the GAF at a level of (say) 55—moderate symptoms. Do we report that the recent event caused a drop of ten points in the GAF level? Generally, we do not. If the previous condition was aggravated by the recent injury, the defendant is liable for the whole

amount of impairment—presumably a drop from where an unimpaired person would be. The only exception is when the recent injury produces a set of symptoms clearly differentiated from the earlier disorder.[13] Clearly, what level you take as the starting point from which you will subtract the current (post-injury) level can make a significant difference in the amount of compensation the plaintiff will receive.

The starting point became an issue in the case of Ellen Clark. Ellen was driving over a bridge on the highway when another vehicle swerved and hit her. Fortunately, she was able to wrestle her automobile back under control, and she came to a stop just shy of striking the guard rail. She sustained a minor bump on her head. But she had a lasting vision of the guard rail getting closer and closer. She shuddered every time she thought of it. Her sleep deteriorated and she had occasional

nightmares, not only of what had happened, but also what could have happened if the guard rail didn't hold and she plunged into the river. There was a pall over her daytime activities; it was hard to teach youngsters in school when she was preoccupied. She had post-traumatic stress disorder.

Fortunately, she had good treatment, and the sharpest symptoms disappeared. Although she still had some insomnia, the nightmares diminished in frequency. Even though she tired easily, she was able to resume teaching. She was driving again, but crossing a bridge caused her anxiety. Progress, but some residual.

According to Ellen's psychiatrist, she was functioning on a GAF level of 60 (the top of the level with moderate symptoms). He said she was 40 percent impaired. He must have thought that

before the accident she was operating at a GAF of 100 (100 minus 60 would be 40 percent impairment)—if he thought about it at all. That would have made her not only a super-person, but at the top of the super range before the accident.

Ellen's attorney felt she had a 50 percent-60 percent impairment. He didn't need to use the GAF; he knew a sick plaintiff when he saw one. Besides, he needed to persuade the jury that Ellen really deserved substantial compensation. Unfortunately for his case, the psychiatrist consulting with the defense rated her with a 15 percent impairment due to the accident. Hoping I could rebut that psychiatrist, Ellen's lawyer asked me to evaluate Ellen.

Actually, in such personal injury cases, the issue of degree of impairment (in numbers) doesn't always come up; the plaintiff's attorney

merely wants you to impress the jury with the symptoms. The lawyer hopes the defense will not find any preexisting problems, but he or she isn't going to go looking for them. In this case, however, the severity of the injury- caused impairment had come up, and a battle of the numbers had already been joined. Therefore, in addition to the accident report and the records and depositions of the psychiatrists involved, I asked for Ellen's evaluations at school as well as her doctor's records before and after the accident.

Prior to the accident, Ellen got reasonably good reviews from her principal, although there were some comments about how she let the children upset her and how she sometimes lost control of the class. She was seen crying with frustration at times in the teacher's lounge. Luckily, she could pull herself together and return to the classroom. Teachers do this occasionally—especially young

ones. It's not particularly a sign of psychopathology.

However, her family physician carried this to a different level. His records indicated she was complaining of occasional insomnia, worry about her school performance, and a gradually mounting anxiety about her ability as a teacher. He prescribed a mild antianxiety pill which sometimes calmed her down. All this before the accident.

When I saw Ellen, she was a pleasant woman of 34, married, with two children. She went over the details of the accident and recounted her reactions to it. She was pleased with the progress she had made in treatment. Her story confirmed what I had read from her psychiatrist. I felt his rating of her current functioning at GAF 60 was quite reasonable.

The next step was to assess her functioning level prior to the accident. In my judgment, Ellen was functioning on the level of 70 before the accident—a few mild symptoms and a little difficulty functioning on the job. A reasonably functioning woman, but not at a level of GAF 100.

In my opinion, the symptoms produced by the accident were sufficiently different and sufficiently related to the accident to constitute a new problem rather than an aggravation of the older one. Coming down from this point, the decrease in her functioning due to the accident was 14 percent. I wouldn't argue with the defense's psychiatrist who rated her at 15 percent.

Needless to say, Ellen's attorney was less than enchanted with my appraisal. He decided not to have me testify at the trial. He thanked me, but he never called me again. I suspect he settled the

case.

As I mentioned in Chapter 1, the lawyer's job is to do the best for his or her client. Better to have a "flexible" expert who can be counted on to maximize or minimize the impairment rating (depending on which side the attorney is on) than one who can't be relied on. Theoretically, at least, the opposing attorney can mute this effect by hiring his or her own "flexible" attorney. While this may be good for the legal profession, it leaves an unfortunate stain on the psychiatric profession. This "bending" of impairment ratings occurs in other medical specialties as well. For example, I have reviewed orthopedic records which gave differing impairment ratings on the same individual.

I do not mean to imply that every time there are different opinions, one or both experts are

either prostitutes or are using junk science. As I stated above, impairment rating is not an exact science. But it is the only science available. Reasonable and conscientious experts can disagree. However, when both experts have essentially the same data and there is a wide disparity, you are left to wonder.

In the pursuit of persuasion, cross-examining attorneys will try to show the expert is biased. Frequently they ask you the standard trick question: “Do you mostly testify for the defense, Doctor?” Forensic psychiatry is largely a referral enterprise. If the evaluation helps a defense lawyer win an important case for the client, he or she may pass your name on to colleagues. Pretty soon, you are getting calls from other defense attorneys. Plaintiffs’ attorneys won’t call you, because they think their chances of a favorable report aren’t very good.

Does that mean the psychiatric expert must stretch the impairment severity in order to get referrals? I would be less than honest if I said the thought never crosses my mind. It is the great temptation of forensic psychiatry. I do the best I can to avoid this breach of ethics. Often, I tell the attorney I cannot be of help, or my impairment assessment is the same as that of the expert on the other side. One of the satisfactions of this approach is that I have developed a cadre of referring attorneys who really want to know my opinion. I can only surmise that the companies they represent are willing to be fair. These lawyers have stuck with me even when I have not rated impairments as severe as they would have liked.

Back to the trick question: “Do you mostly testify for the defense, Doctor?” The answer would have to be “Yes.” But the more telling question, the one I have never yet heard in court, would be, “Do

your findings always support the defense, Doctor?" While I don't keep count, I could say there are many occasions when, because my findings are not supportive, the case has been settled and I did not testify at all.

I had an amusing interchange with a district attorney early in my career. I was testifying about the psychiatric impairment of a defendant in a criminal case. The prosecutor asked me the "Do you mostly" question, and I replied, "I've been waiting for your call, but it never came." The gratifying end to the story was that I actually received his call some time later when he had doubts about the findings of his own expert.

It is generally easier to diagnose that a person has a psychiatric impairment than it is to be absolutely certain about what caused it or how severe it is. We can only be confident to a

reasonable degree of medical certainty. Yet, these are things judges and juries often need to know in order to render their verdicts. Psychiatrists can best help by avoiding psychobabble and not relying on tenuous theories. Plain talk about our opinions and presentation of the data by which we have reached those opinions can help the judge and jury reach their own conclusions.

Notes

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Chapter 5

“Impairments Are Forever!”

If someone’s legs must be amputated because of an industrial accident, he or she will be impaired forever. The legs will not grow back. The victim is also likely to be disabled—unable to work any more. Many medical conditions are permanent and may even deteriorate further. Far advanced cancers, certain serious heart conditions, blindness, and lungs crippled by smoking will never be reversible. Doctors aim to slow the course and impact of the illness, but recovery may be out of the question.

Only a few decades ago, many psychiatric patients were condemned to a lifetime of severe impairment. With the advent of newer

medications, innovative psychotherapeutic and rehabilitative techniques, and an explosion in our understanding of the way the brain works, the picture has become much brighter. Schizophrenia can often be controlled—not cured, but alleviated to the point where patients can improve much of their functioning.[3] People with bipolar disorder, once subject to a lifetime of depressive slumps and manic highs, can now be smoothed out.[1] There are medications which may control impulsive and aggressive behavior.[2] Even that annoying "habit" of going back again and again to make absolutely sure the door is locked can often be controlled by medication and behavioral psychotherapy.[4] The list goes on and the picture is getting rosier. There is still a long way to go, but researchers have already traveled considerable distance.

Good news for the average patient, but not always good news when the patient becomes a

plaintiff in a law suit. If this plaintiff has a psychiatric impairment which renders him or her unable to work and it is judged to be permanent, the financial awards can be considerable. In workers' compensation cases, the plaintiff may get a lump sum of money calculated on the basis of his or her previously expected working life. Disability policies also take into consideration whether the plaintiff will ever be able to work again.

In other accident and injury cases, the awards may be even higher. The attorney may bring in an economist—a relatively new breed of expert—who will painstakingly calculate the plaintiff's potential economic loss in front of a jury. This is more than a matter of mathematics; remember, the courtroom is an arena of persuasion, and all the while the economist is talking, the jury is being impressed with the anticipated years of continued financial suffering. And in these cases, the

monetary award is usually decided by the jury, rather than by some formula. The award may skyrocket.

Since the question of whether an impairment is permanent requires knowledge not usually available to the judge or jury, it falls to the medical expert to render an opinion. Unfortunately, in many cases, this is not an easy call, unless, of course, the "expert" is careless or is a prostitute. Take the case, for example, of Stuart who claimed a minor back injury on the job. Several months later, even though his family practitioner had not noted any significant psychiatric problems, his attorney recommended he see Dr. Starrett for an evaluation. Since this was a forensic evaluation rather then a contact for psychiatric treatment, Dr. Starrett saw the plaintiff on only one occasion.

The psychiatrist diagnosed a severe

depression as a consequence of the back injury. The proof of the causal link was that it had started one year previously, shortly after the accident. And since it had not been treated for that length of time, it had "set in." The doctor said that "any depression that hasn't been treated for over a year can no longer be helped!"

When I saw the plaintiff, I felt he was unhappy about his loss of income and perhaps he had a mild depression, but he was nowhere near meeting the requirements of a diagnosis of severe depression. And suppose he had really had a significant depression, would it have been permanent? How do you know any depression is treatment-resistant until you have tried to treat it? Many people who are more seriously depressed than this man—and for longer periods of time—can be made functional and return to their jobs. I couldn't wait to testify to the judge about the

absurdity of the other psychiatrist's statement, but I never got the chance. The case was settled.

How do we determine if an impairment is permanent? As I discussed in the previous chapter, the American Medical Association has published the *Guides.*[5] The full title of this book is *Guides to the Evaluation of Permanent Impairment.* The Glossary tells us "permanent" refers to medical conditions which are stable (unlikely to change by more than 3 percent in the next year with or without treatment).[6] However, in the psychiatry section we learn that "Determining permanent impairment is often imprecise, and rarely is there certainty that it exists."[7] We aren't fortune tellers. We have no good guidelines except experience of the profession—the reasonable degree of medical certainty again.

This problem occurs not only in psychiatry. A

neurosurgeon evaluated a woman who complained of neck and arm pain after she fell at work. When he evaluated her, he found no objective neurological signs; nor did imaging studies reveal any structural abnormalities. Nonetheless, the pain she described was consistent with irritation of some nerves coming out of the spinal cord at the level of her neck. He felt there was no reason to think she was malingering. Asked whether the condition was permanent, he replied, “I guess I have to send you to the chaplain’s office for the answer to that one, sir. It is entirely possible she could get better. It is also entirely possible she could never get better. It’s impossible for me to say one way or the other.”

However, there are some situations where we can, to a reasonable degree of medical certainty, say that a psychiatric condition is permanent. A condition may be permanent if a person remains

impaired because he or she refuses to go to the doctor or declines to follow the doctor's orders. In most cases, the lack of cooperation will bar that person from claiming permanent impairment. Most cases, but not all. One case, unique in my experience, illustrates an exception to this rule. Sylvia claimed she was permanently unable to work and she wanted to collect her disability insurance.

She was 36 when her marriage fell apart. It was a bitter divorce and custody fight, one which overwhelmed her. She was always somewhat timid, and she tried to avoid confrontations. "I get uncomfortable when I'm angry," she told me. Ultimately, she won custody of the two children, but their father refused support payments. It had been a never-ending series of court battles, and Sylvia was drained. More than drained, she began to experience panics. Unpredictably, she became

short of breath and felt as if her heart was about to pound out of her chest. Her thinking got fuzzy and she was sure she was going to die from a heart attack. She perspired profusely. After a while, the attack subsided, but the memory of what she'd just gone through lingered. Sometimes, these attacks woke her at night; at other times, they occurred during the day. Because she never knew when to expect an attack, she was preoccupied with the anticipation that one might occur at any moment. She began to organize her life so that she'd never be far from help if she needed it. All this, of course, precluded her working as a secretary.

Sylvia had never been one to visit doctors; the idea of putting "drugs" into your body repelled her. Her idea of a healthy lifestyle was to watch what she ate and get plenty of exercise. Not a bad regimen, for starters, but sometimes more is necessary. Sylvia was aware that some

circumstances required professional help. Whenever she felt poorly, she consulted an "alternative medical provider," one who prescribed massages and dietary changes to put her body "back in balance." When she consulted him about her panics, he plucked a hair from her head and sent it off to a laboratory. Sure enough, the report came back stating that Sylvia had multiple heavy metal toxins. These needed to be dealt with by rebalancing her.

At the insistence of her mother and the strong suggestion from the insurance company, she did consent to see a psychiatrist. He diagnosed her as suffering from panic disorder, and he began prescribing an antipanic medication. According to his records, he recognized her fear of medications. He spent time discussing possible side effects and started her on a very low dose, working up only gradually to a reasonable, but not maximum, dose.

Sylvia told me the psychiatrist explained everything; he was very nice and very gentle. She did not experience any side effects, and she appreciated the slow pace at which he increased the medicine. He also tried to guide her through some mental exercises to ease her apprehension.

When the panics didn't respond to the new regimen, the insurance company asked me to do an independent medical examination to see if her problems would be permanent. Sylvia was a pleasant but somewhat dramatic person. She could go through a gamut of emotions within fifteen minutes, depending on what she was talking about. At one point, she held her head in her hand and stared at the floor—the picture of dejection. Softly but firmly, I said, "Lift your head up so we can go on." She looked at me and smiled, and we proceeded. She was very suggestible.

We talked about many things, and I decided that she did suffer from panic disorder and was unable to work. The psychiatrist was following a reasonable course. But when I went over with her in detail the medications she was taking (including the special foods prescribed to put her in balance), she told me, “Dr. Stevenson prescribes two pills in the morning and one at night, but I really think this is too much, so I take only one a day—when I remember to take it.” She was even less inclined to practice the mental exercises.

From his notes, I could see the psychiatrist was unaware of this. I doubt it would have made any real difference. Sylvia was committed to her alternative provider. And since the impairment had gone on unabated for over a year now, the prospect of improvement looked dim.

Medication and behavioral psychotherapy can

improve panic disorder. A recent study showed that about 80 percent of patients so treated "remained well or were (only) minimally impaired five years after treatment."[8] But despite the psychiatrist's efforts, Sylvia was not being adequately treated. Within a reasonable degree of medical certainty, I could say her condition was unlikely to resolve.

I discussed all this with the insurance company. The insurance reviewer told me Sylvia would be placed on permanent disability. It didn't seem fair to me. The permanence of Sylvia's impairment was due to her own actions. She wasn't following her doctor's advice. The reviewer told me that Sylvia's particular insurance contract entitled her to pick out her own provider, and that alternative practitioners were included. The company no longer includes this particular type of practitioner, but that didn't affect Sylvia's contract.

I am not an expert in this alternative type of practice. Even though I am skeptical, I could not say that his treatment would or would not be effective. I do know that assaying heavy metals in hair is an unreliable method of assessing what is going on in the rest of the body at any one time,[9] and I know of no studies that show panic disorders results from heavy metal toxicity. Perhaps, if the company was not bound by this type of contract and a lawsuit was filed, I could have rebutted the practitioner's junk science of heavy metals. But in this case, junk science won out over reasonable medical certainty.

I distinguish between junk science and twisted science. Junk science is based on faulty research, or on no research at all—just anecdote or wishful thinking. Twisted science, as I use the term, occurs when the expert witness uses well-researched concepts and data but misinterprets them,

perhaps because he or she misunderstands the meaning of the studies or perhaps in an attempt to impress the judge or jury. The witness may twist intentionally or may honestly be misguided; in either case it is twisted science. Twisted science cropped up in one case both in the description of the impairment and more blatantly in the assessment of permanency.

Brad was employed by an environmental cleanup company. He was a high school graduate with a flair for mechanics. After the health physicists and engineers figured out the nature of the contamination and how best to dispose of it, Brad was part of the crew that went in and did the job.

During the course of his employment, he worked on various contaminated sites in the region—sites with chemical byproducts of

different manufacturing processes. Gradually he noticed the onset of bouts of mental confusion. These increased to the point where he felt he could no longer work. He stopped work in 1993.

His memory was spotty, and at times he forgot what he was doing or he didn't recognize things. Sometimes he lost track of what he was saying. He was afraid to drive, although he did drive short distances from his home.

Brad's family practitioner suggested his problems might stem from exposure to the contaminants. A doctor who claimed to specialize in toxic problems agreed to examine him. In June, 1994, he found a slightly increased concentration of lead in Brad's urine. He recommended chelation —a process where the patient is given a substance which removes lead from the body. Urinary lead levels decreased to within expected normal limits.

Brad was convinced contamination was his problem because, as he told me, “Right after the chelation, my memory improved and I could recognize things I had trouble with before.” He assured me the symptoms had subsequently returned.

By this time, Brad had a lawyer and was suing for workers’ compensation, claiming his problems were caused by on-the-job contamination. The doctor who performed the chelation agreed, and the attorney sent Brad to a psychiatrist for a medical opinion regarding his mental functioning. Brad told the psychiatrist that the chelation doctor had found “super high” lead levels. (I can only surmise that the attorney did not furnish the actual reports to the psychiatrist.) After his examination, the psychiatrist reported that Brad was leading an almost vegetative life—doing nothing but sitting around all day. He couldn’t

concentrate; he was forgetful and constantly lost track of where he was in a conversation. He had auditory hallucinations. This was clearly a dementia, due to lead. And more important, the toxic material was trapped in the brain. The dementia was not only permanent; the lead would continue to do its damage and the dementia would deteriorate until Brad became like a person with Alzheimer's Disease.

Here, then was a causal chain: excess exposure to contaminants (assumed but not really shown in the record), leading to lead toxicity, leading to a deteriorating brain condition. But apparently the "toxic-problem specialist" failed to obtain records of Brad's previous evaluations. A neurologist had examined him a few months earlier, and Brad had no neurological signs of lead toxicity. Blood tests did not show abnormal lead levels. An electroencephalogram and an MRI of the brain

showed no abnormalities.

Brad had also been examined by an occupational physician prior to seeing the "specialist." Again, a blood sample failed to show elevated lead levels. How, then, could the chelating doctor have found an elevated lead level? Brad had not worked in decontamination for almost a year. The most probable explanation lies in the nature of the test. There is lead in every environment and it is not uncommon to find some lead in the bodies of many people. The chelating doctor used a urine rather than a blood sample. Urine samples are notoriously unreliable for measuring lead; blood samples (which the others used) are the gold standard.[10] The chelating doctor had not used junk science; there are good research data supporting the techniques he used. Of course, the research showed the techniques he used were not the best available. The science was good; the

doctor wasn't. His choice of lead measurement and his interpretation of the data were faulty—twisted science.

The psychiatrist who predicted permanent brain injury fell (or walked) into the same twisted science position. His diagnosis of lead as the cause was faulty. Although hallucinations can occur in cases of acute lead intoxication (intense exposure over a short time span), they are part of a delirious state and they disappear when the delirium subsides.[11] Brad never was delirious.

The psychiatrist had described Brad's "vegetative" life, and he attributed it to lead toxicity. There have been several neuropsychological studies of workers with documented exposure to toxic lead levels,[12] and while some occupationally exposed workers have shown deficits, their problems are not global and

do not lead to the symptoms Brad showed. The workers' compensation insurer sent him to a neuropsychologist who documented some deficits in thinking processes. The result? "A link to lead poisoning can not be conclusively established."

And even if the causal chain from lead exposure to psychiatric problems were established, would the lead be trapped in the brain permanently and cause Brad's performance to deteriorate to Alzheimer levels? "It would," the psychiatrist reported "because of the blood-brain barrier." More twisted science! There is, indeed, something called the blood-brain barrier; certain substances move between blood vessels and brain tissue only with great difficulty. Lead moves very slowly both in and out of brain tissue, but it does move.[13] No study has indicated that after removal from the exposure there will be constant deterioration, finally leading to an Alzheimer's-like

state.

Interestingly enough, the blood-brain barrier is sufficiently strong that chelation does not remove any significant amount of lead from the brain. And yet, Brad reported that right after the chelation, his mental symptoms lifted, at least temporarily. In fact, that was what convinced him lead was the culprit. There is no way the chelation could have cleared his brain of whatever lead might have been there.

That gave me the clue something else was going on. The neuropsychologist provided some of the solution. He documented that Brad had a severe personality problem; he had “strange beliefs” and was subject to “strange intrusive thoughts” and hearing people call his name. Reason enough to interfere with concentration and make you forget what you are talking about

every so often. And my evaluation led me to the same conclusion. In fact, it turned out that Brad had been hospitalized on two previous occasions because of overly severe stress reactions to events in his life. Only this time he understood his psychiatric disturbances in terms of a chemical exposure.

Indeed, I felt Brad's impairment probably would be permanent; longstanding personality problems of the type he had seldom improve much. But the impairment was not attributable to industrial toxins.

I don't know why the company settled the lawsuit; I can only speculate. The nature of the evidence can get quite complicated—laboratory tests, blood-brain barriers, etc. There is always uncertainty about the outcome when testimony from experts is conflicting. It may be that the

company didn't want to take the chance of an adverse opinion from a judge for whom science was not his long suit. I'll never know. The details of settlements are not generally revealed.

Most often the bottom line regarding permanency of a psychiatric condition depends on whether the psychiatrist has treated the patient vigorously. Only then can the expert reasonably testify that the plaintiff's condition is permanent. The medical phrase is "maximum medical improvement." This means that all reasonable remedies have been tried, and while the patient may have improved, he or she has reached a level which has remained stable and is unlikely to improve further.

Henry was a promising student in high school. He seemed to have not only intelligence but also that extra bit of energy which made him outgoing

and popular. He started college, but he soon got so involved in extracurricular activities that his studies took a back seat. College grades were mediocre—significantly below those earned in high school. Toward the end of his junior year, he seemed to run out of steam. His parents agreed he should take the remainder of the year off to "find himself."

What he found was a management training position in a department store. He applied himself with enthusiasm, and soon he became an assistant manager in a branch store. Every so often, his boss had to rein in his enthusiasm. While some of his ideas were inventive, not all of them were practical. But in general, his manager liked him and predicted a good future for him in the company.

Then he began to develop sleep problems. At

first he attributed his insomnia to overwork. He decided to take some time off. As depression began to set in, he consulted his doctor, who put him on an antidepressant, and shortly he was his old enthusiastic self again. Over the next several years, he had recurrent bouts of overenthusiasm and depression, and his doctor finally referred him to a psychiatrist who diagnosed him as suffering from bipolar disorder—excessive highs and lows.

During the ensuing years, Henry had several depressions and one hospitalization when his thoughts came so fast and he felt so exuberant he bought a variety of tools, even though he had no talent with his hands whatsoever. He started to use more and more sick leave. Finally, his psychiatrist said he was unable to go back to work —permanently. The disability insurer asked me for a second opinion.

I reviewed several years' worth of the psychiatrist's notes. In my opinion, he had tried everything. He was very supportive, being available by phone whenever Henry had an emergency. He explained the illness to Henry and encouraged him to accept his limitations. He helped Henry adjust when he could no longer work. As newer medications were developed, the psychiatrist prescribed them. He had ordered a variety of laboratory studies. He seemed to have left no stone unturned.

When I interviewed Henry, I was struck with the volume and speed of his speech. He was overly friendly. Most of the time, his speech was logical, relevant, and coherent. On a few occasions, however, he seemed to bounce from subject to subject. He could catch himself, however, and get back on course.

He filled me in on some historical details. During some of his depressive episodes he had suicidal thoughts. Once, he played with a loaded gun, but then he put it away. The incident scared him and he got rid of the weapon. In his manic phases he was prone to go on spending sprees. “I got stuff I’d never use. I’d store it in the garage. It got so I had to park my car on the street because the garage was full of stuff. I never even opened the boxes. If I wasn’t earning good money, I’d be bankrupt.”

As his illness progressed, work got harder and harder. He struggled to get up for work during his depressed periods. His manager began to complain about his lateness. During his manic phases, concentration was very difficult, and sometimes he was overbearing when dealing with customers. His performance ratings nose-dived. This added to his emotional burdens, because “I

never used to be even average; I always got great ratings."

Henry's family history was loaded with bipolar disorder. His mother, sister, and niece all had been treated for the disorder. An uncle had killed himself. There was no doubt in my mind. I agreed with his psychiatrist's diagnosis. His treatment was vigorous. The man before me was probably operating on as good a level as he ever would; he'd been much worse at times. In my opinion, Henry's impairment had reached maximum medical improvement; for him, he was doing rather well, considering that he still elevated and sank intermittently. And even on this level, his speech and manner precluded gainful employment. What employer would hire him, knowing that the chances of relapse—either up or down—were high? Indeed, according to the records, the intervals between more significant highs and lows

were getting shorter.

Since I evaluated Henry, some newer medications have come on the market. It is possible that one of these might have made him more stable and changed the picture. I hope so. His psychiatrist has probably already tried them. However, when evaluating maximum medical improvement, we can only go with the treatments which are known at the time we see the person. To say that maybe new medications will help him turn the corner sometime in the future is mere speculation, and speculation has no place in the courtroom. There is always that hope in every branch of medicine. Are we therefore to say that no impairment can be declared permanent—that permanent disability payments should never be given? Here comes that term, "reasonable," again. It is reasonable to assess the claimant from the standpoint of what is known at the time. The

insurance company agreed and Henry was awarded permanent disability status.

There are other times when the psychiatrist fosters the permanence. Forty-six-year-old George was unloading a truck when he was jarred by a stabbing pain from his lower back down through his right leg. The MRI revealed that a lumbar disk was wrenched out of place and was irritating a nerve root. His orthopedist tried conservative treatment, but the pain continued unabated. Finally he had surgery. Although the doctor warned him that surgery is not always successful in this type of case, George "knew" this would be the cure he was waiting for.

Unfortunately, it wasn't. Even though he improved to some degree, there wasn't much he could do without considerable discomfort. Sitting in a chair for a long stretch of time brought on the

pain. So did standing, walking, and even lying in bed. His sleep was disrupted. According to his orthopedist, although the pain complaints were somewhat in excess of what would be expected from the examination, there was no doubt the hoped-for results did not materialize. Even with various analgesics, George's movements were limited. The orthopedist rated his impairment at 10 percent, and he said the condition was unlikely to improve.

The news devastated George. The impairment struck at the root of his self-esteem as a man. The pain was bad enough, but now he could no longer support his family. Why, he couldn't even sit long enough to watch his youngest son play football. Working on the car he was restoring was out of the question. And the many things he used to do around the house were going undone.

Gradually, he became irritable. He hated himself for his growing temper, but he wasn't able to stop barking at his family. Often, he just wandered around the living room, now sitting, now lying on the couch. The television was on, but he couldn't pay attention to it. Sleep became even worse; on top of the pain, there were the worries, and sometimes there seemed to be just emptiness. He found himself thinking life was no longer worth living. When he told his wife about these thoughts, she prodded him into seeing his family doctor.

Dr. Jenkins said he was depressed and he prescribed an antidepressant—one of the newer class of such medications. George reported slight improvement. Just about this time, a former coworker killed himself. This man had been diagnosed with inoperable cancer and he must have decided the pain and incapacity wasn't worth it. As George told me later, "I got to thinking. That

could be me. The suicide thoughts started coming back, and I had to fight them off." His depression nose-dived, and his family doctor sent him to a psychiatrist.

Dr. Blackwell raised George's medication up a notch, and George's suicidal thoughts abated. However, the depression continued. After eighteen months of no further progress, Dr. Blackwell said George was 70 percent psychiatrically impaired and he had reached maximum medical improvement. The impairment was permanent. The employer's attorney referred him to me for an independent medical evaluation of his psychiatric status.

I agreed George was depressed, but not 70 percent worth. It was, however, a significant depression. But was it permanent? I reviewed Dr. Blackwell's office records and his deposition. What

leaped out at me was the fact that while he had raised the medication when George first saw him, there was no further adjustment of the dose. Nor was there any attempt to use a different antidepressant or to use other medications which can augment the power of antidepressants. There was an array of treatment options available, but not used. It was obviously premature to declare George's impairment permanent.

Why did Dr. Blackwell not treat George vigorously? He had full psychiatric training. Certainly he knew of alternative courses of treatment. I can only speculate. I have reviewed more than a few cases where the patient is kept on the same dose of the same medication and ultimately is declared permanently impaired. Do the doctors not keep abreast of the literature? Or are they burned out—seeing too many patients for too short a time? This possibly was the case with

Dr. Blackwell. When I reviewed his office notes, I realized that during every visit it was the nurse who saw the patient and wrote the note and the medication recommendation. The doctor countersigned the note and (presumably) wrote the prescription. George told me the nurse spent fifteen minutes with him and the doctor came in for about five. Although the time spent by each party varies, this type of practice has become relatively commonplace in recent years—in part a reaction to managed care (really managed cost) which regulates how much the doctor will get paid for each type of service. To compensate for managed care and the lowered per-patient income, doctors are increasingly packing patients in—managing time rather than taking time. And what is worse, sometimes contemporary medical practice drives an emotional wedge between doctor and patient which allows doctors to settle

for second-best treatment. They may not take the time to know their patients as people, to do a bit of psychotherapy, to get some human feedback from their patients which might inspire them to think a little harder about alternative medications.

Of course, my forensic practice is skewed toward seeing records of the failures—these are the people suing for permanent impairment. On the other hand, I have reviewed the medical records of several courses of treatment where the psychiatrists have gone to extraordinary lengths to help their patients with resistant illnesses. However, quite a few studies indicate that a substantial number of psychiatrists, as well as other physicians, do not treat resistant depressions vigorously.[14] It is a problem in our profession.

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Chapter 6

Long-Distance Evaluations

George III,[1] King of England from 1760 to 1820, is probably best known in the United States as the monarch who treated the colonies unfairly and whose armies lost the American revolution. Far from a despised tyrant in England, however, he was very popular with the common folk. But everyone agreed he had bouts of madness. Although his physicians at the time did their best to diagnose and treat him, they were perplexed. Because the illness came and went, some figured he had a feverish delirium, but there was no apparent fever. Others said the madness resulted from disturbances of the bodily humors.[2] It was a mystery.

If the royal physicians had to testify in court, there would have been a battle of the experts, each testifying to a reasonable degree of medical certainty. And their testimony would have passed the Frye test, because these doctors reflected the "wisdom" of their colleagues. Of course, the king wasn't tried in a present-day court, and it would be years before the Frye standard was articulated, and anyhow, it wasn't articulated in England. But however baffled the physicians were, at least they had the opportunity to examine the patient.

The mystery lingered for well over a hundred years. Medical knowledge advanced, and now modern doctors were interested in the mad king's illness. Since he was long dead, examining him personally was not possible.

Now a question arises: Can you make a diagnosis about someone whom you have never

examined personally? Or whom you have not seen when he or she was actually suffering from the illness? Can you come to a conclusion to a reasonable degree of medical certainty? Can you do an evaluation at a distance in space or in time?

Let us follow the story of George III and see where it leads us. In 1941, Guttmacher studied the historical documents which recorded the king's illness.[3] He decided the king suffered from manic-depressive illness—a disease unknown back in King George's time. People with manic-depressive illness—currently called bipolar disorder—can be plagued with bouts of psychotic behavior, and they don't have fevers. (The idea of shifting bodily humors had long since gone out of style.)

The etiology of manic-depressive illness was not well worked out in 1941. However, this was a period of intense psychiatric interest in

psychoanalysis. Two of its theoretical concepts in vogue when Guttmacher wrote his book are of interest to us: (1) Personality is formed by one's earlier experiences, and (2) stressful events in one's life can stir up unconscious conflicts and even cause "decompensation" into psychotic states. On the basis of his research, Guttmacher put together an evaluation: The vulnerability of the monarch to bouts of manic-depressive psychosis resulted from an unstable personality because of his upbringing,[4] and the stresses of his reign together with family problems initiated the periods of his decompensation.[5] Of course, Guttmacher never examined his subject (the king had been dead for over 100 years), but he relied on records and the prevalent psychiatric understanding. If Guttmacher was testifying, he would have met the Frye standard. But his formulations were not based on tested theories,

and his leap from actual data to formulations was speculation. As I discussed in Chapter 2, speculation has no place in the courtroom.

In the late 1960s MacAlpine and Hunter, armed with newer medical knowledge, investigated King George's sickness. They published an account of their remarkable medical sleuthing in 1969, and they concluded King George suffered, not from manic-depressive illness, but from porphyria.[6]

Porphyria is a disease caused by an excess of porphyrin, a purplish pigment which is found in everyone's cells. The body usually can strike a balance between its creation and excretion. But in porphyria, the balance goes haywire, resulting in too much porphyrin circulating in the bloodstream. Periodic toxicity can produce a variety of neurological symptoms, including weakness, pain, gastrointestinal disturbances, and

bouts of irrationality when the nerves of the brain are attacked.

Supported by countless documents, the result of exhaustive research, MacAlpine and Hunter showed that all the reported symptoms of the king fit what attacks of porphyria can do. Of course there were no laboratory reports; there were no laboratories in King George's time, and even if there were, no one would have known what to look for. But a tell-tale "laboratory" bit of evidence was reported back then: during the attacks, King George's urine was purple—stained with porphyrins.

MacAlpine and Hunter were cautious. They wrote, "A retrospective diagnosis can hardly ever be made with the same confidence as one in a living patient."[7] But they unearthed more evidence. Porphyria is a hereditary disease.

Fortunately, descendants of royalty are generally easier to locate than those of the general public, even after 140 years. They found four living descendants with porphyria. Then they went backwards through whatever documents they could find, and they discovered evidence of several ancestors who had clinical signs of porphyria. The documents included some which even recorded the discolored urine. They traced the illness as far back as Mary, Queen of Scots, who lived in the 1500s.[8]

In my opinion, if they had to testify in court about George III, they would have met the Daubert standard discussed in Chapter 2—conclusions based on evidence which rests on the scientific standards of testability, peer reviewed in professional journals, and widely accepted in the medical community. And they did all that without examining the patient—long-distance evaluation.

Of course, MacAlpine and Hunter were not testifying in court; they were writing a historical treatise. Just how certain one must be about diagnosis depends to a great extent on the use to which the evaluation is going to be put, and on what the consequences of the diagnosis are likely to be. In his book about the psychology of Lincoln's depressive moods, Burlingame, a historian, put it very well when he offered in his book "what I hope are informed guesses about my subject's inner life."[9] Thus he modestly told us the degree of certainty of his formulations—they were informed guesses. And what was his purpose? Burlingame said it was to make Lincoln "more human and understandable."[10] And the consequences? Historians might modify their view of the president, or at least scholarly discussion would be stimulated. Quite appropriate for the historical arena.

Contrast this with the legal arena which, in my view, requires a higher degree of certainty because the aim is decision-making, and the consequences are more pressing. People may gain or lose substantial sums of money, they may lose custody of their children, they may be sent to a mental hospital or prison. They may even be put to death.

Guttmacher and MacAlpine and Hunter were operating in the historical arena, although they might have prevailed in the courts of their time. MacAlpine and Hunter might even have prevailed in today's federal courts. But, as they warn, long-distance evaluation is second best.

Many critics of forensic uses of psychiatry feel that long-distance evaluation may not even reach the level of second best. How can you tell about the mental functioning of people you never met, or

those you didn't interview months or years ago when they did something that brought them to court? Well, the story of King George's porphyria shows that you can, to a reasonable degree of medical certainty, do just that. Of course, we psychiatrists don't have the time or resources to do such a thorough job as MacAlpine and Hunter. On the other hand, sometimes we do have sufficient data, resting on good science, to make a reasonable long-distance diagnosis.

The most common situation is that of a criminal defendant pleading he or she was legally insane at the time the offense was committed. The psychiatric witness renders an opinion about whether the illegal behavior is caused by, or is a feature of, mental illness. Ultimately, the jury decides if it believes the behavior is tied to a mental illness. It can be a puzzling decision, depending in great part on what one considers is

mental illness and what one thinks is not mental illness.[11] I shall discuss this problem further in Chapter 14.

If the defendant prevails, he or she is sent to a hospital, not to prison. If you don't agree with the decision, don't blame the psychiatrist. Blame the judge or jury; they are the ones who decided the defendant was insane. Of course, if, in your opinion, the psychiatrist was an out-and-out prostitute, blame the doctor too. And if you're still upset, blame the prosecutor who didn't get a consultation from a psychiatrist who plays it straight and who might have rebutted the prostitute. However, if you feel the whole system just coddles killers, blame the legislators. They set up the rules, the psychiatrist has followed their guidelines. I must tell you, though, that you might not get very far, The insanity defense has withstood the test of time; it has survived since

the thirteenth century.[12]

"Insanity," then, is a legal term, not a medical one. The laws of the various states give guidelines for the determination of insanity. They are not a list of diagnoses; they are descriptions of the defendant's state of mind at the time of the offense. To help the judge or jury decide, the psychiatrist may be asked to do a long-distance evaluation: See the defendant today and obtain whatever records you can about his or her mental state way back when, and come up with an opinion about his or her mental state way back when. Kind of like interviewing King George long after one of his bouts and getting reports of his behavior when the bouts occurred.

Steve shot his parents while they were sleeping. Some months later, Jim Colquitt, the public defender, asked me to evaluate him. The

guidelines for legal insanity in that state were patterned after a well-known English case which was decided in 1843—M'Naughten's Case.[13] Essentially, Steve could be adjudged insane if he could not understand the nature of what he was doing and if he could not understand that it was wrong. And a doctor could testify about the defendant's mental state at the time even though the evaluation was made at a much later date.[14]

The details of the case were scanty because no one else was in the house at the time. Steve's rifle, fingerprints and all, was found in the yard in plain view. His car was gone. Five days later, Steve returned and he was sitting calmly on the porch, as if nothing had happened.

Some testimony from neighbors indicated they had often seen him roaming the streets aimlessly late at night. He was known to talk to himself. He

had no work record to speak of. According to his uncle, he'd gone downhill since his senior year in high school. There were a few shortlived attempts to work at rather menial jobs, but they quickly ended in failure. Steve mostly just sat around the house, talking strangely. He was considered weird, but harmless.

I saw Steve through a grated window in the county jail. He was a lanky young man with sallow skin and strands of long blond hair streaming over his eyes. His arms seemed to have no muscles at all, and his overly long fingers with their ragged nails clutched his side of the counter like claws. When I asked if he knew who his lawyer was, he pulled out a card and read Mr. Colquitt's name to me. There was no eye contact at all. When I asked what he was charged with, he answered, "My parents had a strict type of complexion. I am in the gangrene ward. I was doused here last Tuesday

and manipulated through military police arrest. Intelligence, military intelligence, U. S. army video network and surveillance, you know."

He let out a brief incongruous laugh and stifled it by putting his hand over his mouth. "I have got several daughters. I had a son. He was killed by a Mafia attack up here. We were shot again today by Mafia sniper attack. I am a bodyguard for the CIA, molted around the specimen tanks and the syringtha, you know. I was given bulletproofing for all this moltenence. I was doused with gangrene sabotage."

Steve suddenly turned and muttered something to the wall. After that, he said nothing else to me.

His sentences were not logical, nor did the parts always seem to hang together. He invented words, often by merging parts of other words

together. His facial expression, flat tone of voice, and short outbursts of bizarre laughter had no clear relation to what he was talking about. He obviously viewed the world as a dangerous place with himself as a target. His view of the world was bizarre.

When I presented the results of this evaluation in court, the prosecutor raised the question of long distance. Citing the amount of time between the shooting and my evaluation, he asked how I could know that what I saw wasn't a mental breakdown precipitated by his realization that he had actually killed his parents. Couldn't Steve's mental disturbance be a reaction to the shooting rather than a causal factor before the shooting?

I told the jury Steve was suffering from disorganized schizophrenia. The florid nature of his symptoms do not suddenly appear full-

blown,[15] and the reports of those who knew him testified to a long-standing illness. Other facts, such as leaving a gun with his fingerprints on it in plain view, were consistent with the mental state of disorganization, not the mental state of one who was trying to cover up a crime he knew was wrong. And the nature of his delusions showed his tendency to misunderstand the real world.

After I left the courthouse, Steve's attorney put him on the stand. It didn't take the jury long to find him not guilty by reason of insanity. With a witness like Steve, what did they need an expert for? They probably didn't. Giving the condition a diagnostic name may have been helpful to the jury, but they probably decided the case on Steve's bizarre presentation. Which they really shouldn't do, because what they were seeing was present tense.

The prosecutor's question to me was an appropriate one. He was saying that even if Steve were crazy now, how could I know he was crazy back then? What I could supply as an expert was the information about the course of the illness leading up to his current presentation, and the relationship of the reports of others who knew him back then to Steve's present state. However, I don't think that was what tipped the balance in the mind of the jury.

The last time I checked (a few years ago), I learned that Steve was still in the hospital, and he had made little progress. Perhaps some of the newer medications are helping him, and he could be restored to sanity and released.

Of course, Steve's case was relatively uncomplicated because not much time had elapsed between the offense and my evaluation.

On the other end of the spectrum, the district attorney prosecuting Donald's case waited a couple of years before asking me to evaluate him. He started his phone call by saying that there was a "strange situation." He told me Donald had shot a motel clerk late at night. The defense attorney called a psychiatrist who hospitalized him. That doctor said Donald was insane at the time of the offense because he had "some kind of blood disease."

When I received Dr. Lampier's records, I realized the "blood disease" was hypoglycemia—too low a level of sugar in the blood. The routine blood screen test taken before breakfast on the morning after admission to the hospital showed a blood sugar level of 45 milligrams. The usual range is 70-120 milligrams. According to Dr. Lampier, the low blood sugar caused Donald to be confused and prevented him from acting in a

rational manner on the night of the offense.

Technically, hypoglycemia isn't a blood disease. People with this condition have difficulty regulating the amount of sugar in their blood. The best-known problem of this dysregulation is diabetes, where the blood carries too much sugar. In hypoglycemia, the sugar level is too low. Because the brain gets its nourishment from the sugar carried to it by the blood, hypoglycemia can cause anxiety, irritability, weakness, poor concentration, and in some cases, even psychotic symptoms. Was that what happened to Donald back then?

I checked the nursing notes in the hospital records. On the morning of the blood test, Donald had been up since 6:30 A.M. The blood was drawn at 7:30. The notes revealed a pleasant young man who slept well. He was cheerful and cooperative

and spent his time socializing with other patients and watching television. Nothing unusual about his behavior was documented. Apparently the low blood sugar had not affected his behavior to any discernible degree. I wasn't surprised. Many people sometimes have blood sugar levels as low as 45 without having any symptoms of hypoglycemia.

Subsequent blood samples tested during this hospitalization showed levels of sugar within the normal range. Of course, this did not rule out the possibility that on the occasion of the shooting his sugar was below normal.

When I interviewed Donald in the jail, he talked easily. He told me all about that evening, even though I had informed him I was consulting with the prosecutor. His account of the events fit closely with what he had confessed to the police

after he was arrested. After an evening of drinking and gambling at a club (where he had lost most of his money), he and a friend drove around until they spotted this isolated motel. Donald admitted to shooting the clerk and taking the money from the register.

I asked him to give me more details about the evening. He'd had pork chops and potatoes, a full dinner at about 6:30 P.M. He'd arrived at the club "about 8:30 or 9:00, maybe." Between 9:00 and 11:00 he'd imbibed five "tornadoes"—tall sweet alcoholic beverages. He didn't recall nibbling on munchies. He'd lost most of his money in the back room at a poker game.

Donald and his friend drove around for about an hour. They stopped at an all-night convenience store and ate candy bars. Then they found the motel, and Donald decided to recoup his losses. He

was home by 1:30 A.M.

I took him back to the motel. “You went in, and then what?”

“So I go in—I look around. The light’s out and there ain’t no one there. I push the buzzer on the counter, and this old fart comes out and turns on the light.”

“What was he wearing?”

Donald thought a moment. “He was in his pajamas—and a red bathrobe.”

“What color pajamas?”

“Let’s see. Oh yeah. I remember ’cause the tops were green. I could see the sleeves sticking out of the bathrobe. And the bottoms were blue. That’s how I remember; they didn’t match.”

I asked him to describe the man.

"I don't know. An old guy with a gray beard and sideburns. Kind of thin and bent over. So I point the gun at him and ask him for the money."

"What did he do?"

"That's the goddamn point. The bastard opens the cash drawer and says, 'Don't hurt me, Sonny.' Sonny! The son of a bitch called me 'Sonny,' like I was some little kid or something. I guess I lost it. I blew him away."

Donald's memory of the details of the motel encounter did not show any confusion or mental clouding. He was even able to find the buzzer in the dark. In addition there was only one recorded low blood sugar in the hospital, and he had not behaved in an unusual manner at the time it was drawn.

However, that low reading was a fasting blood

sugar level, drawn several hours after his previous meal. There is another kind of hypoglycemia-reactive hypoglycemia. It works on a different mechanism from fasting hypoglycemia. Some people get reactive hypoglycemia after they eat or drink. This may even happen after sweet alcoholic drinks. The food or drink raises the blood sugar (as it does in all of us) and the body moves the sugar out of the bloodstream to reestablish normal levels. In reactive hypoglycemia, too much is removed, resulting in low blood sugar.

Reactive hypoglycemia comes on about three or four hours after drinking sweet alcoholic drinks.[16] Donald's time table was wrong for that. Last drink about 11:00 P.M., home by 1:30, and the motel being three-quarters of an hour away from his home. The cure for reactive hypoglycemia is to eat something sweet to put more sugar in the blood. Just like Donald did with the candy.

Therefore, the linkage of Donald's illegal activity with hypoglycemia could not be supported either by his memory of the situation or by the biological dynamics of blood sugar.

Even though Dr. Lampier conducted a relatively short-distance evaluation, he was, at best, tripped up by twisted science—incorrect interpretation of the data. Or, it may have been an intentional distortion on his part. My longer distance evaluation was able to set the record straight. Donald was found guilty and sentenced to life in prison.

Not all long-distance evaluations have the benefit of laboratory tests with concurrent professional behavioral observations so close to the time of the offense. Nor do they always have the benefit of the defendant's memories of such factual details which can preclude a befuddled

mind at the time of the event. Still, there may be some observations psychiatrists can make to help the judge or jury decide whether the defendant was legally insane at the time of the offense.

Quite some time ago I received a call from an attorney in a distant state. He was representing a trucker who had shot his wife. The defendant had been driving all night, and the lawyer thought the lack of sleep might have affected his mental state. Further, his marriage was bad, and in his sleepy condition, he must have acted impulsively. The defendant shot his wife right in broad daylight in a bank parking lot with everyone standing around. Then he fired a couple more shots into the building right next to the door. The court-appointed psychiatrist had ruled out legal insanity, but his attorney wanted another opinion.

He explained why he called me. His client, Matt,

didn't want to plead insanity. Since Matt originally came from Tennessee, the attorney felt a Tennessee doctor might have better rapport with him and could persuade him that a mental problem was the only defense he might have. The lawyer had gotten my name from a Tennessee colleague.

Matt told me his story. To say he had a bad marriage was an understatement. His wife's first recorded infidelity occurred two years after the marriage, twenty years ago. There were several further occasions when she went out with other men; apparently this was well-known around town. Not that Matt was a paragon of virtue, but almost. He tearfully told me had once picked up a girl while out on the road. He still felt guilty about it, thinking he had violated one of the tenets of his family back in Tennessee.

As the years went on, the marriage deteriorated. Matt's wife started drinking and using "tranquilizers." When he was out on the road, he'd call home late at night, but no one was home. She stopped having sexual relations with him. There was even a question of whether she was having an affair with another woman. She left him and went back to Tennessee on several occasions. When he pleaded with her to return and try to repair the marriage, she came back, but her behavior didn't change. He took on more work to try to buy her love with money. Finally, she said she had been staying with him only for financial support, and she moved out and went to stay with a friend. While he was away, she sold most of the furniture in the house. He still tried to win her back. Despite this record he told me, "For twenty years, I had the best woman there ever was alive."

Matt's story about the marriage coincided with

statements made by three of his friends which the attorney had sent me. None of them could understand why he still wanted her back. Two of them had seen him the evening before the incident, and he seemed to be very upset and keyed up.

Matt told me that at the time of the offense, he had been driving at least three days and two nights, with precious little sleep. He got home to his empty house the night before the incident, but he was so keyed up, he was unable to sleep. That's when I asked him about taking speed. Many truck drivers use that drug to keep awake when they are on long trips.

He admitted that he frequently used speed on long trips. As he became more tolerant of the drug, he used higher doses. "Funny things would happen sometimes, like when I was on the road at night, I

thought she was in the seat next to me, but when I started to put my arm around her, she wasn't there." That happened the night before the incident, too. "And she wasn't even in the house. I thought I saw her sitting in the kitchen, and on the couch, but when I reached out to put my arm around her, she was gone. I couldn't sleep. I got up at 5 A.M. and tried to pay some bills, but I couldn't keep my mind on it. I kept writing down the wrong figures or in the wrong places. I took a few more pills. I just had to get her to talk to me."

Since he had no appetite for breakfast, he just got in his car and drove around aimlessly until the bank where she worked opened. He took another pill to stay alert. "I saw her going to the door, but it was all fuzzy, like a fuzzy TV screen. Like there were colored dots floating around her, and then there were like two of her, maybe her girlfriend, but she looked exactly like my wife. I thought it

was her girlfriend, the one who ruined my marriage. I ran to my pickup and got the gun and ran up and shot the girlfriend, but she sort of moved so I shot her again, but that was my wife." He started to weep. "I destroyed the thing that meant the most to me. I still think we could have worked it out."

After the shooting, he drove to his best friend's house. When the police came, he asked them to shoot him. "I'm not crazy, Doc, am I? No one's ever been crazy in my family. I mean, my family's a good family. We ain't got no insanity." I assured him he wasn't crazy, but his mind was messed up at the time—temporarily.

I called the attorney and asked him to arrange a meeting with the best friend. The meeting took place later that day in the lawyer's conference room. The friend confirmed the details of the bad

marriage. He also knew Matt was taking increasing doses of speed—amphetamines.

The story fit the description of an amphetamine reaction—on top of sleep deprivation. What he described were illusions—misperceptions of the stimuli in the environment which could be corrected when he looked further. Not quite hallucinations which come on without the external stimulus. Some of the misperceptions were linked to his concerns about his wife. As I learned later, the woman was entering the bank alone; there was no other woman near her. This was not a drug psychosis (as described in Chapter 1); this was amphetamine intoxication with perceptual disturbances as described by Bowers and Freedman.[17] Sometimes, but not always, this disturbance may herald the onset of a true amphetamine psychosis. Unfortunately, there was no one to monitor his pulse, check his eyes, or

document other physiological changes associated with this type of intoxication. And no one screened him for the existence of drugs in his body. Nonetheless, I felt the whole story was consistent with a diagnosis of amphetamine intoxication to a reasonable degree of medical certainty.

I gave the attorney a list of things I wanted if it were possible to get them: the log book of his last trip to verify the hours and distances he drove, the check book to verify the errors, the results of the court-appointed psychiatrist's evaluation, and a few other items which I felt would further confirm the diagnosis. His secretary gave me the psychiatrist's report and said she'd try to get the other material.

The information in the psychiatrist's report reflected that which I obtained, including the use of amphetamines. He concluded Matt did not

present the symptoms which might meet the guidelines for legal insanity. I agreed with that conclusion, but it did not go far enough. I felt that, because of the intoxication, Matt's judgment was impaired and he could not premeditate (plan ahead in a sound manner) or deliberate (think about the act and its consequences) in a reasonable manner. Over 100 years ago, the Supreme Court handed down a decision which affected those states whose laws allowed for different degrees of murder, depending on the defendant's state of mind at the time. If first-degree murder required the ability to premeditate and deliberate, the jury must consider the effect of intoxication, even if the substance used was voluntary.[18]

To meet the requirements for conviction of a first degree murder charge, Matt must have had the capacity to premeditate and deliberate. If the

jury agreed that his mental state was so clouded by amphetamines, Matt could be found guilty of second-degree murder. He would not be sent to a mental hospital, but at least he would have been given a lesser prison sentence. If the jury disagreed, he'd get life.

Unfortunately, I never had a chance to talk with the attorney about my findings. When I got back to Tennessee, I called his office several times. The receptionist said he'd return the call, but he never did. I told her I was reluctant to testify without talking to the attorney first. The receptionist promised that the lawyer would meet me at the hotel when I went back for the trial, but of course he never showed up.

The next morning I went to the lawyer's office and was told the trial had started and the attorney would come for me when it was my turn to testify.

I wrote down ten questions for him to ask. These would allow me to establish the amphetamine intoxication and sleep deprivation. The last question would tie this condition in to the shooting; the effects of this condition, in my opinion, hampered Matt's ability to premeditate or deliberate at the time of the offense.

The attorney grabbed my pad and we went into court. He asked the first nine questions and I felt the testimony was going well. However, at that point he rested; he did not ask the tenth and crucial question. The prosecutor caught on immediately and never even bothered to cross examine me. Matt's lawyer had only demonstrated a mental condition; he had not tied it into the legal issue at hand. Matt was sentenced to life in prison.

You may be appalled at the idea that if a person kills somebody because of the influence of an

illegal drug he or she took voluntarily, the assailant is entitled to a lighter sentence. Once again, don't complain about the psychiatrist; talk to your legislator who makes the guidelines.

As psychiatrists, we are interested in all aspects of human behavior. What makes a man like Matt endure the actions of his ex-wife and still claim that throughout the marriage he "had the best woman there ever was alive"? This type of thinking is not all that uncommon. Glenn was charged with rape, sodomy, and assault with a deadly weapon. The victim was his wife. His attorney asked my opinion regarding his mental state at the time of the offense, many months previously.

Like Matt, he had tried again and again to repair a doomed marriage. Like Matt, he was repeatedly unsuccessful. And like Matt, he

idealized his wife—put her on a pedestal. Although she had been married before, “She was a virgin in my eyes. She was as pure as anyone.” People like Glenn and Matt have a strong need to put their wife’s negative traits out of their mind, and the anger is often buried, waiting to erupt.[19] Although others had informed Glenn his wife was running around, he felt very certain she wasn’t, “because I trusted her.”

She filed for the divorce, and after it was final, Glenn became aware that she was seeing another man. “So soon after the divorce, and she goes to bed with him. Just like a whore!” The anger broke through. Before, she was entirely good; now she was entirely bad. He decided to show her—to treat her like the whore he felt she was. Using his old key, he entered the house and waited for her. He threatened her with a gun and forced her to have sex with him.

My psychoanalytic training helped me formulate what kind of character problems Glenn brought to the marriage and to the encounter that evening. But there is a difference between psychotherapy and forensic psychiatry. The psychoanalytic formulation is a hypothesis, or a guide of what to look for as therapy proceeds. The therapist doesn't come right out and state the formulation to the patient. The patient must find out the details by him or herself. Often, as therapy proceeds, the formulation must be expanded or revised. The therapist helps the patient come to grips with the parts of his or her character which cause trouble.

As a forensic psychiatrist, I wasn't working with the patient. As we discussed in Chapter 2, my formulation was a speculation and had no place in testimony. When I testified in Matt's case, none of the questions I gave to his lawyer touched on this

formulation; it was irrelevant. It was the sleep deprivation and amphetamine use which clouded his mind.

But with Glenn, there was no sleep deprivation or amphetamine. There was only unleashed anger. He obviously premeditated—waited for his wife. He was in clear awareness (deliberation) of what he was doing and why. I told his attorney I could not be helpful to his case.

Probably the ultimate in long-distance evaluations are the cases of contested wills. Here, the target of the evaluation is deceased; we cannot get his or her story, nor can we assess how the person is functioning even now, let alone at the time the will was executed. However, when the will was signed, the testator (the person leaving the will) must have been of "sound mind." In contrast to "reasonable," which we discussed in

Chapter 2, “sound mind” is described in more detail. The person executing a will must have a rough idea of what he or she owns, must know who are the “natural” heirs (spouse, children, etc.), and must be aware that he or she is disposing of the property in a will.[20]

Can a person suffering from chronic schizophrenia execute a will? Certainly, if he or she is lucid enough to fit the three criteria—especially if delusions don’t distort his or her understanding of the natural heirs. How about a person with dementia—deterioration of the brain’s ability to remember and think? Yes, if the testator was lucid at the time of the signing. Some people with mild dementias have better days and worse days.

These guidelines focus on the testator. There is often another set of guidelines focusing on people

who may have benefited by exerting "undue influence" on the testator—taking advantage of the testator's weakened physical condition or mental vulnerability. In this situation, the psychiatrist may be called upon to determine "the mental condition of the testator as it affects his ability to withstand influence" at the time of the execution of the will.[21] But even if the testator was vulnerable, the person left out of the will must prove the beneficiary actually exerted the undue influence.

These, then, are the major targets of the psychiatric evaluation, all examined from the "distance" of time, with no chance to meet the testator. This is what I faced in the case of the late Charlie Potter. How could I tell what his state of mind was on the day he signed the will? I didn't have a movie or videotape of the event. What I did have were statements of people who knew him

and a record of some of his hospitalizations.

Charlie had an exemplary career as an executive in a large firm. He was also considered an outstanding member of the community—active in his church and community affairs, well-respected for his gentlemanly manners. However, according to statements by his fellow attorneys, he started to go downhill during his 60s and more particularly after his wife died. He made inappropriate sexually tinged remarks to the secretaries, his desk became sloppy, and his work output was haphazard. His dress was slovenly. This formerly well-organized man was becoming unpredictable. At times, he lost his temper over little things.

Before the Board of Directors could remove him, Charlie resigned abruptly, without telling his children. He moved out of the city and bought a

small home in the mountains. Four young men befriended him and suggested ways they could remodel the house. It grew larger and larger, in an unplanned manner. The workmanship was shoddy. They billed him far in excess of what the construction was worth. He counted them as his only real friends. If he needed them, he could call them any time. Sometimes they just dropped in and sat around, consuming his liquor. He even invested money in a business they were buying—essentially, he bought it for them. And this experienced executive did all this without any contract! These were the people he left his estate to; his children got nothing. In fact, he stopped communicating with them.

The medical records were quite revealing. Charlie had diabetes and was not regulating his insulin correctly. On at least two occasions, he was hospitalized with significantly low blood sugar

due to improper use of insulin. On another occasion, his blood sugar was very high and his heart was having difficulty pumping out enough blood. He had difficulty breathing because there was fluid in his chest. On one occasion he had a small stroke. Despite the fact that he was confused from time to time during this hospitalization, the doctor wrote that he was mentally able to handle his own affairs. This note, for some reason, was witnessed by one of the friends.

Shortly before Charlie's final hospitalization, one of his friends drove him to an attorney's office, and they instructed the lawyer to create a new will. Two weeks later, another stroke sent Charlie back into the hospital. On the day after admission, one of the friends called the attorney and told him to rush the will up to the hospital for signature. Charlie signed it, and a nurse recorded that he knew what he was doing at the time.

I could make a diagnosis with a reasonable degree of medical certainty: organic personality syndrome. This was the appropriate diagnostic label at the time; it has since been given another name. The deteriorating course with its social inappropriateness, poor judgment, and irascibility indicated a progressive chipping away of Charlie's brain functioning. The probable cause was a succession of small strokes, smaller than the ones that had landed him in the hospital.[22] It may be that fluctuations in his blood sugar (sugar is the nutrient for the brain) contributed; perhaps further injury was caused by diminished oxygen levels at times when his breathing was impaired by heart trouble.

So much for the diagnosis. Capacity to make a will is not governed by diagnosis, but by the mental functioning at the time the will is executed. The nurse's note that he knew what he was doing

could not, in my opinion, be counted on. And remember the doctor's note, during a previous hospitalization, virtually ignoring the fact that Charlie sometimes got confused and stating he was mentally competent to handle his affairs. On the other hand, I had no way of knowing whether on the day Charlie signed the will he knew how much property he had, who his natural heirs were, or that he was disposing of this property. People with organic personality syndrome can wax and wane in their understanding.

However, I could testify to the issue of his vulnerability to undue influence. Charlie's lack of judgment was well-documented. His readiness to build a large and grotesque house and to pay outrageous bills when his newfound friends presented them to him attested to his vulnerability. I could not testify that there was, in fact, undue influence; that refers to the actions of

the friends, not the state of mind of Charlie. It was the job of the attorney representing the children to present evidence to support that. It seemed to me that there were sufficient data to document that his friends had unduly influenced him—taken advantage of his mental condition—but that's not a psychiatric opinion. However, the jury must have felt the data weren't sufficient, because they upheld the will.

I agree with MacAlpine and Hunter: "A retrospective diagnosis can hardly ever be made with the same confidence as one in a living patient." But there are some circumstances where the court needs information which can only be ferreted out by long-distance evaluations. And if the conclusions are bolstered by sufficient data, the psychiatric opinion can be offered with a reasonable degree of medical certainty.

Notes

1 All names and incidents in this case discussion are accurate as documented in the references.

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9 Burlingame M: The inner world of Abraham Lincoln. Urbana and Chicago: Univ. of Illinois Press, 1994, Introduction, p. xiii

`0 Ibid., p. xix

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16 Service FJ: Hypoglycemic disorders. (In) Wyngarden JB and Smith LH (eds.): Cecil textbook of medicine (17th ed.). Philadelphia: W.B. Saunders, 1985, pp. 1341-1347

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22 Lishman WA: Organic psychiatry: The psychological consequences of cerebral disorder (3rd ed.). Oxford, England: Blackwell Science Ltd., 1998, p. 631

Chapter 7

Prudent Practitioners and the Protection Paradox

According to Chapman,[1] malpractice suits can be traced all the way back to a fourteenth-century horse. In English law prior to that time, you could sue a surgeon only if he (there were no she-surgeons) actually intended to harm you. Since another person's intentions are very hard to prove, surgeons were well protected. Unfortunately, when Agnes of Stratton injured her hand, her surgeon botched the job, and Agnes lost the use of her hand altogether. Nobody accused the surgeon of intending to do such a bad job, but Agnes got a lawyer and sued anyway. Her lawyer pointed out to the judge that when a blacksmith

injured a horse, even accidentally, the horse owner could sue. If a smith who injures a horse because of less than diligent care can be sued, why not a surgeon who injures a human? The judge agreed, and thus the groundwork for malpractice suits was laid. No longer did the standard of proof hinge on the intentions of the doctor. If, despite the best of intentions, a doctor failed to be diligent, he could be sued.

Of course patients who aren't happy with the results of their treatment often feel their doctor didn't act diligently. Thanks to the wonders of modern science and the growth of the litigious society, many people believe there should be a successful treatment for almost everything. Bad outcomes must result from bad doctoring. And bad outcomes can easily trigger a lawsuit. A few decades ago, there was a joke going around: Support your local lawyer; send a boy to medical

school.

However, a bad outcome doesn't necessarily mean the doctor wasn't diligent. Doctors aren't miracle workers. Modern courts have tried to spell out what diligence means. Doctors are diligent if their practices conform to the standard of care of the profession. Like so many definitions in the law, this one just raises yet another question: How do you know what the profession's standard of care is? Generally, the courts say two things are needed: Doctors must show they used current medical knowledge, and they must have taken advantage of all the tools and facilities available to them.[2] Clearly, the psychiatrist has a role as an expert witness in this situation. Who better to tell about the standard of practice in the psychiatric profession?

Of course, the experts don't always agree about

the standard of practice. When this happens, the jury of laypersons may sweep away much of the expert testimony. In a sense, they become the experts and decide what the doctor should have done in the particular situation at issue. Influenced by their own biases—pity for the patient, awe and respect for doctors, or persuasion by those who speak most eloquently during the trial, they may decide on the basis of whether they think the doctor used good judgment—what the law refers to as the "prudent practitioner."

Often, but not always, what conforms to the standard of care is also prudent.[3] However, neither customary psychiatric care nor prudence was evident in the case of Jeanette. As she proceeded through adolescence, she was becoming increasingly depressed. At the suggestion of their family physician, her parents phoned Dr. Tarbow and expressed their concerns.

He replied that what she needed was psychotherapy, and he referred her to Ms. Jordan, a social worker who worked in his suite of offices.

Ms. Jordan saw her three times a week, but Jeanette didn't seem to be making any progress. In fact, since she was getting more deeply depressed, Ms. Jordan set up an appointment with Dr. Tarbow, so he could put Jeanette on medication. He saw her briefly and agreed she was depressed. He started her on amoxapine, an antidepressant widely used at that time. He sent her back to Ms. Jordan and made no follow-up appointment.

As time went on, Jeanette seemed to develop certain disturbing "habits"—abrupt and awkward movements of her neck, her arms, and other parts of her body. Jeanette's parents were very concerned. Self-esteem can be fragile enough in an adolescent young lady; bizarre movements can be

devastating and can aggravate the depression. Finally, Ms. Jordan felt she could no longer help Jeanette, and she discussed the case with Dr. Tarbow. According to the records I reviewed, after seeing Jeanette he concluded the movements showed her depression was getting so deep she was becoming agitated. Since amoxapine was sometimes used to treat agitated depressions at that time, all that was needed was to double the dose. He wrote a new prescription for the patient.

After hanging in for several more weeks, Ms. Jordan again asked Dr. Tarbow to intervene. Jeanette's parents also called the psychiatrist. Dr. Tarbow told them Jeanette was obviously becoming psychotic, and neither he nor Ms. Jordan could treat her. (I found it odd that a psychiatrist couldn't treat psychosis.) Dr. Tarbow called Dr. Gordon to arrange a referral.

By this time, the movements had increased significantly. Dr. Gordon took one look at Jeanette and diagnosed the problem as a neurological side effect of the amoxapine. As Dr. Gordon knew (and Dr. Tarbow should have known), amoxapine is converted in the body to a chemical which can sometimes produce these symptoms.[4] He stopped all the medication and sent her to a neurologist. Unfortunately, the movements continued for a few years, although with the passage of time and what treatments were then available, they ultimately lightened up considerably.

Since neither Dr. Gordon nor the neurologist were willing to testify—not uncommon among doctors in a community—I was asked to render an opinion. I read Dr. Tarbow's deposition, in which he said he never noticed the movements. Later, when confronted with his office notes, he agreed that he did observe "some bizarre activity."

However, he continued to insist Jeanette was becoming agitated and needed the additional medication. And then she became psychotic. What were the signs of psychosis? In the deposition, he said she was hallucinating. However, there was no mention of hallucinations in his office notes.

In my opinion, Dr. Tarbow failed to adhere to the standard of practice in the profession in two main ways: Although Jeanette was referred to him by the family doctor, he failed to examine her; instead he assumed she needed psychotherapy and referred her to a social worker. This, in itself, would not have triggered a lawsuit, because Ms. Jordan had the good sense to know that she was out of her depth, and she got a consultation from Dr. Tarbow. However, once having put Jeanette on medication, he did not arrange for a follow-up to check for adequacy of response or possible side effects. Even when your doctor responds to your

night time phone call by saying “Take two aspirins and call me in the morning,” he or she implicitly invites a follow-up if things aren’t going well.

The second major deviation from the standard of practice was the failure to recognize the side effects. At best, Dr. Tarbow’s testimony about the movements was garbled. However, Ms. Jordan testified that she had described the movements to him when she requested the consultation. Dr. Tarbow should reasonably have had knowledge about this side effect of amoxapine. Of all the antidepressants in use at that time, this drug had the highest incidence of that kind of side effect. And even if he did not know (you can’t know everything about every medication), any time a new symptom comes up after you start a new medication, you should think “side effect?” and look it up. Instead, he doubled the dose, and again he arranged for no follow-up.

Dr. Tarbow neither adhered to the standard of care nor did he act prudently. In fact, when you read all the notes and deposition testimony, you get the feeling he wasn't particularly interested; he acted carelessly instead of prudently. His attorneys probably thought the jury might get the same feeling, because they persuaded Dr. Tarbow's malpractice insurer to settle the case for a substantial monetary award.

Of all the medical specialties, psychiatry is the one focused primarily on the complexities of human behavior. And this is what gets us into the prediction paradox. We are charged by law to assess the risk of dangerous behavior—danger to the patient or to others the patient might harm. And when we conclude that someone, because of mental illness, is dangerous, we must protect the patient or others—usually by hospitalization. If we don't act prudently in this regard, we can be the

target of a lawsuit.

On the other hand, the tools we have for doing this grave task are not very good. Research shows we can't predict future harm. A press release by the American Psychiatric Association in 1983 summed it all up: "...psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, prediction of future violence will be wrong for two out of every three patients."[5] Ennis and Litwak, attorneys, called the process of prediction "flipping coins,"[6] and Steadman, a psychiatrist, called our predictions "magic."[7] We confine quite a few people who might never have acted dangerously (better safe than sorry), and we fail to confine others who ultimately harm themselves or others.

This shouldn't surprise anyone. Violent acts are the result of many factors. People can be provoked suddenly, family circumstances can take a turn for the worse, workers can lose their jobs, etc. Life is unpredictable. And mental illness is not static; it may wax and wane, even when patients are on medication—not to mention when they forget to take the medicine or decide they don't need it anymore.

What we do is "predict" on the basis of risk factors. Statistical data can show what factors are most frequently found in the backgrounds of people who actually killed themselves[8] or were violent toward others.[9] We operate somewhat like insurance companies. Their actuarial tables tell them which types of persons or situations are at what risk, and they set their rates accordingly. If you had a traffic accident within the last five years, your rates may increase or you may find it difficult

to insure with a different company. They aren't saying you *will have,* another accident; they are saying you are *more likely* to have one.

Since the 1960s scientists have become aware that cigarette smoking is linked to lung cancer. That doesn't mean everyone who smokes will develop cancer. It does mean that smoking puts you at greater risk—smoking is a risk factor.

In psychiatry, the standard of care is that with substantial risk factors, we should consider the patient dangerous and take steps to insure safety. And in the law, we are responsible for mishaps on our turf which are reasonably foreseeable; they don't have to be certain.[10] Risk factors increase the foreseeability.

Many people have argued that involuntarily hospitalizing people or keeping them in hospitals because they are *statistically likely* to be

dangerous is overkill; in this country we generally don't confine people to prevent something that *might* happen.[11] Why should we make an exception for those who are mentally ill and likely to be dangerous? Because the legislators and courts have decided such an exception is justified. If you disagree, talk to them about it.

In the eighteenth century, the criteria for committing someone involuntarily to a mental hospital in this country were unimportant, because mental hospitals were almost nonexistent and mentally ill people were cared for at home or in the community. Some were put in jail. Others were driven out of the community. However, as the population exploded and rural communities gave way to urban society, these informal methods of handling those who were mentally disturbed were no longer viable. By the end of the nineteenth century, almost every state had at least

one public mental hospital. Like the ballpark in *Field of Dreams,* "Build it and they will come!" And come, they did. The hospital population grew rapidly—often fueled by families having problems with one of their members. Although the procedure for hospitalizing could be complicated, the criteria used for involuntary admission were quite flexible.[12] Even as late as the 1960s all a doctor had to do was to certify that the patient was mentally ill and needed inpatient treatment, and he or she could be involuntarily hospitalized. If your old Aunt Suzie's eccentricities were embarrassing to the family or if your 19-year-old son wanted to roam the country aimlessly rather than join the family's banking business, you could get a psychiatrist to make a legitimate diagnosis and sequester her or him in a psychiatric hospital.

Things changed about three decades ago when the courts decided a mentally ill person should be

forced into a hospital only if there was urgent need—the patient was *likely* to be dangerous. And the definition of dangerousness had to be spelled out.[13] Many states adopted these three criteria: Mentally ill persons could be involuntarily confined as dangerous if they made a recent threat or attempt of suicide or violence. Or if they placed others in reasonable fear that violence would occur. Or if they were so disturbed they couldn't care for their basic needs.

And here is where risk factors come in. If a histrionic mother yells out, "I'm going to kill myself!" when her children upset her, or an alcoholic man says, "I'll get you!" to an adversary, we don't ordinarily commit them. Beyond the legal threshold, the standard of care requires that psychiatrists evaluate the likelihood of dangerousness, and research on risk factors provides the basis for our evaluation.

Such were the rules in effect when Angela came to Memorial Hospital one evening. She complained of feeling hopeless; she couldn't function, she wasn't sleeping, and she had lost 20 pounds in the last few weeks because she had no appetite. She was drinking to excess.

Angela had several sources of stress. Her marriage was a shambles, and her husband had gotten custody of their five-year-old son who was now living with her ex-mother-in-law. Their younger daughter had died abruptly a few months earlier. Angela's job was in jeopardy because of poor attendance. She was facing a trial for driving while intoxicated—her third drunk driving offense.

That evening, after calling her son to say "Good-bye," she sat alone in her chair for over an hour. She toyed with her sleeping medications for

a while, but finally she put the bottle down and decided to come to the hospital.

This was not the first time she'd made serious suicide gestures. She had been hospitalized in Memorial's small psychiatric unit previously. This time, however, a few hours after admission, she decided to leave. Her psychiatrist felt discharge was too risky, and he wrote out a commitment paper. Since the psychiatric unit was not equipped to handle committed patients, Angela was transferred to Willowbrook General, a larger hospital in the same city.

The Willowbrook emergency room's doctor read the report sent over from Memorial. It detailed what Angela said and did at that facility. His own report of the emergency room evaluation indicated Angela told him the same story. The doctor was prepared to write out the second

commitment paper (two were required) when Angela agreed to come in voluntarily. By the time Angela reached the psychiatric unit, her chart contained both reports.

Angela was put under the care of Dr. Morrison, a psychiatrist on the Willowbrook staff, who saw her the next morning. She seemed brighter. She said the whole thing was a misunderstanding; she'd been drinking and was only playing with the medicine bottle. She denied having sleep and appetite problems. Dr. Morrison decided to have the social worker call Angela's mother and her ex-mother-in-law for more information. He also asked the psychologist to test her. However, Angela refused permission for the staff to call the ex-mother-in-law (not a good sign in itself). Her own mother said she didn't think Angela was suicidal.

That afternoon, Angela told a nurse that Dr. Morrison promised to discharge her on the following day.

The next afternoon, after a session with Angela and her mother, Dr. Morrison discharged his patient with a final diagnosis of major depression. He referred her to a mental health center for a follow-up appointment. He didn't prescribe any medication. A few hours later, Angela took a massive overdose of sleeping pills and died. Her mother sued.

Dr. Morrison's deposition testimony in this case revealed he was aware Angela's story fluctuated and could not be taken at face value. He also had not received the psychological report. (It wasn't written up until a few days later, at which time it indicated a high probability the patient was concealing the depth of her depression). This

didn't phase Dr. Morrison. He said he ordered the tests only to see if the patient would be cooperative. Quite an expense to see if someone is cooperative, when you can observe her cooperation on the unit at no added cost whatsoever!

At the trial, I testified for the plaintiff. In my opinion, Dr. Morrison failed to act prudently by following the standard of care in this situation. Angela had several risk factors. She had a major depression and reported significant insomnia, weight loss and hopelessness, although subsequently she changed her story. She had three significant recent losses— her husband and living son and her daughter. She was abusing alcohol. She had made a very recent suicide gesture. And calling her son to say "good-bye" was a clear sign of suicide potential.

Even the fact that the story changed overnight in the hospital should have warned the doctor to use more caution. And the fact that Angela didn't want to have her ex-mother-in-law contacted should have triggered an inquiry about why.

Dr. Toliver testified in support of Dr. Morrison. In my opinion, Dr. Toliver was not a prostitute, making up vivid fantasies to bolster his case. He was not a junk scientist, relying on untestable theories. Nor was he misusing science, misinterpreting results of research. Yet, in my view, the jury was misled.

Dr. Morrison's lawyer was George Grafton, a skilled attorney. From the way his questions and Dr. Toliver's answers flowed back and forth so seamlessly, it was obvious he had prepared the witness very well. There is nothing wrong with this; it's good lawyering, so long as the attorney

doesn't try to persuade the witness to distort his or her findings. And I had no reason to suspect this attorney strayed from the rule. Dr. Toliver's answers were succinct and based on well-researched facts. He responded quite reasonably to the attorney's questions. He made a very good witness.

The jury may have been misled because of the questions themselves. There is no rule that I know of that says the attorney can't phrase questions in such a way that the answers may mislead the jury. Lawyers often throw up plenty of smoke and mirrors in this arena of persuasion.

Mr. Grafton asked a series of diagnostic questions:

Q: Was Angela psychotic?

A: No.

Did she have delusions?

A: No.

Q; Did she hear voices?

A: No, she did not.

Q: Was she capable of thinking and understanding?

A: In my opinion, she was.

And on and on, all tending to show Angela really didn't show signs of severe sickness at all. Of course, nobody had claimed Angela was psychotic or couldn't think, but that wasn't the point.

Next, Mr. Grafton got around to depression, but he never asked how deeply depressed Angela was. Instead, he asked if depressions were treatable.

A: Yes, they are.

Q: Do depressed people always need to be treated in the hospital?

A: No, most of them are treated in outpatient settings.

Q: Do they always need antidepressant chemicals?

A: No. Many are treated with psychotherapy. Some

depressions resolve spontaneously.

No questions about *this* patient and her needs; just general questions. As if to say, "What's the big deal about depression?"

Then, Mr. Grafton asked whether psychiatrists can predict which patients will kill themselves. Dr. Toliver answered correctly that we can't. He said, "Studies have shown that we are wrong more often than right."

Finally, the lawyer got around to the risk factors I'd named. But while I stressed that it was the *cumulative* number of risk factors which raised the likelihood of danger, Mr. Grafton asked his witness about them separately—one by one.

Q: Are all people who lose family members likely to be dangerous?

Q: Are all people with alcohol problems likely to be dangerous?

Q: Are all depressed people dangerous?

Q: Are all people who can't sleep dangerous?

It was like asking if all people whose parents had heart attacks are very likely to have heart attacks. Of course they aren't. But if those people *also* have bad fatty compounds in their bloodstream, *and if* they smoke, *and* if they don't watch what they eat, *and* if they get no exercise, the odds go way up.

Dr. Toliver answered all Mr. Grafton's questions correctly. But the bulk of his testimony, guided by the attorney's questions, did not deal with the standard of care in treating this particular patient with this aggregate of risk factors.

Of course, the issues in this case were more complicated than I present in this vignette. The trial lasted several days. So I cannot say with any confidence why the jury found there was no

deviation from the standard of care. Dr. Morrison was exonerated.

Was Dr. Toliver obligated to "correct" the lawyer's questions or to expand his answers by talking about the aggregate of risk factors? No, he was not. On the witness stand, you answer the question you are asked. Of course, I have no evidence Dr. Toliver wished the more pertinent questions had been asked, but the lawyer is the quarterback who calls the plays. But if the doctor knew of this tactic in advance, he did lend (or sell) himself to the misrepresentation. On the other hand, the plaintiff's attorney could have asked him the aggregate question on cross-examination. For some reason, this didn't happen.

A psychiatrist's deviation from the standard of care won't add up to a viable malpractice suit unless there are untoward consequences. If I fail

to listen to your heart when I give you a physical exam and you come down with an infected toe, there are no grounds for a suit. Once again, we must examine the causal chain between the deviation and the claimed result. When Dr. Andrews was sued, there were two issues: Did he deviate from the standard of care of a patient judged to be dangerous? If so, was the tragedy that followed causally related?

To add to the complexity, there were two expert witnesses—one on each side—before I was called. My guess was that the lawyer defending Doctor Andrews hoped I'd break the tie on his client's behalf in order to persuade the jury.

One evening, Perry came to the emergency department of the local hospital complaining of depression and suicidal thoughts. Cindy, his wife, was threatening to leave him because of his

drinking. He agreed to come into the psychiatric unit under Dr. Andrews's care.

Dr. Andrews diagnosed him as having major depression and alcohol abuse. By the next morning, the social worker had talked with the patient's wife. Perry had made numerous threats to harm himself over the past year. He had a severe alcohol problem. When he drank, he'd accuse his wife of infidelity and become physically abusive. Cindy couldn't take it any more.

Because Perry had several risk factors—imminent loss of wife, alcohol abuse, major depression, suicide threats and spouse abuse—Dr. Andrews felt caution was necessary. He put him on level 3, which meant he was to leave the unit only in a group and accompanied by a staff member. He could go no further than the cafeteria or the outside smoking area.

The next day, Perry said he wanted to leave. At that time in that particular state, when a voluntary patient wanted to leave, the doctor could keep him or her for three more days without instituting formal commitment procedures. This would give the patient a chance to reconsider in case the decision to leave was impulsive. Meanwhile, the doctor would have a further period of observation. Perry was furious when told he'd have to wait.

According to his notes, Dr. Andrews was increasingly concerned about his patient. He felt it was too risky to let Perry leave. He was prepared to commit him if he didn't change his mind. However, a day later, while out with the group in the smoking area, Perry walked off. The staff member, occupied with others in the group, never saw him go. Dr. Andrews immediately filed commitment papers. He called the police to tell them of the escape. He also alerted Perry's wife.

Several days later, Perry phoned Dr. Andrews and told him he was he was no longer depressed. He wanted to go back to work. He agreed to stay away from Cindy. After a long and pleasant discussion, Dr. Andrews agreed, and he informed him the commitment was no longer in force. He suggested outpatient treatment, and Perry was willing to set up an appointment with a mental health center.

Perry returned and went back to work. Two months later, on the way home from a local bar, he spotted his wife in the company of another man. He took his gun out of the glove compartment and killed her.

It didn't take Cindy's family very long to file a suit against Dr. Andrews for failing to protect her from this mentally ill and dangerous man.

Did Dr. Andrews deviate from the standard of

care in not ensuring Perry would remain on the unit? All the experts agreed Dr. Andrews believed Perry was depressed and was an abuser of alcohol, and the likelihood of danger was high enough to conform to the commitment guidelines. It was not our job to agree or disagree with the doctor's assessment. If a doctor does a reasonable assessment, and he or she comes to a reasonable conclusion about dangerousness, that conforms to the standard of practice—even if subsequent events prove the doctor wrong. Remember, we are talking about *likelihood*, not about absolute prediction.

One expert testifying in deposition for Cindy's family said the treatment was shoddy. When Perry wished to leave so quickly after admission, and when he got so angry upon learning of the three day provisions, it was foreseeable that he might try to leave without authorization. In his opinion,

Dr. Andrews should have put him on level 1, which would have restricted him to the unit. The doctor should have known Perry was an escape risk, and the hospital procedure for patients who were at risk for going AWOL was to assign them to level 1. I checked the hospital's Policy and Procedure Manual; it was all there in print.

The expert working with Dr. Andrews's attorney disagreed. Dr. Boynton said that when the patient signed the 72-hour paper, he was merely opening up the option to leave after the three days elapsed. He made it sound almost like a contract, like a promise to stay for three days. In my opinion, he was painting a picture of a peaceful transaction, an agreement between equals. But the "contract" was coercive. Perry had to sign the paper; the hospital could legally hold him longer if he didn't sign his intention to leave. Further, Dr. Boynton seemed to ignore Perry's anger at being

forced to stay because of the regulation. As the family's expert said, Perry's anger should have been a signal of how badly he wanted to leave.

Dr. Boynton had another reason for saying there was no deviation from the standard of practice. He said that most of the time, patients will cool down and take back the three-day paper. While this might be true, there was nothing in the chart to indicate Perry was changing his mind. On the contrary, notes of a staff meeting two hours before Perry walked off showed the staff was increasingly concerned about Perry. The doctor was prepared to institute commitment proceedings immediately after the three-day period elapsed if Perry wanted to leave.

Dr. Boynton made another point which spoke even more directly to the standard of practice. He felt that restricting Perry to the ward would injure

the doctor-patient relationship and reduce the chances of working things out. It is prudent to do everything you can to strengthen the collaboration.

This is an issue that has plagued psychiatry for the last several decades. There is no question that treatment is enhanced when the doctor and the patient work together. The patient must trust the psychiatrist in order to comply with medication and to discuss painful and sometimes embarrassing issues. Patients should see their psychiatrists as helpers, not as judges or jailers.

On the other hand, society needs to protect people from danger. "I am not my brother's keeper" may be all right for friends and relatives, but it is not sufficient for psychiatrists. Society has asserted that we have a *special relationship*[14] with our patients. The state licenses us and gives us

certain rights and powers that others don't have. And with these rights come certain duties, one of which is to protect patients and other people who might be harmed by them when we reasonably can.

The conflict between protecting the therapeutic alliance and dangerousness is increasingly being decided in favor of preventing harm to self and others. The Court in *Tarasoff,* stating that protecting the patient-doctor confidentiality must give way to safety, put it this way: "The protective privilege ends where the public peril begins."[15]

Even though I was consulting with Dr. Andrews's attorney, I had to give him the bad news. In my opinion, the possibility of escape was foreseeable and the patient's dangerousness had been deemed likely. Therapeutic considerations

should have been given a back seat. I could not agree with the conclusions of my colleague.

But if that was malpractice, did Dr. Andrews's actions (or failure to act) cause Cindy's death? Was there a causal chain? Once again, opinion was divided. The psychiatrist consulting with the attorney for the family saw a direct causal connection. Perry should have been committed and treated for more than a month, or as long as it took until he was no longer potentially violent. Since Perry's actions showed he was not motivated for treatment, Dr. Andrews should have known that a longer and more difficult therapeutic task lay ahead.

Dr. Boynton asserted there was no causal chain. He agreed that Perry was unmotivated. But the issue wasn't whether the lack of motivation would make the hospitalization longer. It was

whether the lack of motivation made successful treatment likely. And which condition were we talking about? Depression or alcoholism? By the time of the killing, there was evidence the depression had significantly cleared; Perry was back at work. As for the alcohol problem, there is no evidence that extended inpatient treatment of people with alcoholism is particularly efficacious.[16]

Dr. Boynton also pointed out that people with alcoholism are often a danger, particularly to their wives. Without a significant additional diagnosis, we do not commit wife abusers; we get restraining orders forbidding contact with the wife, or we send them to jail for battery.

In my opinion, time was a significant issue here. In assessing whether an alleged action or omission is causally related to an unfortunate

outcome, the amount of time which has elapsed between the two events must be taken into consideration.[17] And the guideline for involuntary hospitalization says the likely danger must be imminent, not way down the road sometime.[18] When he came back and went to work, Perry did not immediately kill his wife. The bit of good news I had for the defense attorney was that I agreed with his expert on the time issue. Two months had elapsed since Perry left the hospital. Furthermore, even if Dr. Andrews committed him, Perry would probably be out by then. And he probably would still have been an alcoholic and jealous. When Dr. Andrews last spoke with him, he was no longer imminently dangerous. Time had broken the causal chain.

Weighing the deposition testimony of both attorneys' witnesses, the parties decided to settle the case rather than to rely on the uncertainty of a

jury trial.

The standard of practice in any medical specialty is not carved in granite. Various practitioners, all of them prudent, may approach a clinical problem in a variety of ways. The expert witness must be careful not to be an advocate for his or her favorite way of doing things. By making allowances for differences of opinion and relying on accepted procedures based on research in the field, the psychiatric witness can testify about the standard of care to a reasonable degree of medical certainty.

Notes

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12 Grob GR: Mental illness and American society. Princeton, N.J.: Princeton University Press, 1983, pp. 3-29

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16 Edwards G et al.: Alcoholism: A controlled trial of "treatment" and "advice." Journ. Studies Alcohol *38:* 1004-1031,1977

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Chapter 8

Nursery Crimes

Adults can—and they sometimes do—beat and maim children. They may burn them with hot irons or over open flames; they may kick them, or punch them with fists, or strike them with chair legs or hairbrushes; they may sexually molest them or kill them.[1] As many as 63 percent of these child fatalities are the result of abuse by the children's biological parents.[2]

Child abuse is not a rare phenomenon. In 1992, 2.9 million cases were reported in the United States; 1,200 children died. And the numbers keep growing.[3] When physically abused children come into the hospital, they require a disproportionate amount of time because the diagnosis is complex,

and treatment of multiple wounds is extensive. Neurological problems are common, and other bodily systems may be disordered. In one study, 70 percent of severely abused children died, and 60 percent of the survivors had residual defects.[4] There may also be severe residual emotional problems for survivors of physical and sexual abuse.[5]

For most of history, this problem was a well-kept secret. It was almost inconceivable that parents would do such a thing. Disciplinary punishment, yes! Children might need to be tamed, or they would turn into delinquents. But malevolent abuse? Never! Or at least rarely.

Even when these children showed up in hospital emergency rooms, bruised or burned, doctors didn't formally conclude they'd been abused. Perhaps the physicians did not want to get

involved in what might be a legal problem. Generally, the focus was on *treating* the patient, anyhow. Besides, there was a prevailing medical attitude of patient (and in these cases, family) confidentiality.[6]

Such was the situation in 1946 when Cafley,[7] a pediatric radiologist, came across a puzzle while doing his research. He noticed that X-rays of several children showed evidence of old arm and leg fractures and telltale signs of old bleeding. Being a good medical researcher, he wondered what disease could cause this phenomenon. Could it result from weak bones? A related blood-clotting illness, perhaps? He could not figure out the answer.

Gradually, doctors began to realize these problems didn't arise from diseases within the children's bodies. Still, resistance to the truth

prevailed. The findings were attributed to accidents or parental carelessness.[8] Finally, in 1962, Kempe and his colleagues[9] defined the "battered child syndrome" and opened the door to the public acknowledgment that these injuries resulted from intentional acts.

Societal outrage was rapid. Little children are defenseless; they have no one to trust but those who may betray them. Child abuse was tagged as a major public health problem. States passed laws requiring professionals to report suspected child abuse to Departments of Human Services (DHS) or Child Protective Services (CPS). Then came the task of verifying that the abuse actually occurred. And if so, who was the perpetrator?

How did the psychiatrist get into the act? The diagnosis of abuse is a matter for physicians trained in specialties other than psychiatry. They

are the experts who can interpret their observations to the court. (We will consider the case of sexual molestation which may leave no marks on the body later in this chapter.) And identifying the abuser is a matter for the police or the investigative social worker who can report to the court, not as expert witnesses, but as the people who can uncover the facts of the case.

The psychiatrist got into the act when Kempe coined the phrase, “battered child syndrome.” Prior to that time, a syndrome was a set of signs and symptoms residing within the sick person. Kempe and his team, which included a psychiatrist, enlarged the concept of the syndrome to include the cause which resided outside of the body of a sick person. We now had not only the sick child, but the sick family. Kempe’s group described the parents as “psychiatric deviants” with “defects in character structure.” The

consequences of this way of thinking have led to many productive research hypotheses and therapeutic efforts. However, as I discussed in Chapter 2, the standard required of an expert witness has its own special requirements. Hypotheses are not sufficient in court. And in my opinion, much of the psychiatric testimony in this area does not reach the level of a reasonable degree of medical certainty.

It is helpful to consider battering abuse and sexual abuse separately. With regard to identifying the existence of battering abuse, the psychiatrist has no role whatsoever. This is the province of the emergency room physician, the pediatrician, the orthopedist, the radiologist, or any other diagnostician involved with the examination and treatment of the child's bodily injuries.

When the evidence points to child abuse, child

protective agencies, such as state Departments of Human Services or Child Protection Services have a high interest in finding out who did it. And beyond these agencies are the courts which have the final say about who the perpetrator is and what the consequences will be.

Older children can identify their abusers, although they may be reluctant to do so out of fear, or when the parents are the abusers, out of conflicted feelings about those who both care for and torture them. Infants cannot identify their abusers, but the circumstances surrounding the event (e.g., who was in the house at the time) can often point to the abuser. Can the psychiatrist offer anything useful that meets reasonable testimonial standards?

Consider the case of Billy Hunter. Billy was a little over one year old when he was brought to

the hospital by his parents. They said he developed a rash a few days ago. It started as a diaper rash but then spread to his trunk, buttocks, arms and legs. His mother first tried to treat it with powder, but it soon developed into blisters, which she punctured. She applied an over-the-counter medication to the "sores." When Billy developed a fever, Mrs. Hunter's mother insisted she take him to the hospital for examination.

The doctors easily identified the "sores" as burns. Mrs. Hunter seemed surprised. She was the only one who bathed Billy, and he never expressed any pain or discomfort during the bath. Perhaps he had backed into the space heater, and the sores from the initial burn had spread. When the doctors told her burns don't spread, she said she just couldn't remember anything that would have caused the problem.

The case was turned over to a clinic which the hospital had set up to evaluate suspected child abusers. The social worker asked Mrs. Hunter why she waited so long to bring Billy for treatment. She replied that she still owed the hospital money from previous visits and she was afraid they wouldn't treat him. Among those previous visits had been Billy's sister who had a broken arm. On that occasion, Mrs. Hunter said she had pulled the child abruptly and the arm was caught between the slats of the crib. Another child had died in infancy. She had been losing weight for over a month, and one morning she was found dead in her crib. According to Mrs. Hunter, an autopsy showed the child had ulcers and "intestine problems."

The social worker took an extensive history, which revealed that Mrs. Hunter had been battered and sexually abused as a child. Even as an

adolescent, when she went to live with an uncle, she was subjected to beatings and sexual abuse. She had been raped at the age of 15. When she was 17, she gave birth to her first child. She had no idea who the father was. She gave the child up for adoption.

Mrs. Hunter dropped out of school when she was sixteen. She held a variety of menial jobs, and apparently was not a success at any of them. Mostly, she attached herself to a succession of men who more or less took care of her in return for sex. She didn't enjoy it, but it was the price she had to pay. She and her husband were married four years ago. She was content in this marriage. Her husband worked "most of the time." He helped her with the children. They went to church several times a weeks, and they took the children with them.

According to the social worker, Mrs. Hunter rarely smiled; she "appeared to be depressed." When she described her past history, she went into overly long detailed accounts; her memory appeared sharp. However, in describing the events of the last few days, she was vague and "evasive."

On the other hand, Mr. Hunter was pleasant. He agreed that the marriage was going well. According to him, their sexual life was good, and they both enjoyed it. He seemed "unusually unconcerned" about his child's problem. "I don't know nothing about rashes and babies, and stuff. My wife takes care of all that." He said that she is the disciplinarian in the household, because he is afraid he might be "too hard on the kids." He did whip one of the children two years ago, but it left marks. "Marks show, and that don't look too good." He said his own childhood was normal, but he did remember being whipped by his father.

The social worker listed her concerns on the report: Billy's injuries were severe. Although his parents were the sole caretakers, they couldn't account for what happened. They delayed seeking medical attention, not only for Billy, but also for the child who died. Mrs. Hunter had "accidentally" fractured another child's arm. Mr. Hunter admitted being too hard a disciplinarian, and his concern was that marks from whipping "don't look too good."

Both parents were sent for psychological evaluations "in order to determine their capacity to care for their children." Amazing! With the social worker's report, was there any question? In my opinion, any judge who couldn't answer should not be sitting on the bench. True, we don't know for certain who abused the child, but we do know, without a shadow of a doubt, there was abuse. And there was a pattern of neglect. Why did they need

expert psychological (in this case) testimony?

Two reasons come to my mind. Admittedly, they are speculations— not admissible in court, but admissible in this book so long as they are identified as speculative. Perhaps by providing data about the parents' character structure, this clinic could make a more forceful, "scientific" presentation to the judge. Or perhaps, like in many clinics back in the era when funding was widely available, more work meant more funded positions.

The psychologist gave each parent a battery of seven tests. Each report was several pages long; half of the report repeated the information from the social worker's report. In addition, the psychologist noted that Mrs. Hunter, while outwardly calm, had inner turmoil. When stressed, she tended to retreat into fantasy—

preoccupations with her daydreams. She was a dependent, somewhat sensitive and mistrustful person. Intellectually, she was below the average range.

Mr. Hunter seemed "preoccupied with religion." He went to church several times weekly, and he was studying on his own to be a minister. He said he and his wife had prayed to find the right date the Lord wanted them to get married. When the date came to him, the marriage took place, "just as the Lord wanted it to." The proof the union was the Lord's work was that the marriage was good. He said that before he was saved, he gambled and used drugs; now he was a new person. "That's the power of the Lord."

The tests showed Mr. Hunter had feelings of inadequacy for which he compensated by a tendency to brag. He was also conflicted about his

destructive impulses. There were “tendencies toward resentment of nurturing women.” The report was full of “the tests suggested” and “he has a tendency toward.”

The psychologist concluded the Hunters had many risk factors for abuse potential. He never actually said they had been abusers. He had studied their characters; he certainly wasn’t accusing them of anything but character flaws. But we already knew from the reports of the emergency room and the social worker that there was parental neglect and probable abuse. Viewed in that light, if the judge still had any doubt about who inflicted the abuse, the psychologist’s report would have pointed the finger at the parents.

In legal terms, what the psychologist provided was character evidence. This is evidence based not on facts of the incident at issue but on the

character of the person involved in the situation discussed at the trial. For example, in a criminal trial, lacking substantial evidence to prove the defendant actually perpetrated the offense, the prosecutor might want to show the jury what a bad character the defendant has. The jury might then conclude that this kind of person could well have committed the offense. But character evidence is not admissible as a means of proving guilt in a criminal trial.[10]

Even in civil cases, character evidence is at best problematical, because it may distract from the facts of the case and it may be prejudicial.[11] However, the rules of procedure and evidence are much less formal in family and juvenile courts, and many judges not only allow character evidence, but seek it.[12] But was the character evidence in this case valid to a reasonable degree of medical certainty? Look how the character evidence in this

case played out.

The children were removed to foster care, and the Hunters consulted a legal services attorney in an effort to get them back. The attorney asked me to review the reports and interview the parents. I agreed with much of what the psychologist reported about Mrs. Hunter. But did that make her an abuser? Were these features really risk factors for abuse potential? Are there any consistent risk factors which reliably point to someone actually being an abuser?

Reviews of the literature reveal that different researchers find different risk factors, some of which are inconsistent with others.[13] One researcher estimated that "20% of the population of parents have child rearing attitudes and experiences that are so similar to known abusers as to make them indistinguishable from abusers

on any dimensions except the absence of documented abuse."[14] Yet if we were to testify on the basis of their profiles, all of them might be fingered as abusers.

It seemed to me the psychologist was all too ready to find flaws in Mr. Hunter's character. For example, his negatively-toned description about Mr. Hunter's religiosity did not stand the test of my discussion with the man. Mr. Hunter was a member of a primitive fundamentalist sect, and what he described were beliefs common to that particular religious group. No real pathology there.

Was I therefore prepared to say that it was safe to bring the children back into the household? Much to the lawyer's regret, I was not. All I could tell him was that the psychologist's conclusions rested on very shaky grounds. And, as I told him before he sent the material to me in the first place,

I did not believe that psychiatrists had much, if anything, to add in these types of cases, except to rebut other "experts."

I put all this in the report. I never did find out what the judge decided. It often happens that I get no follow-up from the attorney.

Of course, not all cases of child abuse result from battering. Sexual abuse has been very much in the news in the last few decades. Over 200,000 cases of child sex abuse were reported in 1993—an 83 percent increase since 1986.[15] This probably represents both considerable underreporting and false reporting. Detecting sexual abuse of children poses a more difficult problem than detecting battering, because molestation may not leave any tell-tale marks on the body. Although doctors may find vaginal or rectal tears, the lack of these injuries does not

mean the abuse did not occur.

Often, the abuse comes to our attention because a parent informs the authorities what the child has told him or her—or what the parent claims the child has said. The case may hinge on the veracity and reliability of the witness.[16] Children think differently from adults and they may be more likely to be suggestible, to misunderstand, or to confuse fact and fantasy. Expert testimony poses no great problem so long as it describes children's thinking. However, in my opinion, the testimony should not single out a particular child witness as having distorted the facts unless there are specific data. And unless there are specific data, generalizations about children's thinking should not be used to imply that the event did or did not occur.

How, then, are the judges to conclude that the

event—with no marks on the body and no third-party witnesses—did or did not occur? No wonder judges turn to "experts" for their opinions. And that's just what the judge did in the case of Carolyn.

Three-year-old Carolyn Archer was in the middle of a dispute between her parents. The parents had been divorced since Carolyn was six months old. Sally Archer had custody of Carolyn and her four-year-old brother, Jeremy. Dwayne Archer lived with his mother, and he was allowed to take the children every other weekend.

The discord between Sally and Dwayne boiled over when Dwayne started going with Louise. According to Sally, Carolyn told her Louise had inserted her finger and "needles" into her vagina and rectum on three successive visits. She took the child to the family physician, who found some

"redness around the vagina." No tearing or bruising was discovered. Because of the allegations, the doctor notified the DHS.

When the DHS social worker interviewed Sally, she learned not only about the alleged molestation, but also about Dwayne's immaturity. Sally said he was unstable, and she doubted he could adequately supervise the visitation. The social worker referred Carolyn to Dr. Groves for an evaluation.

Dr. Groves and Carolyn played with the anatomically correct dolls. Carolyn undressed the child doll and immediately stuck her finger in the doll's vagina. She said that was what Louise did to her, and it hurt. She also reported that Louise had inserted a hot needle and once even the handle of a teaspoon.

Dr. Groves found Carolyn to be

developmentally on target. She was an active girl —outgoing and friendly. She "did not appear to be afraid of anyone." The words she used to describe body parts were appropriately childlike.

Sally told the doctor her daughter had changed over the past few weeks. She was cranky, slept poorly, and she had developed a terrible temper.

Putting all this together with the social worker's report, Dr. Groves concluded that the abuse "probably" did occur and that Louise was "likely to have been the perpetrator." The judge agreed to put restrictions on Dwayne's visitation; he could not leave Carolyn alone with Louise.

However, Dwayne hired his own lawyer who insisted on another evaluation, and the judge made the restrictions temporary, until the next evaluation report came in. Dwayne's lawyer called me.

I told the lawyer that neither I nor any other psychiatrist could state whether the events actually occurred, and if so, whether Louise was the perpetrator. He responded that he understood I might not be able to do this. However, I might be able to neutralize the report of the other doctor. With no guarantees, I agreed to see the child. I asked the attorney to have Dwayne bring Louise along when he brought Carolyn to my office.

Carolyn was just as Dr. Groves described her—friendly, outgoing, and active. She talked easily as she played with the toys. She looked up at me and told me her mother had stuck her finger with a needle while she was sewing. She showed me the finger, but there was no mark on it. She proceeded to undress the anatomically correct dolls and stuck her finger in the boy's rectum. "That's Jeremy," she said. I asked her if anyone stuck their finger in Jeremy that way, and she replied

"Louise." This was the only report involving Jeremy in the record.

"How do you know?" I asked.

"I know."

"Really? How do you know all that?"

"My mom—nobody told me." She was matter-of-fact about all this— not a hint of anxiety. "Louise did it to me, too," she added. She took the girl doll and jabbed its vagina and rectum.

"Just with her finger, or something else, too?"

"No, she used her finger!" she replied, with a charming three-year-old look that reminded me that we adults just don't understand very much. And she busied herself with a tea set.

After some more play—she was very easy to play with—I suggested that she wait in the waiting

room with her daddy while I talked with Louise. Louise talked easily about her relationship with Carolyn's father. She expressed bitterness about "that woman's" accusations. "She's been trying to break us up ever since we started going together. She even accused Dwayne of doing bad things to the kids."

"Bad things? Like what?" I inquired.

"Oh, you know, like the stuff she accuses me of." She proceeded to tell me what a jealous woman Sally was. Then she lowered her voice and said, "I wouldn't do anything like that to a kid. I know what it feels like—my daddy used to do that to me." We talked about that for a while, until she regained her composure.

Following this interview, I observed Carolyn and Louise playing together. Carolyn volunteered to sit on Louise's lap and they played happily

together. It seemed to be a comfortable relationship, and Carolyn showed no anxiety.

I reported these observations to Dwayne's attorney. In my report, I explained that I could draw no conclusions from the interviews. Psychiatrists may be good diagnosticians and therapists, but we are not very good detectives. Children do modify their stories, sometimes because the original story was not based on fact and sometimes because of the way they remember them, or the way they were coached. The report about Jeremy could be true or it could be an elaboration of Carolyn's story. The one new sound fact I could add was her saying, "My mom ... nobody told me." While this could indicate the story was originally planted by her mother, it might also be a reflection of her mother's having rehearsed her in preparation for her visit with me. "Be sure to tell him about what Louise did to you,

dear, but don't say I told you to say anything." Quite a bit for a young child to keep orderly in her mind.

Certainly the way Carolyn and Louise related in my office was impressive. It didn't look as if Louise had made Carolyn uncomfortable. But maybe there had been gentle sex play, and the various details somehow got attached in the little girl's mind or in her discussion with her mother. Who knows where the idea of a hot needle and teaspoon came from? And was this the child who was cranky and had a terrible temper at home? Or perhaps Carolyn reacted to other things at home which had nothing to do with Louise. A multitude of questions, each one with many possible answers. I know of no research to guide me in choosing among these various answers. And, I pointed out in Chapter 2, there is no room for speculation in courtroom testimony.

After receiving my report, the judge felt the data he had did not warrant enforcing the restriction, and it was lifted. Now, it may be that some of you readers will look at what I described and disagree with my conclusion. Why, you may ask, am I so blind I can't see the obvious? You and the judge are entitled to come to your conclusions on the basis of what is obvious to you; indeed, that's the only way the judge could operate in this case. But the expert must testify to things that are not so obvious—*uncommon* knowledge.

But what about Louise? Didn't I find things about her that could establish her as an abuser? Would psychological tests have helped? As in the case with battering, there are no consistent sex abuser profiles, and testing doesn't help.[17]

Essentially, profiles are built on risk factors. Why do I accept risk factors when it comes to

assessing dangerous patients (Chapter 7) and reject them when it comes to abuse? There are two reasons: There is greater agreement among studies of risk factors of dangerousness. And if I fail to use risk factors in assessing dangerousness, I may be sued for not protecting someone. That's the law, and it dictates our standard of practice. There is no such law when it comes to profiles and risk factors in child abuse cases. Unless, of course, I have good reason to believe a parent is mentally ill and imminently dangerous, in which case we revert to the commitment law discussed in the preceding chapter. Otherwise my only legal duty is to report cases to DHS when I *believe* abuse has occurred. This legal duty is not testimony; I don't even have to have enough data to conclude anything to a reasonable degree of medical certainty. It is up to others to present testimony to the judge.

Unfortunately, sometimes our testimony rests on concern or ideology, rather than fact. It is difficult not to feel sympathetic toward the child who may have been abused. And our sense of justice pits us against the accused. Of course money also enters in; it is tempting to position ourselves to get repeat referrals to evaluate and to treat "victims."

During the heyday of the nursery school sex abuse scandals, I was teaching at a medical school. One day, a colleague asked me if I would join with other faculty in helping families of many children who had been molested at a local nursery school. He seemed surprised when I asked him how he knew the abuse had occurred. He told me that he knew it happened because it was even in all the newspapers. I declined. The department chairman called me in and said that he hoped my forensic work wouldn't interfere with what the faculty

were doing with these families. I responded that if I was asked to consult, I'd have to call the case as I saw it.

Shortly thereafter, a lawyer representing the nursery school requested that I evaluate two of the children. I had never done this type of work before, but the lawyer was having difficulty in finding a psychiatrist or psychologist to work on the defense team. I confess I was pleased to be asked to work on such a high profile case. I said I'd be willing to try, but I doubted I could throw any light on the situation. Since the children were so young, I thought it wise to work with a female colleague. I called every woman professional I knew who was more experienced than I. They all declined. Several of them came right out and said they get referrals from DHS—not only to testify, but subsequently to treat the children. They couldn't testify for the other side. Finally, I settled

for a woman who was a good psychologist but was as inexperienced in this area as I. As I predicted, we were unable to say whether the abuse had occurred. Of the several adults who were accused, only one was convicted, and the judge subsequently let her out of jail.

A few years later, a strange thing happened. I received a call from DHS. They wanted me to evaluate a child who said she'd been molested. I told the caller I was surprised to get her call. I reminded her that she had seen me in court quite a few times testifying that a psychiatrist can't say whether the abuse actually occurred. And I added that DHS had a whole cadre of experts that it used to support their allegations of abuse. I told her I'd talked to several of them when I was looking for a woman to help me when I worked with the defense on the nursery school case.

The DHS worker replied that she knew all that. But she said that this case was different because they were suspicious that the abuse *didn't* occur. That's why they were calling me. I declined politely. There was, and still is, a cottage industry where some protective agencies and some therapists feed on each other. And like the lawyers, the DHS knew where to get testimony which favored their point of view.

The story of the nursery school accusations had a strange twist to it. Although I was consulting with the defense, I received a phone call from the assistant district attorney. He expressed concern about the evidence against the people running the school. The evidence consisted of the interviews of the children performed by a policewoman and a social worker from DHS. He felt the children were goaded into naming the teachers by a series of leading questions and promises of ice cream once

they told the whole story. He wanted my expert opinion. With the permission of the defense lawyers, I agreed to review the videotapes. Indeed, the interviews were loaded with leading questions. The assistant D.A. resigned from the case, but another was assigned to prosecute this high-profile case.

In court, as the jury viewed the tapes, I pointed out how the interviewers guided the children's answers. Evidently the jury didn't buy it; on the basis of this evidence, they convicted one of the teachers.

In retrospect, I wonder whether my testimony was a result of my professional expertise or whether it was a judgment call based on common knowledge. The assistant district attorney who called me reached the same conclusions as I did about the leading nature of the questions. And he

had no psychiatric training whatsoever. Since that time, psychiatrists and psychologists have published numerous sets of guidelines for doing neutral interviews.[18] But I still wonder if this is the proper venue for psychiatrists, rather than detectives, communication specialists, or social workers. If we have no special expertise in detecting abuse or abusers, we shouldn't be doing the interviews—guidelines or not. We do know something about the vulnerability of children to suggestions by adults, but so does everyone else.

A few years after the nursery school scandals peaked, there was an upsurge in patients who, in the course of psychotherapy, claimed to have recovered repressed memories of having been sexually abused years before. These patients sometimes confronted or even sued the family members they identified as the abusers. Soon one cadre of "experts" said the "recovered memories"

had been implanted by the therapists. A new abuse "syndrome" was articulated—the false memory syndrome. Another cadre insisted the memories were accurate. Each side relied on a spate of studies to support its views.[19]

Recalling past events is a very complicated process—or rather several very complicated processes—for there are various types of memory and recall which involve activity in various areas of the brain. However, for our purposes, we can simplify the questions which must be asked: (1): Is it possible for a person to be unable to recall sex abuse in childhood (let's call that "not remembering") for many years? (2): If so, can he or she later recover it from memory? (3): Can the recalled memory be implanted by a psychotherapist? (4): Do some therapists actually strongly suggest early sex abuse to their patients? (5): Are the recalled events accurate?

(1): It is possible for childhood victims of sexual abuse to have amnesia for years and then to recall the abuse. Williams[20] selected 129 women who, as children seventeen years earlier, had been studied when they were brought to the hospital with allegations of having been sexually abused. The hospital records documented the evidence of the sexual abuse in all these children. Now, seventeen years later, Williams inquired about whether they had ever been abused. Thirty-eight percent had no memory of the abuse. Not remembering sex abuse is possible.

(2): The abuse which was not remembered can subsequently be recalled. In the Williams study, 16 percent of the women reported they had forgotten the abuse for many years before they subsequently remembered it. None of these women were in psychotherapy.

One example from my clinical practice drove the point home to me. A mother I had in treatment asked if I would see her adolescent daughter. The young lady was starting to develop an “orderly” habit. She’d always been neat, but now she had to put her books in alphabetical order on her desk and to straighten up things that were hardly out of line to begin with. If things were not in order, she felt a vague discomfort.

Other than her compulsion, she was quite a remarkable person. Her school grades were excellent. She had many friends, and she was active in several extra-curricular activities. She was a talented artist, although lately her paintings took on a more symmetrical pattern. She got along well with her parents.

The case seemed simple enough—she was developing a compulsive disorder. There were

three possible courses of treatment. She could take medication, she could have behavioral psychotherapy, or she could have both. She opted for only the medication, and her mother agreed.

A week later, her mother called to report the medication was having disturbing side effects. Surprisingly, the "orderly" daughter started to spatter paint indiscriminately on her canvases. I wasn't sure this was a side effect of the medication, but the young lady stopped the medicine anyway. A few weeks later, the mother came in for her own appointment, and she told me what happened. Her daughter had spontaneously recalled having been molested by a former family friend in another city years before. She had the good sense to write this friend about her recollection. It must have been an unusually tactful letter, because the friend acknowledged the incidents and apologized. Following this, the

compulsion lightened. It remained, but on a tolerable level.

(3): The "recalled memory" can be implanted by a psychotherapist. I know it did not happen in the case of this young lady, because I made the error of not asking about abuse when I took her history, and she'd had no previous treatment. Well-researched studies of therapist suggestions and patient suggestibility do not support the conclusion that it can happen.[21] Individual reports and anecdotal evidence suggest that it can. While not conclusive, the accusation of Joseph Cardinal Bernardin of Chicago could be a case in point.[22] During hypnotherapy, Steven Cook "recalled" having been sexually molested years before by Father Bernardin. So convinced was he that he filed suit against the cardinal. Of course, the suit became a major news-media event, much to the embarrassment of many. Some time thereafter,

but before the suit came to trial, Mr. Cook thought it over and realized that the "memory" was unreliable. He withdrew the suit and the judge dismissed the case.

(4): Unfortunately, some therapists do strongly and repeatedly suggest to their patients that the symptoms they suffer from result from childhood abuse, and they tell them it is important that they search their memories until they find it. I had one such case.

A woman came to my office and asked for a second opinion. She had intermittent periods of promiscuity under rather risky circumstances. For two years, her psychotherapist told her this was her attempt to work through (get over) her childhood sexual victimization. She gave her one of the many books describing symptoms and repressed memories. But search as she might, the

patient couldn't actually find any abuse in her memory bank.

I told her that while this diagnosis was certainly possible, we should explore other avenues as well. After asking about other symptoms, I discovered that she had periods of hypomania—not quite manic, but over-active—rapid speech, sleep disturbance and impulsivity. There were others in her family who had similar problems. It is not uncommon for hypo-manic episodes to be accompanied by impulsive behavior and heightened sexual interest. I prescribed a mood-stabilizing medication and followed her for several years. She had no recurrence of the promiscuity.

Why do therapists sometimes jump to the conclusion that childhood sex abuse must have occurred? Some have had little or no training in

diagnosis; they are not aware of alternate possibilities. Others follow what they have been taught, and their teachers followed what they have been taught. Many of the journals they read have articles which can't pass scientific muster. Most psychotherapists have little exposure to the research methods or findings underlying their practices. Still others may have an ideological agenda: Women are taken advantage of by men. While many men do take advantage of women, this is no basis for making a diagnosis.

(5): Are the "recalled memories" accurate? This is the ultimate forensic question. Unless the alleged perpetrator confesses, the answer must be equivocal. Let's review the first four questions: Not remembering can, but needn't occur. Some victims have it, some do not. Child abuse which is not remembered can sometimes subsequently be recalled. Some, but not all, memories may be

implanted by psychotherapists. Some, but not all, psychotherapists use repeated and strong suggestion. This leads to the fifth and ultimate question. Some, but not all, "recovered memories" are accurate. How can we psychiatrists tell which is which? We can't!

The scientific study of memory has not yielded unequivocal guidelines for the detection of past events. According the American Psychiatric Association, "There is no completely accurate way of determining the validity of reports [of recovered memories of child sexual abuse] in the absence of corroborating information."[23]

Unfortunately, the debate is guided as much by ideology as by science. As Brown put it: "My concern is that the standard of science drops when concern about public issues takes priority over careful science. The application of memory science

... is very much in its infancy."[24]

Brown and his colleagues do have hope for the future. While they maintain that "No 'litmus test' currently exists to distinguish between true and false reports of abuse...," they seem optimistic that more sophisticated research will "increase our precision in determining true from false allegations."[25]

I wish I could share their optimism. The social problem of child sexual abuse cries out for scientific answers to give to the court. But, in my opinion, there is a basic and unsolvable flaw in research on the accuracy of recalled memories. In order to know if your test or technique accurately points to abuse, you have to have some way of measuring it against the fact that it did, indeed, occur.

Researchers often bolster their reports by

citing the validity of their tests or procedures. There are many different types of validity, but, once again, the only one that really counts (and is rarely cited) is the one which measures these devices against whether the event actually occurred.[26] Unless you can show that your device accurately fingers both true and false memories of abuse, the use of the word "valid" is misleading.

So, it gets down to having some way of knowing whether the abuse really occurred, in order to test your procedure against it. Williams[27] seems to have solved that problem. She reviewed documents from hospital records citing examinations and reports of sex abuse at the time of the reported occurrence. But were these documents accurate? Thirty-four percent of her sample had documented medical evidence of genital or anal trauma. I'm willing to agree that this is a good corroborative data of the trauma.

But 66 percent lacked such evidence; the documents recorded *reports.* Reports are allegations; they may or may not be true. And one finding, often not mentioned in subsequent references to her research, is that three (documented) women she interviewed were excluded from the study because they maintained they had fabricated the abuse. Were there other such cases in the documents—cases where the women were not so frank in the research interview? Or did witnesses fabricate or misperceive at the time the hospital recorded the incidents? We will never know. And this is why psychiatric methods to determine the accuracy of allegations of sex abuse or belatedly recalled memories of such abuse must fail. When there is no evidence on the body or no confession from the alleged perpetrator, there is no good way I can think of to be sure that members of the research

sample were or were not abused.

Where does that leave the forensic psychiatrist? In my view, giving testimonial opinions about the vagaries of memory is legitimate but may be prejudicial if it tends to point to the *accuracy* of the particular memory in question. The best we can say is that we don't know, and neither does the "expert" on the other side who claims he or she does. We can't help the court with this vexing decision; the judge or jury will have to decide on the basis of common knowledge.

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Chapter 9

Custody Battles

Shortly after King Solomon received the gift of great wisdom and understanding, he faced a child custody problem. This wasn't your run-of-the-mill custody dispute between divorcing parents nor between family members. It wasn't a fight between foster and biological parents. Before the king were two prostitutes. They lived together and had delivered babies within a few days of each other. One child died, and each woman claimed the living child was hers.

King Solomon decided the issue on the basis of character evidence. He ordered the infant to be cut in half—one half given to each woman. One woman agreed, while the other woman gave up

her claim in order that the child might live. “This is the kind of woman,” the king must have thought, “who has the attributes of the child’s mother.” Character evidence! The king, being the judge (and the king, of course), had the privilege of relying on this evidence.

Now the king did not necessarily infer that this woman would make the *better* mother. For all we know, when the other woman got over her fit of jealousy and spite, she might have raised a great fighter to help Solomon with his expanding empire. The woman who got the child might be rather timid, if not masochistic, and she might have raised a wimp. But what happened to the child wasn’t the question. The question was the identification of the biological mother—good mother or not. In fact, in modern-day courts, the child might not have been given to either mother because they both were prostitutes—more

character evidence. That's not the kind of environment we want for our children.

The issue, then, wasn't what was best for the *child,* but rather which *woman* had the right to the infant. Indeed, throughout most of history, the focus has been on the interests of the adults rather than the children.[1] During feudal times, while women and children belonged to the man of the house, they were also the property of the lord of the manor. Not much in the way of custody disputes there. After feudal times, children were the property of the father. In the largely agrarian economy, children working on the farm were economically valuable. However, with the industrial revolution, the father worked out of the home to earn the family's income. Children were "economically worthless,"[2] unless, of course, they too worked in the factories.

Gradually, however, the focus shifted to the child's nurturance. It was true the child had needs, but it was assumed that the mother could and would provide for them. Thus, the role of mother gained dominance in custody disputes. Especially during their "tender years," children needed their mothers. In many courts at that time—and even now—an idealized image of the loving mother held sway. As one judge rhapsodized, "There is but a twilight zone between a mother's love and the atmosphere of heaven...."[3]

In all these conceptions the specific needs of the child were not very important. Custody decisions were decided predominantly on the basis of which parent had the right to the child or on the basis of which parent was automatically assumed to be better for the child. There was little need for psychiatric experts.

However, times were changing in the early twentieth century. Child labor laws were promulgated. Education was becoming compulsory. The child was coming into its own. In 1925, the court stated that the custody decision should not be based on the disputes between the parents but on "what is best for the interests of the child."[4] The child's needs should be paramount in the custody decision.

While the child's needs could be defined by educational opportunities, financial support, religious needs, and even social status, little by little, psychological needs were included. Ultimately, in many courtrooms, the best interests of the child became largely defined by which parent-child relationship offered the child the best psychological opportunities for his or her development.[5] And here, the courts needed (and welcomed) the specialized information given by

the experts in this area.

Judges tend to give great weight to the expert's recommendations.[6] And experts from the various professions studying children are more than willing to provide this information. Psychiatrists and other professionals seem to know what children need. And we seem to know what kind of parents are most likely to fulfill these needs—and what kind of parents will not.

This is character evidence, but it is cast in a different light from its use in abuse cases. In abuse cases, the judge decides on the basis of a historical fact—did the abuse occur? The character evidence is used (really misused) to make the judge believe the "expert" can help him or her know whether the allegation was accurate. As I discussed in the previous chapter, much of our expert testimony in abuse cases, based on character evidence, proves

or tends to prove nothing except how professionals may overreach.

However, in custody cases the decision may rest on which parent has the most appropriate character. Character evidence is right on target; it is relevant to the issue at hand.[7] The message is not lost on the warring parents in a bitter custody dispute; they engage in character assassination. And the Stricklands pulled out all the stops.

Professor Kenneth Strickland was a distinguished authority on linguistics. Katy Strickland was a high school graduate who worked as a secretary in the public school system. Kenneth first saw her in the travel section of a bookstore, and he was smitten. He could not resist going up to her and striking up a conversation. Her travel had been restricted to looking at pictures; he had actually been to all these places. Katy was

very impressed. They had coffee, and the relationship began.

Every so often, Katy had her misgivings; he seemed so far above her. He'd never fit in with her friends. Kenneth stuck with his fantasies; she was like a beautiful block of marble waiting to be sculpted into the wife of his dreams. Katy insisted on a trial separation, but after a while, she found she missed him. A few months later, they married and Katy moved into Kenneth's house.

It didn't take long for the honeymoon to end. Kenneth was neat; Katy was a lackadaisical housekeeper. He felt she was unreasonable; she felt he always wanted his own way. He was embarrassed at her comments at a faculty dinner; she thought they were all snobs. Unfortunately, like so many families in such a predicament, they decided that what they needed—what they could

have in common—was a child. The following year, Kenneth Junior—KJ—was born. But things went from bad to worse, and when KJ was four, they decided on a divorce. They each wanted custody of KJ.

My entry into the case was rather unusual. Katy's attorney called me and said the judge wanted me to evaluate both parties. Shortly thereafter, Kenneth called me with the same report. I called the court clerk who confirmed the request. But each parent had already been evaluated separately by different psychiatrists. Each doctor had ordered psychological testing.

Katy's doctor said she was emotionally labile and tended to be uncomfortable when left alone (Kenneth worked long hours and went away to conventions). She had a tendency to be suspicious, but not to the level of paranoia. Intellectually, she

was in the average range. She had developed good coping mechanisms which were very helpful to her in the face of “intense stress because of her husband’s abuse. She is well able to care for her child, even when the pressures are great.”

The report from Kenneth’s doctor was more glowing. He had superior intelligence. He was focused and had “an admirable work record. He also had many cultural interests.” He tended to be somewhat rigid in his thinking, but he also had emotional warmth.

But Kenneth’s psychiatrist was concerned about Katy. “Although she is well-meaning, she is not very well educated. She has not achieved much in life. Her outbursts of temper are signs of her instability.” I wondered how the doctor knew about this woman he had never examined. Kenneth gave me the answer several weeks later

when I talked with him. He and the doctor shared the “many cultural interests”; they were friends. The psychiatrist had a conflict of interest and should have referred Kenneth elsewhere for the evaluation. In fact, at one point, when Katy had been very angry, Kenneth had his psychiatrist friend fill out a commitment paper, but the doctors at the psychiatric hospital refused to admit her because she didn’t need it.

While it was obvious to me the psychiatrist was unfit, my task was to see if either parent was unfit, and to decide what was in the best interests of KJ. I arranged to see each parent separately and together with KJ. I also arranged to see KJ alone.

Each parent had a list of accusations against the other. Kenneth reported that Katy used drugs. KJ had told him she was having an affair. She was rarely home and left KJ unattended. She was

mentally ill, and Kenneth had a copy of the commitment paper to prove it. She had a terrible temper. She was lazy and a terrible housekeeper. She was overly suspicious. “She keeps accusing me of having an affair with my secretary.” Katy reported that Kenneth lost his temper and had struck her on several occasions. Once, she had to go the emergency room. (Kenneth said she provoked him and hit him first.) She said her husband wanted to bring up KJ to be a college professor. “Not if I can help it!” she barked. On one occasion, Kenneth got into an argument with Katy’s friend, Annette. He scratched the side of her car.

Fortunately, neither parent accused the other of physically harming KJ. He seemed to relate well with both of them. He was a pleasant, somewhat reserved boy whose language and manner were age-appropriate. He drew a picture of his family. I

asked him what they were doing.

"They're yelling. I don't like it."

"What are you doing?" I asked.

"I'm going to my room." He drew a box around himself.

KJ knew his parents were going to separate, and he wasn't happy about it. He wanted to be with both of them. "Daddy teaches me things and we go in his car."

"And Mommy? How about her."

"She buys me toys and things. She makes supper."

"Does Mommy ever go out and there's no one in the house?"

"Sometimes she goes somewhere, and she takes me to Stella's." He shifted his position on the

floor, a little uneasily. I asked if he wanted to draw another picture. He drew two figures with their faces close together.

"Who are they?"

"Mommy and the bad man. They're kissing."

"How do you know?" I asked.

"Daddy told me. One time he said they were in the bedroom kissing. I went there and I saw them."

"Was your daddy home then?"

"He was in the living room."

So far as I could tell, KJ was comfortable with each parent. In his four-year-old mind he'd sorted out what each of them brought to their relationship with him. But he was uncomfortable when they were together, which made it difficult for him because he wanted them both.

In my report, I listed the various accusations, most of which I could not substantiate. There was the report from the emergency room documenting Katy's cut lip. There was the suggestion, at least, that Kenneth had primed KJ about the "affair." That didn't mean there was no affair. I just had no data. I also had no data about Kenneth and his secretary.

It was apparent both psychiatrists' assessments were generally accurate. But did Katy's lability and "lack of achievement" make her a bad parent? And did Kenneth's intelligence and cultural interests make him a good parent? Or did this tell us more about the values of Kenneth's psychiatrist? I have occasionally read reports which judged the better parent on the basis of his or her sharing the psychiatrist's values. Is a college professor a better parent than a secretary? Is a person with a dignified demeanor better than

someone who shows a full range of emotion? And did the tests fail to reveal that Kenneth, too, could have emotional dyscontrol? Or didn't his psychiatrist know that behind the studied demeanor was a man who struck his wife and cut her lip?

I told the judge I couldn't choose between them. What I didn't tell him was that some of the court's money spent on me might better have been spent on a trained investigator—a social worker or a detective—in order to get to the bottom of the accusations. The judge decided to award custody to Katy, but to give Kenneth liberal visitation. He followed my suggestion that they meet jointly with a counselor to try to ease their antagonisms—anger which could only hurt KJ.

Not long afterwards, a paper by Beaver[8] convinced me that, at least in many cases, trying to

decide which parent will act in the best interests of the child is usually a futile exercise. As we have seen with the Stricklands, the data given to the evaluator is colored by the custody battle. Further, we are evaluating the parents under the very stressful conditions of a contested custody case. We take the data and extrapolate the parent-child relationship into future time. It is possible that the parent who relates well to the infant will not be able to let go or to relate nearly as well to the child as he or she grows older. In fact, as the author wisely points out, sometimes, a parent's short-range negative impact on the child may help him or her learn to adapt and develop coping skills. And how do we know what the future holds? We evaluate the mother and father, but what if one of them marries again? Then, there is an unevaluated additional parent.

With regard to the psychiatric evaluation,

probably the most important point the author makes is that there are many variables that go into good parenting. How do we assign weights to them? Which are more important? We see a whole host of variables when we look at the recent guidelines for custody evaluations issued by the American Academy of Child and Adolescent Psychiatry.[9] Seventeen areas should be assessed. These include the nature and degree of the attachment (sense of security in the relationship between the child and each parent), the child's preferences, educational needs, sibling relationships, parents' physical and psychological health, styles of parenting and disciplining, and several others. Are the child's educational needs more important than sibling relationships? What weight should we assign to each factor?

The guidelines assert that "the assessment of the quality of attachments between the parents

and the children *is the centerpiece* of the evaluation" (italics mine). This suggests that attachment should be given more weight than some other factors. Rutter's recent review of the literature[10] reveals that attachment theory has been enormously productive for child development research. However, several studies he cites cause me to be concerned that we don't often have a sound enough data base for making decisions about attachment in the forensic situation.

How do we assess the degree and quality of attachment to each parent? There are some strategies which are used during the child's infant years, but even these are subject to criticism. And when it comes to older children, Rutter says, "The issue that is only partially resolved concerns how to measure attachment qualities after the first few years of life." And we must remember we are not

observing parent and child under the relatively calm conditions of the research setting; we observe them in the midst of a bitter custody dispute.

Of course, if there are huge differences in the quality of the relationship between the child and each parent, we might be justified in drawing a custody conclusion, even though there is no way of assessing and comparing finer degrees of attachment. But if the differences are that huge, does the court need the specialized knowledge of an expert? Consider the case of the Carvers.

Doreen Carver married her husband on the rebound from her first divorce. Doreen was a marketing director in a medium-sized company, while Philip Carver was a minister. He was quite a contrast with her first husband who was an engineer.

Doreen came to the marriage with her 12-year-old son, Johnny. Philip's quiet, steady manner was a relief from the turbulent first marriage. Or so she thought until the clash of lifestyles became apparent and she was bored and disgruntled. By this time, Doreen and Philip were parents of another child—three-year-old Alice. Doreen had moved out and divorce was in the air. Custody had to be decided.

Philip wanted Alice, and Johnny's biological father (Doreen's first husband) wanted Johnny. Both men had gone to court together and obtained temporary custody of their biological children. According to Doreen, she had a poor lawyer.

Both men said they had evidence that Doreen was an unfit mother. They said she was often very angry at Johnny and called him derogatory names. She threatened to leave, and she threatened to kill

herself because of Johnny's demanding nature and insolent remarks. Johnny's school behavior was variable, and he had trouble relating to his peers. The school counselor was aware of Doreen's outbursts, and she stopped informing her of Johnny's school problems in order to protect the youngster. Doreen, herself, admitted she found it hard to keep her temper under control when dealing with her son.

Alice was another story, however. She was a quiet, somewhat docile child. Her behavior did not provoke outbursts from her mother. Although Doreen scolded Alice from time to time, the intensity was far less than the outbursts leveled at Johnny. On the other hand, Alice was far younger than Johnny. Perhaps when she was older ... who could tell?

However, in this day and age, lawyers feel the

need to add the opinion of experts. The attorney representing Johnny's biological father obtained a court order to have him and his mother examined. The biological father gave the psychologist an account of what he had observed and what Johnny told him. He also described Doreen's behavior when they were married. After interviewing Doreen and giving her a battery of tests, the psychologist found that Doreen was brought up in a dysfunctional home. She alternated between trying to discipline Johnny in a rigid, overly controlling manner and blowing up when that failed.

The psychologist found Johnny to be self-centered and emotionally labile—clearly a reaction to the stress of his mother's outbursts. He felt comfortable in his assessment that Doreen was not good for Johnny.

Philip's lawyer asked me to evaluate the parents and Alice. In many ways, Alice was a miniature Philip—pleasant and friendly. When she tried to dress the doll, her three-year-old fingers weren't up to the task. Instead of becoming distressed, she tried again and again. Finally she put the doll to bed and turned to other toys. She glanced at her father. He said, "Dolly's sleeping." She and Philip seemed quite comfortable together.

I saw Doreen without the child. She, too, was pleasant and cooperative. She readily acknowledged Johnny made her upset and she lost her temper. She couldn't put up with him any more, and she was willing to let him stay with his biological father. "But Alice...," she said wistfully, "I won't get to put her to bed anymore. I'll miss her." It sounded as if she was ready to capitulate and give the child to Philip. We talked a bit more, and she discussed the possibilities of a promotion at

work—an area where she felt most comfortable and competent.

I never got to see Doreen and Alice together, nor was I asked for a report. Much later, I discovered that in a three-way mediation session with all the lawyers present, Doreen agreed to give up the children to their respective fathers, but she got fairly liberal visitation rights.

Recently, I phoned Philip's attorney to find out what happened to the children. Johnny calmed down quite a bit in his father's home. However, now in college, he still showed emotional lability from time to time. His peer relationships improved, but he still had a tendency to be self-centered. According to the attorney, he was doing well in school.

Alice still had her own pleasant manner and was doing nicely. Both children continued to visit

their mother, and the visits were going well. Doreen had been seeing a psychiatrist for psychotherapy and medication. She had, indeed, advanced in her career.

With regard to Johnny, what did the psychologist's report add to what was obvious to everyone—other than technical terms? The statements from the two fathers and the testimony from the school counselors and from Johnny would have tipped the balance. Even Doreen realized she and Johnny were not a match. With regard to Alice, it might have been a closer call, but Doreen herself was ready to relinquish custody and move on with her career.

Without such obvious evidence, judges are faced with an impossible task, and they don't have the resources of Solomon. They are only too happy to shift the decision to "experts." But the problem

of assessing relationships in the less obvious cases casts doubt on the validity of psychiatric opinions in an attachment-centered inquiry.

Even if there were a sound clinical way to assess the degree and quality of attachments during the process of divorce, what weight should we assign to this factor when put alongside the other sixteen variables suggested by the American Academy of Child and Adolescent Psychiatry? Should it outweigh the parent's style of discipline (excluding abuse, of course)? The parent's work schedules? The parent's and child's social support network (grandparents, friends, etc.)? Well, maybe it should if attachment is the major factor determining how the child will turn out later in life.

Rutter points out that while attachment theory predicts that poor childhood attachments will

deprive the individual of the security and confidence necessary for intimate relationships later on, we don't know that these attachments are more important than other factors influencing the child as he or she grows up. It "has not been put the test in a rigorous fashion as yet."[11] Further, while there is some evidence that poor childhood attachments are associated with "various forms of later psychopathology," the relationship is only a moderate one. Other factors play a significant part. Besides, other studies don't even show this moderate association.

There are many variables that go into the way a child will develop. Relationships and parenting styles are important, but we can't ascribe everything to them. There are social factors, peer groups, unpredictable experiences, and biology.

Let us revisit Johnny and Doreen. Recall that

the psychologist deduced that Johnny's emotional outbursts and self-centeredness were consequences of Doreen outbursts, and this made her an unfit mother. I have no argument with that, but that isn't the whole story. Johnny continued to have these qualities for many years. And so did Doreen, although hers were tempered somewhat by her treatment. It is certainly possible that some portion of Johnny's behavior reflected an inherited temperament. It was obvious Alice was a chip off her father's block; probably Johnny was a chip off his mother's. When studying relationships, it is so easy to attribute everything to unfit parenting. Quite possibly the temperaments of mother and son were grinding against each other—Johnny provoking his mother and vice versa. Alice's temperament didn't bring out the worst in Doreen.

In a way, if there were a valid method of quantifying each variable we could have an

"Unfitness Profile." And if there were a way of weighting the variables we could arrive at an "Unfitness Quotient," and we would be on sounder ground when testifying on the basis of observations, interviews and tests. Strong and his colleagues point out that juries (in custody cases, judges) "bring into the courtroom their own preconceived 'profiles.'"[12] These profiles are "impressionistic." But Strong and his colleagues are law professors, and they reflect a judge's faith as they go on to say that psychological profiles "may have been derived in a more or less systematic way, and some may have been tested by verifying that they give correct ... predictions."[13] Would that this were so, but in custody cases, the evidence for that hope is just not there. I can find no formula for weighting; no study of predictive profiles. There is no way of comparing "unfitness quotients" in cases where

the differences between the parents are not large and obvious.

Does that mean that psychiatrists have no role whatsoever in custody evaluations? Not necessarily, but, in my opinion, our role should be very limited. First, of course, we could rebut the expert who claims to be able psychologically to detect the better parent, but the judge probably wouldn't believe us, because that would force the judge to use his or her own impressionistic profile without "expert" backup. However, there are two other possible roles for us: uncovering facts for the judge to use in his or her impressionistic profile, and informing the judge of research-based guidelines.

Sometimes, in our interview, we can uncover or support facts that may be helpful to the judge. This was what the judge requested me to do in the

case of Jerry Cummings. Jerry's son, Bob, was a fourteen-year-old boy with a serious behavior problem. He'd run away several times, he drank beer, he was picked up for driving his father's car while underage. Jerry's wife had died a few years earlier, and Bob seemed beyond Jerry's ability to control. When Bob made a suicide threat in school, the Department of Human Services came in and took custody of the youngster. They placed him in a residential treatment program. In addition to individual therapy, both father and son were seen together.

After discharge, the doctors recommended Jerry and Bob seek further counseling. In the meantime, Bob, still a ward of the state, was placed in a group home. Initially, his behavior was not unreasonable, but after a while, he yearned to go home. He ran back to his home, and after a few days, Jerry notified DHS. They took him back to the

group home.

During many telephone calls, Bob pleaded with his father to take him back home. Finally, Jerry saw a lawyer and sued for the return of custody of his son. The custody dispute in this case was not between parents, but between a parent and the State. It was not a bitterly fought dispute with accusations and allegations. But the DHS was concerned that Jerry was unable to exert enough disciplinary control. Jerry's position was that he had attended his follow-up psychotherapy religiously, and he now was better able to discipline his son. His therapist agreed that Jerry had made significant progress in treatment. The judge asked me to evaluate whether Jerry was now able to discipline his son.

Jerry told me he'd allowed his son to take the car because he "begged and begged."

“Does he still beg?” I asked.

“Yes. But, I don’t always listen now.”

“Would you give me an example?”

“Like when he ran away, he kept saying, ‘One more day, just one more day,’ but after a few days, I called DHS.”

“What did they say?”

He smiled. “They were kind of mad, because I was supposed to notify them immediately. But, I figured maybe the kid needed a couple of days’ break.”

It turned out Jerry had evidence his son had visited at other times when he wasn’t home. Food was taken from the refrigerator, sometimes the door was left unlocked. Bob still had a key.

“Did you call DHS?”

“Not really. I guess he got back to the home OK, because they never found out he was missing. Why create a fuss? Bob would only get mad.”

“So, what would happen if Bob got mad?”

That question was the cue for Jerry to tell me about his philosophy of parenting. In his opinion, Bob needed a friend in his father—especially now that his mother was gone. Above all, creating a scene was to be avoided, and Jerry knew he must handle his son gently to avoid confrontation. “Like one time he called me and said he ran away from the treatment center and was at a friend’s house. I told him to go back to the center and hang in a little longer there, and maybe things would get better.” However, Bob came home, and it was a few days before Jerry notified the center, even though Bob’s therapist had called to say he was missing.

Jerry summed himself up this way. “I’m not a leader. I never was. I listen to others. I’m always optimistic things will work out OK if we just don’t get into arguments. Maybe I give in too much—I don’t know.”

I learned a great deal about Jerry’s upbringing, and I could speculate about some of the forces that made him the way he is. But that would be just that—speculation, and it has no place in the courtroom. Besides, I had enough facts in the form of Jerry’s track record and the things he told me about his dealings with his son to form an opinion that even he would have agreed with. Jerry could not bring himself to set limits on a son who was out of control and who knew how to wrap his father around his little finger. True, my opinion was based on my inferences, but there were actual data—not theory—which would allow the judge to see how I reached my opinion.

The conclusions were obvious from the data; you didn't need to be a psychiatrist to see that. In fact, you didn't need to be a psychiatrist to get the data; any competent interviewer could get those data. But, in my view, such data gathering is also appropriate for a psychiatrist. Many psychiatrists are able to empathize with the person being interviewed. This empathy may guide the interviewer into lines of questioning which may yield parental statements relevant to the custody decision. It may help uncover facts about a parent's sensitivity to the child's needs or the parent's approach to resolving disputes among siblings—or any of the other variables mentioned in the guidelines of the American Academy of Child and Adolescent Psychiatry. But these facts (statements made by the parent) should be presented as relevant, but not necessarily the most important factor in the decision. The judge

should do the weighting.

Research has yielded some guidelines about what may happen to children of divorce. For example, in general, children adjust equally well if there is joint or sole custody, if the mother or the father has custody, or if the child is placed with the parent of the same or opposite sex. More important than the type of arrangement is the degree of parental conflict.[14] Studies such as these may help the judge correct preconceived notions.

However, they are predicated on an "other things being equal" situation; they can't predict what will happen as a result of the custody decision in any individual case.

There has been a recent resurgence of attention paid to the rights of biological parents.[15] Often, this pushes the best interests of the child into the background when the biological parents

seek to regain custody after the child has lived for an extended period of time with a guardian or foster family. Historically, the courts have been reluctant to prevent biological parents from reclaiming their children.[16]

But what about the case where the mother gave up the child shortly after birth and years later wishes to reclaim him or her? If it didn't make any material difference to the child, the competing interests would be between the mother and the foster parents. However, some research data show that it does make a difference to the child.[17] Unless there are serious and obvious defects in the current relationship, disrupting it to preserve the rights of biological parent is most often traumatic for the child and can have lasting consequences. It is not in his or her best interests. I testified to that effect in such a case, but the judge removed the child from the family that brought her up and

returned her to a biological parent who had not seen or visited her for several years. In his opinion, the interests of the parent outweighed the interests of the child. I disagree; in my opinion, that is bad social policy.

There are, then, some types of situations where we psychiatrists can present expert testimony in custody cases. Unfortunately, in the close calls—where we might really be needed—we don't have much to offer. As in every forensic issue, there are some prostitutes selling their opinions to increase referrals. But it is my impression that most of the misguided testimony is a result of sincere concern for the welfare of the child. These psychiatrists are using whatever tools they have been given—concepts which they have been taught and which seem to work well in the therapeutic situation. But the courtroom demands a different standard; concepts without reasonable research data are

junk science. Especially in custody cases, where emotions run high, psychiatrists do have a way to go to learn to distinguish theory from research-based data.

Notes

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Chapter 10

"Sex Play"

Paula Coughlin[1] was not amused. In 1991, she was a naval lieutenant who flew helicopters—a "bright star," according to her superiors. In retrospect, her big mistake was to attend the annual convention of the Tailhook Association. This association of Naval and Marine air personnel met annually for symposia and discussion about naval subjects. But there was also free time for partying. And there was also alcohol. By the time the party was over, 83 women and 7 men had been assaulted sexually, many in a hallway of the host hotel, the Las Vegas Hilton. Paula Coughlin was one of them. A group of men lined the hallway and when women tried to pass through, the men

made them “run the gauntlet.” They pulled at their clothes and groped them. According to Paula, when she finally got to the end of the line, she fled into an empty room and cried. She was afraid she’d be raped. She was ashamed that she’d been attacked. She was even ashamed she was crying.[2]

Paula was the original whistleblower, but no one would listen. After she went public, the Navy mounted an investigation. She accused the naval personnel of sexual harassment and abuse, and she pointed to a captain as the “most brazen” molester in the line. At the hearing, the captain acknowledged he was at the convention, but he stated he was not at the scene of the melee. He had witnesses to back up his statements. He also had character witnesses who described him as a person unlikely to do such a thing. Besides, he was battling cancer. His lawyer pointed out Paula had previously identified someone else as the

molester.

The Navy's investigation encountered difficulties. The prosecutors ran up against a "code of silence," making it almost impossible to establish anything.[3] It didn't take long before the Navy dropped charges against fully one-half of the men accused of participating. However, the Pentagon sharply criticized the investigation, charging that the Navy's investigators "sabotaged their own agents' efforts because of their hostility to women."[4]

Finally, Paula resigned from the Navy; she said she'd had enough of the harassment and ostracism she received because she blew the whistle.[5] She sued the Tailhook Association for the sexual misconduct and the Hilton Hotel for not providing sufficient security. The Association settled, but the hotel decided to fight the case.

During the Hilton trial, the defense attorneys tried to convince the jury of several points. They said Paula did not suffer post-traumatic stress; she was merely angry. Paula said she'd been suicidal. A witness testified Paula wore provocative clothes in the evening. Another witness, Lieutenant Diaz, testified Paula had let another officer shave her legs. Paula vehemently denied both accusations. A woman—a resident of Las Vegas—said she was in the hotel at the time and observed the proceedings. According to her, it was just a crazy bunch of people who were playfully displaying their genitals and grabbing women's buttocks. "It was just a sort of joke!"[6]

If it was a joke, Paula Coughlin was not amused. Neither was the jury. They awarded her $1.7 million as compensation for what was done to her, and an additional $5 million as punishment for the hotel's not offering reasonable protection.

It took them less than one hour to decide on the $5 million punitive award.[7]

Among the many allegations of sexual harassment reported by the press in the last decade, the Tailhook scandal was one of the few in which there was no doubt that sexual misconduct occurred. And it was arguably the most egregious recent example of sexual harassment in this country. But the cases the press reports—usually allegations against prominent figures—are barely the tip of the iceberg. The government agency overseeing Federal employees reported that 44 percent of women and 19 percent of men surveyed said they had been subjected to some type of sexual harassment in 1994.[8] This number had not changed since 1980, despite increased awareness of the problem. The vast majority of these incidents were not reported to supervisors. Yet, workplace sexual harassment cost the

government about $327 million over a two-year period.

In the United States, the history of this type of behavior goes back to colonial times.[9] While women had always been subjected to unwanted sexual activity, this harassment became almost institutionalized on the southern plantations where slaves were considered fair game.

Although sexual misconduct occurs in many settings, I shall focus on workplace harassment in this chapter. And since the majority of such incidents involve men harassing women, I shall confine my discussion to this type of situation. With the industrial revolution, sexual harassment crossed the racial divide and lodged in the workplace. Women were cheap factory labor, and they could be easily replaced if they caused a fuss. They were supposed to be the guardians of proper

sexual behavior, and if the harassment came into view, it was the woman who was considered responsible; she was the one likely to lose her job.

In the years following World War II, the role of women changed dramatically and the sexual revolution was ushered in. With this new openness, partly fueled by oral contraceptives, many men felt more comfortable in making sexual overtures in the workplace and elsewhere. And in the workplace, sexual harassment continued, often because male employers had power over women's livelihoods.

However, along with the changing role of women in the 1960s came the civil rights movement. Title VII of the momentous Civil Rights Act of 1964 made it unlawful for employers to discriminate against an employee "with respect to ... conditions or privileges of employment, because

of such individual's race, color, religion, sex or national origin...."[10] The courts refined the statute by interpreting what conditions and privileges really meant.

Freedom from sexual harassment was one such privilege and condition. This harassment was defined in two ways:[11] First, *quid pro quo* harassment could occur when the employee could get benefits (such as raises or promotions) in return for sexual favors or could lose benefits if she refused such favors. Second, creating a hostile or offensive working environment—soliciting sex, telling dirty jokes, making sexual remarks—could also trigger charges of sexual harassment.

Quid pro quo is understandable enough, but what actually is a hostile and offensive working environment? One off-color joke told to a crowd of people? Complimenting a coworker on her new

dress? Paula Coughlin felt she was harassed, but a woman who witnessed the gauntlet said it was all in good fun—it was a joke at a party.

As one court noted,[12] this may be a difficult call, especially because men and women have different standards about what constitutes offensive behavior. The court stated that hostile environment has two dimensions: severity and pervasiveness. One off-color joke is not very severe, but repeated salacious remarks can make the environment offensive. On the other hand, it takes only one rape to make it offensive. The court must weigh these two factors and decide if the alleged conduct amounts to sexual harassment. And it is the judge who decides. How does he or she decide? The court stated that regardless of whether the judge is male or female, the judge decides if the behavior is the type that a *"reasonable woman* would consider sufficiently

severe or pervasive...” (italics mine). You will recall my discussion in Chapter 2 regarding reasonable persons. It is a legal fiction which allows the trial to proceed. And if the judge thinks the charges reasonably (in women’s terms) add up to sexual harassment, the jury uses its powers of reasonableness when it considers the verdict.

There may also be the vexing problem of consensual sex. If the woman complied with the man’s request, is she really a victim of harassment? Possibly, said the court. She might have complied because she feared for her job if she refused. The employer must have a stronger defense than compliance.[13]

But things get much more complicated when we realize that in some surveys, as many of 70 percent of male and female workers have dated others on the job. Some have even gotten married.

Proximity can breed friendship; it can even breed love. How do you distinguish courting behavior from sexual harassment? According to the court, sex-tinged behavior is harassment when it is unwelcome.[14] The court incorporated the guidelines stated by the Equal Employment Opportunities Commission. The conduct is sexual harassment "if it has the purpose or the effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment."[15] An offensive environment need not target any specific person; if sex is pervasive in the atmosphere, it may be unwelcome or disturbing to workers.

Where do psychiatrists fit into this picture? Shafran[16] provides a useful framework for considering possible roles for the forensic psychiatrist. (1): Did the conduct actually occur? (2): If it did, did it meet the criteria for sexual

harassment? (3): If it did, how injured was the plaintiff?

When there are witnesses to the conduct, they can establish the facts. But when there are no witnesses, we get into a "he says—she says" situation. In 1991, when Professor Anita Hill accused Judge Clarence Thomas of past sexual harassment, their stories were entirely different. Judge Thomas was up for appointment to the U.S. Supreme Court, and the allegations had potential consequences of national significance. A reporter for the *New York Times* asked several psychiatrists and psychologists about the discrepant testimony.[17] They offered three possible scenarios: One or both may be lying, each may have had a distortion of memory, or the accuser could be suffering from a delusion. None of these professionals could throw any light on the facts of the case. I note a fourth possibility-even delusional

people can be harassed.

As in the case of the nursery crimes described in Chapter 8, psychiatrists are not detectives, and we cannot tell whether an allegation about an historical fact is true or false. It would be convenient if certain symptoms were specific to victims of sexual harassment. However, victims of harassment may suffer so many different types of symptoms, there is no such thing as a typical post-harassment syndrome. Reactions may range from anger to depression (mild or moderate), guilt, humiliation, loss of self-esteem, feeling dirty, headaches, anxiety and fear of going outside, and even vulnerability to respiratory infections.[18] Different people react differently.

However, psychiatrists can help the jury understand why a plaintiff might appear to be lying when she may have really been a victim.

Bertha needed this help when she sued the Ingram Company for sexual harassment. According to her attorney, the lawyers representing the company were pulling out all stops in order to discredit Bertha. They said that while she and her supervisor did have a sexual relationship, it was consensual. Bertha even invited Brad into her home. The relationship continued over several weeks, and Bertha never complained to anyone. She had a history of moving from job to job, and she had quit this one and gone back home. The lawyers obtained her medical records, and they indicated she told her doctor she was upset because of her financial situation. She never told him about the affair. Almost a year elapsed before she suddenly went to a lawyer. The company's lawyers accused Bertha of being out for financial gain because she was in debt.

I told the attorney I probably could not testify

to the truthfulness of Bertha's story unless there were gross distortions or serious internal contradictions. However, I might be able to explain this type of behavior.

Bertha was the middle child between an older brother and a younger sister. Her father owned a prosperous hardware store in a small farming community. "Maybe that's why I'm like I am," she said. "You know, middle child and stuff."

"What are you like?" I asked.

"Oh, you know, independent. I don't like to lean on anyone, and I don't like anyone leaning on me." She went on to tell me she was fortunate in having a lot of energy. "I'm a doer. I don't waste time thinking about things."

"What things?"

"Anything that bothers me, I just put it out of

my mind. I don't worry a lot, except now about my finances. Usually I'm an optimist. I always think things will work out, but now, with what I owe my folks, I don't know."

"Are they pressing you for money?" I asked.

"Oh, no. Dad can afford it, but like I said, I don't like to be dependent on anyone. Ever since I graduated high school, I've always made my own way. I left home when I was eighteen. Dad gave me money for one month, and I got an apartment here."

In response to my question, she said she didn't have a job at first. But she knew she'd find one in the city. And when she did, she immediately paid her father back. Here, in a nutshell, was the energy, the optimism, and the independence.

It was true that she went from job to job, but it

was always in search of advancement and better pay. Bertha was not career-oriented; she was happy to work as a secretary. But better pay was proof she could make it on her own. The money was important, but so was the pride that came with success.

Not that she was a workaholic, however. She had friends, and she had a reasonably active dating life. At 32, she had no thoughts of marriage. In fact, she never wanted to have a serious relationship. “I don’t want to make a commitment,” she said. “Maybe it’s because I don’t want to give up my independence.”

There was an underside to her independence. She told me about one fellow whom she dated for almost a year. He wanted to get engaged, but the more he pressed his suit, the more crowded she felt. She was anxious and she developed dizziness

and nausea. Apparently, when she tried to put it out of her mind, it went to her body.

At the Ingram Company, she was recognized for her skill as a secretary, and she was offered a better-paying position as office manager at a branch in another city. She jumped at the chance, and borrowed money from her father for the move. Shortly thereafter, an uninsured motorist hit her car. While she was uninjured, the auto was totaled. Ever the optimist, she decided to get a new car. Even though she now owed more than ever before—car payments and her father's loan—with the raise in salary Bertha knew she could pay the debts off. But she didn't count on Brad, her supervisor.

When Brad first started making remarks, she thought it was "typical office flirtation, like you get wherever you work." While not pleasant because

Brad was married, the remarks were tolerable. When he started pressing her for a date, she pointed out that she didn't date married men. Optimistically, she thought that would end the matter.

It didn't. In fact, Brad's advances became more openly sexual. He'd comment about her body and how nice it would be if they went to bed together. And he added that he could make her job more attractive, or he could make it less attractive. Bertha had already heard from coworkers that Brad could be vindictive. She began to feel trapped; she needed the job and the money. She also needed her self-respect, and she continued to turn him down.

One evening, Brad appeared at her apartment. She was shocked. She thought, "Oh my God! What have I gotten myself into!" She told me she felt

cornered and went numb. He took off her clothes and when she didn't resist, he had intercourse with her. She claimed she had no feeling.

He came back to her house three or four times (she couldn't remember the events quite accurately) during the next few weeks. One day, he called her to his office and started to embrace her. She shouted, "Keep your damn hands off me!" He whispered, "Leave my office and keep your mouth shut. And you damn well better improve your work; you've gotten very sloppy lately." That ended the sexual advances.

It was true her work was slipping; she couldn't concentrate. Every time he came near her work station, she felt dizzy. Several times she vomited in the ladies room. She was irritable. She had trouble sleeping. Once again, her body was protesting. She went to the company physician, but she was too

ashamed to tell him what the problem was. He treated the symptoms; he gave her a minor tranquilizer. It didn't help, and finally she admitted defeat and quit the job.

Out of money and out of pride, she could no longer be independent; she forfeited the new car and went home. Her father gave her a job in his store, but the comfort of a supporting family did not assuage her symptoms. In fact, in a way, it only drove home the fact that she could not make it on her own. She consulted her family physician when the symptoms continued, but she said the problem was her financial stresses. Finally, one evening when her mother heard her crying in her bedroom, Bertha broke down, and she told her mother what happened. Her parents insisted she see a lawyer.

Bertha's story had many of the ingredients of a

sexual harassment case. There was the offensive environment (unpleasant, but tolerated), and the overt advances which were unwelcome. There was even an implied *quid pro quo*—"I can make your job more—or less—attractive." The harassment was both severe and pervasive.

The company pointed out that the sex continued repeatedly, but while there was no resistance, it could hardly be called consensual. As so often happens when women are sexually harassed, they may feel guilty and humiliated. Remember, even Paula Coughlin was ashamed she'd been attacked at the Tailhook convention. And Bertha said, "Oh my God! What have *I* gotten myself into!" As if it was something *she* did. Guilt feelings and humiliation can account for long periods of silence. And in Bertha's case, where pride of independence was so important to her, one could understand why she was reluctant to

advertise the experience.

Bertha did confirm one thing the company lawyers said: She did need the money. But that didn't negate the other factors. And while you don't need to have psychological injury to win a sexual harassment case[19] (the fact of harassment depends on what went on, not how the victim reacted), Bertha's symptoms were consistent with her story and with the type of person she was.

Did that mean her account was true? I had no way of knowing if it was true in whole or in part. And that's what I told her attorney. But I also told her Bertha's story was not unusual. The facts the company's lawyers were using did not necessarily establish that Bertha was lying. I heard subsequently that the company settled the case.

Even though technically you may not need any psychological injury to win a sexual harassment

case, it helps. Since the courtroom is an arena of persuasion, greater injuries may yield larger awards. In fact, the threat of larger awards may prompt companies to settle the case before a trial altogether. Here all the issues of causation and impairments described in Chapters 3 and 4 come into play. And here there may be differences among the opinions of various professionals. Charlotte's case pointed up how a close call may lead to a such a difference.

Charlotte's story might be called a run-of-the-mill harassment story, although if it happens to you, there is nothing commonplace about it. During the first year of her employment, George, her supervisor, befriended her. Talk was casual—the job, their children. One day, however, he came up behind her and placed his hands on her shoulders. He remarked that she was very attractive. She brushed his hands away and

thanked him for the compliment. Shortly thereafter, he began groping her. When she protested, he would leave her office. When George continued his advances, Charlotte told a coworker. This woman said he had done the same thing to her, and she complained to the boss. However, nothing was done. It was only when Charlotte came to the firm that George stopped harassing the other employee.

One afternoon, Charlotte had to get some supplies in a rather secluded storage room. George entered the room and pulled down his pants. He started to grope her, but the sound of footsteps interrupted them. After that incident, Charlotte did her best to avoid him. Although the frequency of the episodes diminished, it was apparent George wasn't about to give up. Finally, overcoming her embarrassment, she reported him to the boss, who said he'd conduct an investigation. According to

Charlotte, the only thing that happened after that was that she was demoted. Consequently, she called a lawyer.

Apparently, emboldened by Charlotte's lawsuit, several other employees revealed George had approached them also. With that array of potential witnesses, the fact of the harassment was not at issue. The remaining question was whether Charlotte was psychologically harmed by the incidents. The company had Charlotte examined by a psychiatrist.

Dr. Stern not only evaluated Charlotte himself, but he also sent her to a psychologist for testing. The psychological tests revealed Charlotte had a long-standing mild depression—dysthymic disorder, in diagnostic terms—which probably had been present even before she worked for this company. She also had a personality disorder with

avoidant traits—a tendency toward shyness and low self-esteem. Personality disorders are also long-standing. “Even in the clinical interview,” Dr. Stern reported, “she says she is meeting all her work and family requirements. She remains actively involved with her church. In fact, Charlotte feels she is capable of effectively carrying out the duties of the position from which she had been recently demoted.... Any reactions she might have had were transient and expectable reactions to the harassment.” Very little in the way of psychological injury caused by the harassment.

Charlotte’s attorney sent her to me for another evaluation, and hopefully an opinion more favorable to her case. Essentially, I agreed with Dr. Stern’s findings, but I felt they didn’t go far enough. His report implied that there was no psychological injury attributable to the harassment; everything was long-standing—just

as before. He failed to spell out what the “transient and expectable reactions” were.

Charlotte was having trouble sleeping, and she didn’t wake up refreshed. She no longer felt quite safe at home. Sometimes, she dreamed of being grabbed and having to fight her way to safety, and she woke up frightened. Occasionally she had the feeling people were talking about her, and she was embarrassed. Prior to the harassment, when men glanced at her admiringly, her self-esteem got a much-needed boost. “Now, if they look at me, I feel like a piece of meat.” She tended to avoid one-on-one situations with men. As she left, she turned and said, “I hope I haven’t ruined your day.”

“What do you mean?” I asked.

“People don’t like it when you tell them sad stories, because it makes them feel sad.”

In my opinion, Charlotte had the symptoms of a post-traumatic stress disorder, albeit a mild one. She'd been exposed to a distressing event, one which involved the integrity of her body and her sense of herself. She was feeling increasingly caught in a bind between continuing in her job and having to fend off her supervisor. The stressful situation kept coming back to her in her dreams. Her mind couldn't relax enough to allow restful sleep even when the dreams didn't occur. And while she was able to continue in many activities, she tried to limit contacts which might bring back thoughts of the supervisor's actions.

While I essentially agreed with Dr. Stern about the severity (or lack of it) of Charlotte's problem, there was a difference in emphasis. True, she had a preexisting condition, but now there were new symptoms which aggravated it. And the symptoms could causally be connected with the supervisor's

actions. I explained all that to Charlotte's lawyer. The jury would have to decide which emphasis to accept. The case never got to court, because it was settled.

Why did Dr. Stern and I reach essentially the same conclusion but with different emphasis? Perhaps it was because he consulted with the defense team and I consulted with the plaintiff's attorney. One study[20] found that plaintiff's experts more frequently report diagnoses indicating significant reactions to the harassment, while psychiatrists working with the defense team more frequently use long-standing personality diagnoses which de-emphasize reactions to the harassment. I do remember, however, consulting with a defense team and coming up with the same kind of emphasis that I used in Charlotte's case. The lawyer thanked me and never called me again. Perhaps Dr. Stern had the same experience.

While there are good reasons for claiming emotional problems because of harassment, there are also good reasons for avoiding such a claim. Once the plaintiff puts her emotional condition into the claim, her whole emotional life becomes fair game for examination. The employer's team may gain access to records of any psychiatric treatment she has had. Psychiatrists consulting with the defense can probe for anything they can use to discredit the plaintiff, to search for other possible causes of the plaintiff's discomfort, or even to show that things in her background may be complicating the way she remembers the alleged harassment incidents.[21]

These are legitimate pursuits; not every harassment allegation is true or happened the way the plaintiff describes. But consider a woman who has felt degraded by a severe and pervasive harassing experience, a woman who feels guilty

and embarrassed. Does she really now want to have her past sex life paraded in open court?

A few years ago, Attorney Sidney Crowe called me. He told me he was given my name by a colleague with whom I had consulted on workers' compensation cases. Like his colleague, Mr. Crowe was representing the company, but this was against a claim of sexual harassment. Sarah Lewis complained that harassment by a supervisor had caused her significant psychiatric problems. I agreed to evaluate her, but I told Mr. Crowe I'd call it the way I see it.

"That's what I want you to do," he replied. Maybe so, maybe not.

Sarah was a woman in her thirties. Her plain but pleasant face was pulled taut by worry. Her arms never stopped shaking. The story was similar to those I'd heard before. A supervisor who moved

quickly from sexual innuendoes to propositions. An employee who hoped it would all go away if she declined. His unwanted touches, her fear for her job. Years ago, when I first became aware of sexual harassment, I was surprised that a supervisor would be so bold as to come to the employee's home. Nowadays, I almost expect to hear about it. And true to the script, Sarah told me how she became numb when he appeared, and she felt unable to resist.

Sarah's story was consistent and not unusual; whether it was true or not, I couldn't say. The best I can do in most of these cases is to assume the truthfulness and to see if the reactions reasonably follow from the accusation. It's up to the lawyers to argue the truthfulness.

According to Sarah's psychiatrist, she had severe general anxiety disorder and panic

disorder. She had even made a suicide attempt several months ago and was briefly hospitalized. His diagnoses seemed reasonable to me.

After an extensive discussion about her current status, I turned to her past history. There was no family history of official psychiatric problems but her family was not functional. Her parents divorced when she was three. Her father "came by every so often." He drank.

"Did he abuse you—physically or sexually?"

"Yes." Very softly said.

"Which? Physically or sexually? Or both?"

"Both," she whispered.

"Did you tell your mother?" I asked.

Sarah started to weep. "She knew. She did it too. She played with me too."

I let her cry. When she regained a bit of her composure, she said, “That man, every time he comes at me—he has my mother’s blue eyes.”

The foundation for Sarah’s shame and humiliation and the basis for feeling trapped and overwhelmed were laid many years before the harassment. But Sarah had survived, even if somewhat psychiatrically crippled. The harassment at work revived and added to the intensity of the earlier feelings. Post-traumatic stress disorder could be added to the diagnostic mix.

When I discussed this information with Mr. Crowe, the attorney was delighted. “So, maybe she’s unusually sensitive—sees harassment where it doesn’t exist.”

I’d heard that argument before. I’d even read a professional paper advocating that idea as a

defense—the "hypersensitive" plaintiff.[22] I explained that I could not say, to a reasonable degree of medical certainty, that she was hypersensitive to the extent that she saw harassment where it didn't exist. "Besides," I added, "as I understand it, a finding of harassment rests on whether the conduct of the man would be offensive to a reasonable woman, regardless of how sensitive this particular woman might be."

Mr. Crowe's tone flattened as he agreed. "But what about the degree of her reaction? Maybe if she wasn't raised in this kind of family, she wouldn't be so messed up now?"

I was sure Mr. Crowe knew the law better than I, but even I knew the basic dictum that you take your plaintiff as you find him or her.[23] It doesn't matter if the plaintiff had a preexisting condition in these types of cases; if the defendant's actions

made these conditions worse, he or she is liable for the whole reaction.

I guessed that something else was going on in the attorney's mind, and I decided to confront it. "Look," I said, "I've done the evaluation. I have the facts as she told them to me—even the dirt on her family. If I'm called to the stand, I will report what I know fully and honestly. You know, and I know, that the threat of this exposure will only add to Sarah's grief. Maybe she's not up to it, and maybe she'll cave in and not press her suit. But on the other hand, maybe she won't cave in, and the jury will have more pity for what they see as 'this poor girl, how she's suffered all her life—and now this!' I'll cooperate with you on the stand, but it's your call about whether you want to risk it."

The company must have decided the risk was too great, and they settled the case.

Advice like this and testimony based on data from the plaintiff is an appropriate function of the psychiatrist. However, of all the types of forensic psychiatric situations, sexual harassment cases are the ones which can arouse the strongest feelings. We all have our biases[24] when it comes to the role of women. Some think women are exploited by men with power; others think women's claim of powerlessness is a ploy to exploit men. Psychiatrists are not immune to the continuing war between the sexes. Only if the forensic psychiatrist is doubly careful to maintain objectivity can he or she avoid the temptation to veer from the data and become an advocate.

Notes

1 All names and incidents in this case discussion are accurate as documented in the references.

2 New York Times, October 4,1994, p. A12

3 Ibid., May 1,1992, p. A14

4 Ibid., September 25,1992, p. Al

5 Ibid., February 11,1994, pp. 24-25

6 Ibid., October 28,1994, p. A22

7 Ibid., November 1,1994, p. A24

8 Merit System Protection Board: Sexual harassment in the federal workplace: Trends, progress and continuing challenges. Unpublished document, 1995

9 Skaine R: Power and gender: Issues in sexual dominance and harassment. Jefferson, N.C.: McFarland and Co., 1996, p. 31

10 42 U.S.C. §2000e-2(a)(l)

11 Bundy v. Jackson 641 F. 2d 934, 943-946 (1981)

12 Ellison v. Brady 924 F.2d 872, 878-9 (1991)

13 Meritor Savings Bank v. Vinson 477 U.S. 57, 68 (1986)

14 Ibid.

15 29 C.F.R. §1604.11(a)(3) (1980)

16 Shafran LH: Sexual harassment cases in the courts, or therapy goes to war: Supporting a sexual harassment victim during litigation. (In) Shrier DK (ed.): Sexual harassment in the workplace and academia: Psychiatric issues. Washington: American Psychiatric Press, 1996, pp. 133-153

17 New York Times, October 14,1991, p. A10

18 Charney DA and Russell RC: An overview of sexual harassment. Amer. Journ. Psychiatry *151:* 10-17,1994

19 Harris v. Forklift Systems, Inc. 510 U.S. 17, 22 (1993)

20 Long BL: Psychiatric diagnoses in sexual harassment cases. Bull. Amer. Acad. Psychiatry Law *22:*195-203,1994

21 Feldman-Schorrig SP and McDonald JJ: The role of forensic psychiatry in the defense of sexual harassment cases. Journ. Psychiatry and Law *20:* 5-33, 1992

22 Ibid.

23 Restatement of the Law of Torts 2d, §461,1965

24 Gold LH: Addressing bias in the forensic assessment of sexual harassment claims. Journ. Amer. Acad. Psychiatry Law *26:* 463-478,1998

Chapter 11

Unfitness for Duty

Shortly after midnight on March 3, 1991, the highway patrol was racing after a speeding white Hyundai sedan. When the car turned off the highway and into the local streets, its pursuers called the local police department for assistance. The Hyundai tore around the city streets at 55 miles an hour in a 40-mph zone. By the time the Los Angeles police officers caught the speeder, 10 patrol cars and a police helicopter had been called in to assist in the chase.

The wail of the sirens and the roar of the helicopter woke up the neighborhood residents, many of whom went outside to see what was going on. According to their reports, the driver got

out of the car with his hands up, and he lay down on the ground. This might have been voluntary or in response to police orders; the residents were too far away to hear police commands. On the other hand, one witness thought there might have been a scuffle, and the police said the driver began to charge at an officer.

Whichever version is correct, ultimately the driver was on the ground. His name was Rodney King.[1] He was a 25-year-old unemployed construction worker who had recently been released from prison. He was on parole, having served six months of a two-year sentence for a robbery during which he had brandished a tire iron. However, the police at the scene didn't have this information.

George Holliday, one of the witnesses, videotaped what happened next. An officer

shocked Mr. King twice with a stun gun and was in a position to administer further shocks if necessary. Two officers took turns beating him with billy clubs, and a third officer intermittently kicked him in the head. At least ten other officers stood by and watched. Only one policeman briefly tried to intervene, but then he withdrew. The residents were shouting for the police to stop. "Don't kill him," they cried. The police ignored them. At the end of the beating, the officers handcuffed Mr. King. They hog-tied him and dragged him, face down, to the side of the street. During all this time, Mr. King offered no resistance; he was pleading with them to stop.[2]

According to police audiotapes[3] the following lighthearted exchange occurred between Sergeant Koon on the scene and the watch command:

Koon: "You just had a big-time use of force ... tased and beat the suspect ... big time."

Command: “Oh well, I’m sure the lizard didn’t deserve it, ha, ha!”

And from one of the officers: “Oops!”

Command: “Oops what?”

Officer: “I haven’t beaten anyone this bad in a long time.”

Command: “Oh, not again ... Why for you do that? ... I thought you agreed to chill out for awhile….”

But for Rodney King there was nothing lighthearted about the situation. The doctors at the hospital reported he had nine skull fractures, a shattered eye socket, a broken cheek bone, a concussion, a broken leg, injuries to both knees, and damage to a facial nerve which left his face partially paralyzed. And all this while lying on the ground.[4]

Chief Daryl Gates described the incident as an “aberration.”[5] Perhaps it was; in a police force of over 8,000 officers, a few cases might be called

"aberrations." However, in 1972, the city paid out $533,000 in settlements of such cases. By 1990, that figure had grown to $8 million.[6] A rather expensive aberration!

Three officers and Sergeant Koon were acquitted of misdeeds by a state court. However, a federal court convicted one officer and the sergeant of violating Mr. King's right to be kept free from harm while in custody.[7]

What interests us here, however, is not the fate of the officers but the nature of their actions. They used brutal force where it was not necessary. They acted as if it were a joke. They failed to restrain the active perpetrators. All this was done with such callousness that the policemen didn't even seem to mind that the neighborhood residents were watching and pleading with them.

During the period when many of these men

were recruited and hired, the Los Angeles Police Department, like most major departments across the country, required the applicants to take a battery of psychological tests and to have a personal evaluation by a psychologist.[8] How, then, did these men ever get hired?

Let us start by assuming the department had screened out the obvious negatives, such as disqualifying physical problems, a history of violence, inadequate education, a record of poor job performance, a criminal record, etc. Our focus will be on the process of screening out those applicants with psychopathological traits which would interfere with proper police performance. There is a variety of personality tests and other procedures in use for screening police officers. Unfortunately, "serious questions remain as to the validity and reliability of such procedures."[9]

We must understand what psychologists mean by validity. As I mentioned in Chapter 8, the term "validity" is used in a variety of ways. Some test-makers say their test has face validity. All this means is that the questions on the test obviously relate to the thing the test is supposed to measure (on the face of it). Some psychologists state their test is valid if it correlates with other tests purporting to measure the same thing—convergent validity. There are several other types of validity,[10] none of which get to the bottom line of what the screening is supposed to do. The bottom line is whether the test can predict how the applicant ultimately will perform on the job. This is predictive validity. Studies have shown that personality tests "tend to show inconsistent correlation with police performance …."[11]

Why is the predictive power of the tests so inconclusive? In the first place, there isn't general

agreement about what traits a good police officer should have. Ask the chief and then ask the patrolman on the street and you may get two different views. Second, the test-taking situation is very different from the actual situations which may come up suddenly. Further, stresses at home may unpredictably influence behavior on the job. And of greatest importance is the actual value system which the new recruit learns as he or she picks up the informal rules of older colleagues. The code of silence, present in every profession, demands that you protect your colleagues when their behavior has crossed the line. But you'd never admit to that on a personality test. Indeed, you might join the force vowing to be true to the Boy Scout oath, but you soon learn that you have to go along to get along. Subtle and overt messages from higher up on the chain of command can set a tone which allows or even encourages misdeeds.

We can see these factors in the Rodney King case. The sergeant didn't intervene. Only one patrolman tried to stop the attack, and he did it only briefly. People joked about the incident, calling the victim a lizard. Half an hour before the incident, two of the officers were recorded exchanging racial jokes with foot patrolmen. Rodney King was a black man. Rather than immediately condemning the incident, Chief Gates said Rodney King created it by speeding and resisting arrest. Besides, the incident was an aberration. And, according to the audiotapes, one of the perpetrators already had a record of stepping over the line. The department's reaction was to tell him to "chill out for a while." With a value system such as this, the policeman on the job becomes a different person from the one who took the test.

"Shaping" the employee on the job does not

occur only on the police force. On a social occasion with friends, my wife and I were invited to play an "ethics game." Our host had a mid-level management position in a large manufacturing company. The Human Resources Department had developed the game and passed it out to all employees. The game consisted of a series of situations requiring ethical decisions in the factory, and each contestant got points for the correct answer. Halfway through the game, we gave up, because as the host said, "If you acted like this game says, your supervisor would see that you got fired—if you didn't get punched out by your fellow workers first."

If the tests are so inconclusive, are they of any use at all? Surprisingly, they are. They may weed out *some* of those people whose traits clearly point to an unsuitable candidate, even if they don't get all of them. Of course, they will also weed out

some people who don't deserve to be left behind. While this is unfair to those applicants, from a business and safety point of view, when there are considerably more applicants than job spaces, the company can tolerate losing some potentially good candidates.[12] In the case of policing and some other professions, better safe than sorry. As I discussed in Chapter 6, you don't judge the usefulness of a procedure solely on the degree of its accuracy; you must consider the value of the procedure in the context of where it is used. In some situations, such as murder trials, you need a high degree of confidence that you are accurate; in other situations, such as employment screening, you may settle for less accuracy if the procedure has some utility.

But what about the bad apples who slipped through? They never would have progressed to the testing stage unless it was thought they were

good candidates. Without the tests, they would have been accepted anyhow.

Management is not entirely free to pick and choose from among the applicants they feel are qualified. The 1964 Civil Rights Act[13] prohibited discrimination in employment, and the courts have underlined this prohibition.[14] The U.S. Commission on Civil Rights has called into serious question whether the psychological tests used in employment have subtle biases which may systematically tend to discriminate against certain classes of applicants.[15]

If biases can creep into standardized tests, how much more likely are they to crop up in the personal interview by a psychologist or psychiatrist. I encountered an unusual interview bias in the case of Robert Strong. Robert had applied for a position as a deputy sheriff in a rural

county. By law, he had to be evaluated by the local mental health center. The psychologist at the center administered an MMPI-2 test and conducted a personal interview. Her report to the sheriff indicated that while the MMPI-2 showed no outstanding psychopathology, Robert had acted in a hostile and defensive manner in the personal interview. She sensed Robert was hostile toward women. Therefore, she had reservations about clearing him for employment.

The sheriff considered the report inconclusive. It may be that he felt Robert was a good recruit. It may be that he needed another deputy and there were few applicants. It may be that he just wanted to cover himself legally by getting a more strongly worded report. Whatever the reason, he asked me to reevaluate Robert.

I read the report of the MMPI-2. It showed

Robert had answered the questions in a “frank and open manner.” There was no suggestion of undue defensiveness. All the scales were within normal limits, and while there were some positively and some negatively toned traits (all of us have some of each), nothing stood out with respect to the position he was seeking. As the psychologist wrote, the problem arose in the interview. Her report said nothing more than that Robert was hostile and defensive. She cited no actual data to back up her conclusions. What did he say that was hostile? What signs did he exhibit to indicate defensiveness? Unfortunately, I have read many reports that are confined to conclusions or interpretations without showing the evidence on which the opinions are based. A good forensic report will cite sufficient data to allow the reader to understand how the reporter reached the conclusion. Or if the interpretation is too

specialized for the layperson, at least another psychiatrist should be able to understand how the opinion was reached.

Robert told me he had already started his on-the-job training in the jail when he traveled to the mental health center for his interview. While he had not yet been issued a uniform, he did have handcuffs which were in his back pocket at that time. His account of the interview went like this:

"The lady came into the waiting room and asked if I was ready. She didn't introduce herself. She was kinda hateful. I said, 'Yes, ma'am.' and I followed her to her office. She saw the handcuffs in my pocket and she asked if I always carried handcuffs. I explained I was just coming from work. She said, 'Tell me about your father.' I asked if that question was relevant. She said, 'We always ask these questions. Why are you mad?'

"I told her I don't like people asking about my personal business. 'Not you, but people in general.' She said, 'If that makes you mad, you must have something to hide.' I told her I love my dad; he's a good man. Then she said, 'OK, it's over.' The whole thing lasted about thirty minutes." If the interview lasted at least that long, there was more to it than he recounted. He was giving me the summary of his impression of the interviewer.

Whatever the psychologist's attitude, Robert wasn't very smart in fending off her inquiry about his father, even though many other deputies in that area also guard their "personal business." On the other hand, the psychologist's reply was standard psychobabble and was a challenge in itself.

I inquired about his relationships with women. He had been married once, but he divorced his

wife when she cheated on him while he was working in another city. He paid child support and had a good relationship with his daughter. His mother was “the neighborhood grandma—all the kids liked her.” He got along well with his dad. Robert had worked under several female supervisors in the various jobs he’d held, and there were never any problems. When he was younger, he did get into a “hotheaded” argument with a male foreman, and he was fired. He was honorably discharged from the Army.

I had to evaluate Robert not in terms of what I might think would make the ideal deputy, but in terms of what I knew about the type of deputy in his community. Perfect? No. Reasonable, yes. I could find nothing in what he told me to indicate he had a particular hostility toward women which would interfere with reasonable job performance. The most I could come up with was that somehow

the interview with the psychologist got off on the wrong track and didn't recover. What I had heard through the grapevine (but didn't mention in my report) was that this psychologist had an "attitude" about men.

With the personal interview, we must be as careful as possible not to let our own biases influence either the way we conduct the interview or how we interpret the data. I concluded that I found nothing in my evaluation that would preclude Robert from working as a deputy sheriff in that locality. Notice my wording! I didn't say he would make a good employee. As I have described above and the research on testing bears out, we cannot predict good employee behavior with any confidence. But we can sometimes weed out unsuitable employees.

If that is the case, is there really any role for a

psychiatric interview? In my opinion, there is, but it is a limited one. We are on safest ground when we are evaluating someone who might be suffering from disqualifying psychiatric illness.

A manufacturing company had a concern about an applicant for a position as sales representative. The job would require him to travel around to potential purchasers to secure orders and to respond to any difficulties which might arise after the equipment was in use. The pace was fast and the sales goals were ambitious. It was a job with some potential stress. Jack had a good track record and seemed quite appropriate for the job. The problem was that four years ago, he had been hospitalized on a psychiatric unit. According to him, he'd recovered and was doing well. Still, he had made a suicide attempt and had been diagnosed as having had a severe major depression. With this record of mental illness, how

safe was the company and Jack, himself, if he got the position?

Although the Americans with Disabilities Act requires employers to accommodate employees with disabilities, they may decline to employ them or they may discharge them if there is no reasonable way the employee can be accommodated without causing "undue hardship" to the employer.[16] The question, then, was whether Jack's problem would cause him to be depressed again if the job he sought proved to be too stressful.

I examined Jack's medical records. He never previously had psychiatric consultation, and there was no record of mental illness in his family. He had developed headaches, and his family doctor diagnosed migraine and prescribed two medications. The headaches continued and the

doses were raised. Then the “psychiatric problems” started. Jack reported some confusion and concentration difficulty. He had difficulty sleeping. The doctor added a sleeping medicine, and when the sleep pattern didn’t change, he added an antidepressant medicine with strong sedating properties. Essentially, medicine after medicine was added. Usually an energetic person, Jack found his energy lagging. He was losing his sexual ability as well. The doctor diagnosed depression and added yet another antidepressant medicine. One day, Jack drank some beer and took too many of his pills. His wife came home and roused him, and she called the doctor who admitted him to the psychiatric unit of the local hospital.

When a consultant took Jack off all the medications, his mind gradually cleared and his energy returned. Nevertheless, the diagnosis of

major depression, severe, was written on his discharge summary.

Jack gave up on his original doctor, and the new family practitioner put him on a different migraine medication which controlled the headaches. When I saw him, he'd been free of all the other medicines for three years, and he felt like his old self.

It was not difficult to account for Jack's condition. The migraine plus the medication cocktail he took produced all his symptoms, some of which mimicked the symptoms of depression.

As for the suicide episode, Jack acknowledged he'd wanted to die. He was always an energetic man who depended on his wits to make a living. He could no longer face the possibility he'd be a mental cripple for life. What was there to look forward to? He was reacting to severe stress, and

during a period when he couldn't think too clearly anyway. I could find no psychiatric reason Jack could not perform well on the job.

In many companies, the Americans with Disabilities Act applies not only to pre-employment screening, but also to long-time employees who have become disabled. Actually, it is often in the company's best interest to salvage employees with disabilities. Employee turnover can be costly. The company may have invested considerable time and money in training the new recruit. A worker's on-the-job experience is a valuable asset. A psychiatric evaluation may be helpful.

Roger was a foreman in a large construction company. In many ways, he showed he knew the business. However, recently his effectiveness was ebbing. He was losing the respect of those he

supervised, and he was getting more irritable. Then, he began to call in sick. Finally, he took medical leave because of persistent panic attacks. He would wake up with cold sweats. When thinking of going back to work, his heart would pound and he'd gasp for air. The longer he stayed away, the less he was bothered. In addition, he was now seeing a psychiatrist who prescribed antipanic medication. By the time I saw him, he was virtually symptom-free. He was able to go in to the company's offices to discuss his status without having panics. However, he dreaded going back to work as a foreman, and he was asking for a different position. The company wanted to know if he could function on the job. They also wanted to know whether work would trigger another bout of illness.

When I examined Roger, I was immediately struck by his over-attention to detail. When I

asked about his difficulty, he started giving me a lengthy work history, including his education and his military service. He was working up to the current job, but not without background. This is circumstantial thinking. Often, you can't even interrupt a person with this type of train of thought; you just have to sit back and let it all wash over you until he or she reaches the point where your specific question is answered. Fortunately, Roger was able to respond to my structuring. But what did come out in his speech was that he had an almost moral conviction that rules are made to be followed. The laborers who worked under his supervision had a much more laid-back approach. The various craft people (carpenters, equipment operators, etc.) seemed to pay more attention to the rules of their unions than to the requirements of the work at hand. Inefficiency bothered Roger, and the stage was set

for conflict.

If inefficiency bothered Roger, conflict bothered him more. His relationship with the workers deteriorated. As his anger mounted, his attitude toward the "lazy" workers hardened. But Roger also had difficulty in expressing anger, and it boiled over as panic attacks. Violence was not in his repertoire. My diagnosis was panic disorder, situationally triggered.

We discussed his work possibilities. He wanted to return to work, but "if they put me back with those guys, I'm not going to cut them any slack anymore." He felt their lack of respect was due to the fact he had tried too hard to be a nice guy. It was inconceivable to him that his rigidity might be contributing to the problem. Obviously, if he returned to the same situation, his panics were likely to resume—even despite the medication.

The best medicine would be a job transfer to a position which could utilize his knowledge and experience in a setting less likely to cause these conflicts. The company agreed to give him some additional training and move him to an office position.

Many large companies employ industrial psychiatrists as part of the management team. They may recommend treatment and workplace accommodations for employees, such as Roger, in accordance with the Americans with Disabilities Act. They may also weed out workers whose disabilities render them unsuitable for continued work anywhere in the organization.

However, the psychiatrist working in industry can run into the same ethical problems as the freestanding forensic psychiatrist. As I described in Chapter 1, it is tempting to bend the data to fit

into the needs of the person or organization that is paying you. The freestanding forensic psychiatrist wants continued referrals; the industrial psychiatrist wants to retain his or her high-salaried position with the company. From the standpoint of testimony, there is little difference between a prostitute on the street and a concubine in the company. But even if the psychiatrist approaches the evaluations with more honesty, he or she also runs the danger of identifying too closely with the management team. His or her opinions may be shaped not by venality but by the attitudes and value system of the organization's management culture.

This becomes problematical especially when the employee is not claiming a disability, but management seeks to establish that the worker is psychiatrically impaired. Employers are not above attempting to use the psychiatrist against an

unsatisfactory employee. It may be difficult for the industrial psychiatrist to maintain objectivity.[17] The American Psychiatric Association has stated that the "risks of abuse and misuse of psychiatry are inherent when a psychiatrist employed by an organization conducts an examination of an adult who is required by the organization to undergo examination."[18] However, a group of occupational psychiatrists stated that, in their experience, the bulk of the referrals are made by employers who wish to help the worker work more effectively.[19] In their opinion, only infrequently will the employer use a psychiatrist to obtain information "with which to 'hang' the employee." This may well be true, but it would be difficult to set up a systematic study in order to get data.

Why would an employer want to use a psychiatric evaluation as a means of "hanging" an employee? As I described in the previous chapter,

sometimes it occurs when a worker threatens to sue for sexual harassment. Psychiatric scrutiny might turn up things which are useful for the company's defense. The risk of exposing a checkered past may persuade the alleged victim to drop the lawsuit altogether.

However, there are other situations where the company wants to get rid of an employee. This may occur, for example, with whistleblowers or disruptive workers. But why bother with a psychiatric evaluation? Why not just fire the "offender"?

The twentieth century has seen a proliferation of laws protecting the rights of workers.[20] Prior to that time, workers were subject to virtually the total control of their employers. It was only at the end of the nineteenth century that some courts began to allow workers to organize and to strike.

However, strikebreaking by violence, including the use of government troops, was common. The 1930s was a pivotal decade in labor relations in this country. Congress granted unions the right to collective bargaining.

After the end of World War II, strikes against large corporations reached such record numbers that Congress tipped the balance between management and labor more toward management. Indeed, this balance is a dynamic one, sometimes challenged in the courtroom. And while management can use its discretion in hiring and firing, the constraints imposed by the Civil Rights Act, the Americans with Disabilities Act, and other legislative prohibitions against certain types of antiunion activity cause employers to seek solid reasons for dismissing an employee. One of these reasons may be the employee's inability to perform safely or productively because of some

psychiatric condition which the company cannot reasonably accommodate. Regardless of the real reason, it is helpful for the company to have a "flexible" psychiatrist. Lawyers who may have to defend companies against suits for wrongful dismissal advise the employer to "take a detailed history of personal problems."[21]

Carl worked in a paper mill. The company was already at odds with the community because the gasses it emitted had a foul odor. More days than not, the town smelled like rotten eggs. In addition, the company's liquid waste flowed into the river. Fish were dying. In the eyes of an increasingly vocal group, the dead fish were a clear sign the company's pollution was causing all sorts of illnesses in the city. Cancer, asthma, rashes—you name it, most everything was attributed to the company's blatant disregard for the community.

For its part, the company maintained that the odor and the river contamination were the price the city paid for hosting the paper mill, a mainstay of the economy in the area. But the price, while inconvenient, did not pose any serious health risks. Their health scientists had studied the plant and declared it safe.

About three years into the job, Carl began to notice the company taking short cuts which resulted in safety hazards. He reported these safety violations to his supervisor who said these small infractions of the rules had to be tolerated in order to keep production up and costs down. While there were occasional small accidents, no major disasters happened. However, when Carl's wife, Judith, developed lupus, a systemic disease involving the production of certain antibodies, Carl put two and two together and got four—or was it five? If the company could be so callous

about safety within the plant, it could be just as callous about safety in the community. Judith's family physician said he had reviewed the company's health studies, and it was very unlikely that pollutants from the company could have produced her illness. However, activists in the town claimed the doctors were in league with the company to cover up the situation. Carl thought they might be right, and he joined the group. The activists were more than glad to display their new recruit; after all, he was an insider and he knew what the company was doing.

Management took a dim view of Carl's activities. At first, health personnel from the corporate offices tried to dispel what they claimed were Carl's incorrect conclusions. Pretty soon things developed into a we-versus-they situation. Carl felt he was being harassed because he was a whistleblower. Management felt he was

destructive to the company in a town where they had enough troubles without him. He was sent to corporate headquarters to meet with the company psychiatrist. The psychiatrist said Carl was paranoid and his disorder was likely to further impede his job performance. Carl was furious and he consulted an attorney who sent him to me for an independent evaluation.

I read the psychiatrist's report. Essentially, Dr. Spann recorded Carl's complaints about the safety infractions and the health problems. When Dr. Spann couldn't convince him that his fears were unfounded, he concluded that Carl had fixed delusions. Even the MMPI-2 confirmed Carl's paranoid tendencies. Carl was sick and should be started on antipsychotic medications! And working at the mill was just an added stress, feeding into his illness.

My impression was quite different. Certainly Carl was concerned. He was worried about his wife. “I don’t know, Doc,” he said. “There are too many coincidences. Everybody’s getting sick and the company only seems to care about production.”

“What don’t you know?” I asked.

“Maybe I’m wrong. Not about the safety stuff, I mean. I see that with my own eyes. And the company doesn’t do anything about it. But the sicknesses, the dead fish and all. It looks mighty damn suspicious. And you can’t trust the company.”

Delusions are false beliefs, but they are beliefs which tend to be fixed. If you challenge a delusion, the person is likely to get angry. “Maybe I’m wrong” points away from a delusion. Delusions are also false beliefs not shared by associates. There

was nothing bizarre or unusual about Carl's beliefs, and these beliefs were the fabric of the activists' protests. I have no way of knowing whether the activists' beliefs were correct or incorrect, but they weren't delusions.

But what about the MMPI-2? It was true there were some features pointing to suspiciousness. That scale was minimally elevated. Carl reported that he believed he was being plotted against, that someone had it in for him, that he was being talked about, that people were saying insulting things about him. When I asked him about those responses, he referred only to the actions the company was taking against him—sending him to a psychiatrist and saying he was paranoid. He felt the company was trying to get rid of him (plotted against him). Once again, I had no way of knowing the company's motives, but in my view Carl's suspicions were not unreasonable. These answers

didn't rise to the level of delusions.

So much for my diagnosis of Carl. As for Dr. Spann, in my opinion, maybe he didn't understand what constitutes a delusion (although most psychiatrists do). Or maybe he had absorbed management's ideology that troublemakers are unreasonable even though the company tries to look out for their welfare. Perhaps, his diagnostic acumen was warped by the organizational culture. Or maybe he was a concubine. A prostitute by any other name...

Although fitness-for-duty disputes may end up in the courts, often they do not. Nonetheless, the psychiatrist's report should reflect the same standards required in other courtroom testimony: helping the decisionmakers by presenting specialized information backed up by data and reaching the criterion of a reasonable degree of

medical certainty. And in my opinion, we are on safer grounds when we pose the question not in terms of whether the applicant or employee is fit for duty, but rather whether we can support the conclusion that he or she is unfit. That is the opinion we may have to defend on the witness stand.

Notes

1 All names and incidents in this case discussion are accurate as documented in the references.

2 New York Times, March 18, 1991, p. A1; p. B7

3 Los Angeles Times, March 19, 1991, p. A20

4 New York Times, March 10, 1991, p. A23

5 Ibid., March 7, 1991, p. A18

6 Ibid., March 18, 1991, p. B7

7 Ibid., April 18, 1993, p. I1

8 Los Angeles Police Department: personal communication

9 Blau TH: Psychological services for law enforcement. New York: John Wiley and Sons, 1994, p. 110

10 Silva S: Psychometric foundations and behavioral

assessment. Newbury Park, Calif. Sage Publications, 1993, pp. 65-124

11 Henderson, ND: Criterion-related validity of personality and aptitude scales. (In) Spielberger CD (ed): Police selection and evaluation: Issues and techniques. New York: Hemisphere Publishing Corporation, 1979, pp. 179-195

12 Blau: Psychological services, pp. 110-111

13 42 U.S.C. § 2000e-2(a)(l)

14 Dothard v. Rawlinson 433 US 321, 328-331 1977

15 U.S. Commission on Civil Rights: The validity of testing in education and employment. Unpublished document, 1993

16 Perritt HH: Employment dismissal: Law and practice (4th ed.) (vol. 1). New York: John Wiley and Sons, 1998, pp. 244-245

17 Glasser E: Ethical issues in consultation practice with organizations. Consultation *1:*12-16,1981

18 American Psychiatric Association: Statement on employment-related psychiatric examinations. Amer. Journ. Psychiatry *142:* 416,1985

19 Group for the Advancement of Psychiatry: Introduction to occupational psychiatry. Washington: American Psychiatric Press, 1994

20 West Group: West's encyclopedia of American law (vol. 6).

St. Paul, Minn.: West Group, 1998, pp. 371-374

21 Perritt: Employment dismissal, p. 84

Chapter 12

“Troublemakers”

One June morning in 1860, Mrs. Elizabeth Packard[1] saw her husband approach her bedroom with two physicians and a sheriff. Not yet dressed, she locked her door and started to put on her clothes. Her husband gained entry by chopping out the window with an ax. Since she was not fully clothed as yet, she ducked under the covers. The doctors felt her pulse and said she was insane. They had asked her no questions.[2]

Mrs. Packard was not entirely surprised; she had seen this coming for a long time. On several occasions, her husband, a Presbyterian minister, had threatened to put her away. Now he told her that, in accordance with the law, he was placing

her in the asylum in Jacksonville, some distance from their home town of Manteno.

The law was, indeed, on his side. This was Illinois in the mid-nineteenth century, and the law stated that “married women and infants, who, in the judgment of the medical superintendent are evidently insane or distracted, may be entered or detained in the hospital on the request of the husband of the woman ... without the evidence of insanity required in other cases.”

Elizabeth Packard didn’t put up a fight, but she did actively refuse to participate in what she referred to as her “kidnapping.” She was carried on to a lumber wagon and taken to the train depot. A crowd of her sympathizers and well-wishers had gathered there to defend her, but the reverend’s brother-in-law, Deacon Dole, controlled the crowd by telling them that not only was the commitment

backed by the law, but "the interest of our beloved pastor and the cause of the church required it as an act of self defense."

Upon her arrival at the hospital she was taken to a relatively pleasant, if sparse, ward by Dr. Tenny. He was not the hospital superintendent. Apparently this was standard procedure. It was only the next day that she met with Dr. McFarland, the superintendent. Other patients told her that none of them ever met with him. Perhaps this visit was a bow to her social position as the pastor's wife in the community. However, not long afterwards, she was moved to a filthy back ward with more seriously ill patients. She stayed there for three years before being discharged.

Why did the Reverend Packard send his wife to the asylum?[3] When Elizabeth was 19, she had an attack of "brain fever" (probably delirium) during

which she saw visions. After six weeks in the hospital, she fully recovered. Three years later, at the prompting of her father, she married the Reverend Theophilus Packard who was fifteen years her senior. Both families were prominent in their respective Massachusetts towns.

Despite the fact that Mrs. Packard found her husband cold and domineering, their marriage was relatively uneventful for the first fifteen years. They had five children, and Mrs. Packard assisted her husband in Bible class.

However, when the Reverend Packard moved the family west, Mrs. Packard began to do things which did not meet with her husband's approval. She started working in the community rather than staying in the home. She developed an interest in Spiritualism. She invited visiting Universalist ministers into the house. She began publicly to

criticize Calvinist teaching. And (perhaps worst of all), she asked to be dismissed from the Presbyterian church in order to join the Methodists. Shortly thereafter, he had her committed.

According to his diary, he felt her derangement was probably due to inborn tendencies, but her ideas posed a threat to his children and to his church. Since mental illness was not well defined at the time and since he had high ministerial status while she had the status of a housewife, it wasn't difficult to commit her. The Reverend Packard, however sincere he may have been, put his wife away because she was making trouble.

But if she was a troublemaker, was she also insane? Some troublemakers are, some aren't. The line between the two can sometimes be blurred. I shall address this problem in Chapter 14. When

we look at Mrs. Packard's case, we must consider her actions not in the light of today's knowledge, but against the ideas about insanity in mid-nineteenth-century America. Who better to turn to than Dr. McFarland, who presented her case in 1863 to an assembly of asylum superintendents.[4] She was suffering from "moral insanity"—an acceptable diagnosis at that time. To document this diagnosis, he recounted how she thwarted her husband and "tore the church all to pieces." Although moral insanity was supposed to be accompanied by deterioration of the intellect, Dr. McFarland acknowledged that her superior intellect remained intact for the first two years. It was only when reading the book she was writing that he discovered she had a delusion that she was the female Holy Ghost, a sign of intellectual problems. Indeed, Mrs. Packard did feel she'd been chosen by God to work on behalf of the insane.

Even today, people get “the call” to a religiously inspired vocation. This, in itself, does not constitute a delusion nowadays, nor did it back then.

Elizabeth agitated for improved hospital conditions and for a fair hearing for herself. Finally, she mobilized several patients in the back ward and they secretly began to destroy hospital property. She was a troublemaker all right, but the hospital gave in and living conditions began to improve. After she threatened to expose Dr. McFarland and the hospital, he maneuvered the trustees of the asylum to eject her. Apparently she was not insane enough to merit further commitment.

The Reverend Packard was not happy to have his wife home. He boarded her with her stepsister in another city. She returned to Manteno, and

eventually he locked her in her room and boarded up the windows. Somehow, she sneaked a note to a friend who started court proceedings against her husband. He had to show the judge why he was keeping his wife prisoner.

When the trial started, the judge changed the rules. He stated that the issue was not imprisonment but whether Mrs. Packard was, indeed, insane. The Reverend Packard brought in three doctors, one of whom said she was "hopelessly insane." Another said he was one of those who had previously certified her as being insane, but "three quarters of the religious community are insane in the same manner." The third of the Reverend Packard's witnesses said he wasn't sure. A letter from Dr. McFarland said she was "incurably insane" at the time of her discharge. Even against the background of the period, discharge is a strange way to treat the

incurably insane.

None of the doctors testifying in Mrs. Packard's behalf said she was insane. Neither did the crowd of townspeople who knew her well. After a seven minute deliberation, the jury declared her sane.

There is much more to the Elizabeth Packard story. She wrote several books and worked hard for the improvement of conditions in mental hospitals. In 1865, the Illinois legislators repealed the law denying married women the same rights in commitment that others had. In Massachusetts, she urged the legislators to change the law so that deviant opinions and ideas could not trigger commitment unless there was also deviant behavior. She wanted to protect those who had original ideas and who wished to reform society. With her books and energy, Elizabeth Packard played a significant role in shaping the practice of

hospital psychiatry in the nineteenth century.[5] Not bad for an "insane" woman.

As for the Illinois law which put Elizabeth in the hospital, one legislator said, "Thus we see a corrupt husband, with money enough to corrupt a Superintendent, can get rid of a wife as effectually as ever was done in a more barbarous age. The Superintendent may be corrupted either with money or influence, that he thinks will give him position, place or emoluments."[6]

It is bad enough when psychiatrists collude with local individuals who have inconvenient problems with nonpsychotic troublemakers; it is much more ominous when they collude with governments. Possibly the most widespread activity of this kind in modern times occurred in the former Soviet Union. There is ample documentation that one way the Soviet

government dealt with political troublemakers was to have them examined by psychiatrists who declared them insane and committed them to mental hospitals.[7] The case of Pyotr Grigorenko in the 1960s illustrates the process.[8]

Grigorenko was an active member of the Communist Party. An expert engineer, he advanced through the ranks of the Red Army. During World War II, he received several decorations, and he achieved the rank of major general. Ultimately, he taught at a prestigious military academy, where he was appointed chairman of the cybernetics department.

However, in 1961, he began openly to criticize what he felt were the excesses of the Khrushchev regime. He stated that the special privileges of the political elite did not conform to the principles laid down by Lenin. Despite being removed from his

academic post, he formed a dissident group—"The Group for the Struggle to Revive Leninism." He was arrested and sent to Moscow's Lubyanka prison, and from there to the Serbsky Institute for a psychiatric evaluation. He was diagnosed as suffering from a "psychological illness in the form of a paranoid development of the personality...." The data on which this was based were his reformist ideas and his grandiosity. Since his views were unshakable, the doctors concluded they had reached delusional proportions. He was not responsible for his actions and was therefore involuntarily sent to a special psychiatric hospital. While there, the government stripped him of his pension even though, by law, a mentally ill military officer was entitled to a pension. After six months, he was found to be in remission and was discharged for outpatient follow-up.

If Grigorenko's "illness" were in remission, his

political views were not. He demanded his pension be restored. Although he finally started receiving his pension again, it was severely cut. He became much more active in his dissent, and he stirred others to protest some of the State's actions. The KGB gave him several warnings, and finally, in 1969, they'd had enough. Since Grigorenko had a following in Moscow, he was lured to Tashkent, half a continent away. Again he was arrested and evaluated by a psychiatric team. These doctors reported he was not psychiatrically ill, but he was responsible for his actions. He had firm convictions which were not delusional; they were shared by many of his colleagues. Having examined the records of his previous hospitalization, they concluded that he had not been ill at that time either.

The KGB brought him back to Moscow, and three months later, they arranged a second

evaluation at the Serbsky Institute. Once again, these doctors found that Grigorenko had "a paranoid development of the personality" manifested by reformist ideas. This diagnosis was "confirmed" by the fact that he'd had the same illness when he was diagnosed previously in the Serbsky Institute. Only this time it had gotten worse. He had to be hospitalized in a special psychiatric hospital again. Finally, after almost four years, he was transferred to an ordinary psychiatric hospital. It was no coincidence that this occurred when the World Psychiatric Association was to meet in Moscow. The hospital selected was some distance from Moscow in an area closed to foreign visitors. Many months later, in deteriorating health, he was discharged.

There is much more to Grigorenko's story, but this capsule will suffice for our purposes. He was, indeed, a troublemaker, but was he also

psychiatrically ill? Once again, we must look at his condition, not by today's American diagnostic standards, but in the light of Soviet standards in the 1960s.

In the Soviet nomenclature, the word "psychopathy" did not refer to people with antisocial personalities—those who have little conscience and use others, legally or illegally, for their own ends. Instead "psychopathy" more closely referred to what we call "personality disorders"—people whose persistent styles of thinking and behaving cause difficulties in their lives.[9] In Soviet psychiatry, sometimes, as in the case of paranoid development of the personality, the style of thinking might include "reformist delusions" together with the patient's overvalued idea that he or she holds the key to social reform.[10] In 1968, even the American nomenclature included the diagnosis of paranoid

personality[11] which was close to that described by the Soviets—without the addition of "reformist delusions," of course. Against the Soviet template, Pyotr Grigorenko could have been ill, although his "paranoid" ideas were shared by others in his group. Against that template, almost any dissenter could be diagnosed as ill.

The notion of reformist delusions was very much in vogue in the Soviet culture. I was with a group in the Soviet Union in the late 1970s, and we spent part of an afternoon with an economics professor. Since we were invited to ask any question we wished, I mentioned the American street protests during the Vietnam War and asked if such protests could occur in the Soviet Union. He responded that any citizen who had lived through the enormous progress made in the Soviet Union over the years would have to have something wrong with him to join a street protest. Was he

just spouting the party line or did he actually believe it?

This, then, brings us to the question of the psychiatrists. How sincere were they? Were they prostitutes collaborating with the government, or were they following the tenets of their profession, using the science of the day? Bukovsky and Gluzman, both dissenters, classified several different types of Soviet psychiatrists.[12] Three types are of interest to us. "Novices" enthusiastically love their profession and are not very worldly. They tend to accept what is taught without question. We were all novices in the early part of our training; some never outgrew it—uncritically accepting what their instructors taught them. And the instructors may have accepted what *their* instructors taught. Such is the perpetuation of junk science.

On the other hand, “Philistines” have achieved a comfortable social status. They are of average intelligence but have a higher opinion of their talents than what is justified. They are social (and political) conformists, and, like the economist who responded to my question, they cannot really relate to those whose views are not within the social norm. They honestly feel there is something wrong with the dissenter. “But you had an apartment, a family, a job. Why did you do it?”

“Professional hangmen” know when they are tuning their diagnoses to the demands of the State. While novices and Philistines may use junk science, professional hangmen are prostitutes. Were the psychiatrists at the Serbsky Institute hangmen?

The Serbsky Institute of Forensic Psychiatry was a premier hospital for the psychiatric

evaluation of people accused of committing crimes. According to the law, the three psychiatrists who examined Grigorenko had to do more than diagnose him; they had also to come up with recommendations. In both of Grigorenko's evaluations at the Serbsky Institute, the psychiatrists recommended compulsory hospitalization in a special psychiatric hospital.

The special psychiatric hospital[13] was essentially a prison. It housed mostly violent patients who were committed after being found not mentally responsible for their illegal acts. While there were psychiatrists, they were subordinate to those who worked for the Ministry of Internal Affairs. Indeed, in contrast to the ordinary psychiatric hospital, the special hospital was not even under the Ministry of Health. It was a brutal, punitive environment, ill equipped to rehabilitate someone with a paranoid

development of the personality. Some dissenters were sent to ordinary psychiatric hospitals even if they had more malignant diagnoses. Ordinary psychiatric hospitals,[14] under the Ministry of Health, were generally oriented toward rehabilitation, although there were abuses there as well. Why, then, did the Serbsky psychiatrists recommend Grigorenko for the special psychiatric hospital? For that matter, why was their diagnosis so different from that done in Tashkent, far from the center of State power? Questions such as these —and many others—strongly suggest the Serbsky psychiatrists were hangmen—prostitutes.

A different twist to the psychiatric handling of dissenters occurred in the United States in the case of the poet, Ezra Pound. “Pound had been a commanding presence in the world of letters. If contemporary poetry sounds different, looks different on the printed page, from the traditional

poetry of the nineteenth century, it is in large part due to the practice and endless inflammatory preaching of Ezra Pound."[15] His friends included some of the most outstanding writers of his time—several of whom he had helped and encouraged in their early careers. But everyone agreed he was eccentric. He considered himself an expert in economics, and he disliked the government's policies, which he believed were controlled by a Jewish conspiracy. He was living in Italy when World War II broke out. An admirer of Mussolini and Fascism, he aided the Italian propaganda effort by writing and broadcasting short-wave programs decrying English and American participation in the war and railing against all the evils he saw in the United States' policies.

When the American army moved up the coast of Italy in 1945, Pound was apprehended. Here is where his psychiatric story begins—a remarkable

tale well researched and told by Torrey.[16] He was sent to an army prison near Pisa. Although most of the prisoners—misfits in the American army—were housed in tents, those requiring special observation were put into the "cages."[17] These were actual cages, open on all sides, screened by steel netting, and easily heated by the summer sun. Sharp spikes protruded from the ground around the perimeter. At night, acetylene torches illuminated the cages. Pound was charged with treason, and Washington wanted him held under the strictest observation.

After about two weeks, he was having nightmares and brief periods of confusion and anxiety. He was examined by two army psychiatrists who noted that he was essentially normal, but due to his age and a personality which "lacked resilience," he was unable to cope with the conditions of the cage. He was suffering from

anxiety, frustration, fatigue and claustrophobia. The condition may have also been aggravated by heat and dehydration. He was removed to a tent, and he had no more “spells.”

Two years earlier, Pound was indicted for treason by a District of Columbia grand jury. Now a prisoner of the United States, he was brought back to Washington to stand trial. The penalty for treason could be a long imprisonment or even execution. And after the lengthy and bloody war against monstrous enemies, the public was in no mood to coddle traitors. His friends were very concerned. They rallied to his defense, helped him get an attorney, and planned his defense. The defense would be that he was incompetent to stand trial.[18]

At that time in order to be tried for a criminal offense, the defendant had to be able to participate

with a reasonably clear mind. As the judge told the jury, Pound had to be mentally sound enough to be able to “cooperate with counsel, to stand trial without causing him to crack up or break down ... to testify ... to stand cross examination."[19] If he were found incompetent, he would be sent to a psychiatric hospital indefinitely, unless he was restored to health and could stand trial. Ezra Pound agreed to this defense strategy.

Here we have a situation different from that which confronted Pyotr Grigenko. The Soviet dissenter protested he was not insane; the American dissenter said he was. Of course there were other differences also. The Soviet special psychiatric hospital was really a brutal prison; being sent to an American psychiatric hospital was better than being in prison and certainly better than being executed.

Of the four psychiatrists selected to examine Pound, Dr. Winfred Overholser stood out as the most eminent. He was in line to become the president-elect of the American Psychiatric Association. He was the Superintendent of St. Elizabeth's Hospital, Washington's major psychiatric hospital. He was well-published and was recognized as one of the preeminent forensic psychiatrists in the country. In short, he was a heavyweight.

As Torrey documents,[20] Dr. Overholser had the respect of the other three psychiatrists. There is reason to believe that two of them initially concluded that Pound was merely eccentric but was not insane. They also cited the report of his psychiatric examination in Italy where no insanity was found. However, Dr. Overholser had stipulated that the doctors should file only one—unified—report, and his view prevailed. His

diagnosis was that of a paranoid state. He found Pound to be grandiose with “pressure of speech, discursiveness, and distractibility.” Pound’s abnormal personality had undergone further deterioration; he was insane and couldn’t stand trial. In my view, this sounds eerily similar to the Soviet diagnosis of paranoid development of the personality.

During that period, Dr. Overholser was writing a textbook on psychiatry, and he described what he meant by a paranoid state. These patients could put on a good front, but underneath, they were hiding delusions and hallucinations. They could sometimes become assaultive. But there were no data indicating Pound had delusions or hallucinations— either up front or underneath. He had never been assaultive.

The more junior psychiatrists at St. Elizabeth’s

could not see Pound's insanity. Their notes in the records didn't flatly contradict their Superintendent, but they failed to support his diagnosis. Dr. Duval, a senior psychiatrist at St. Elizabeth's, subsequently recalled that the general feeling among the doctors was that Pound was neither insane nor incompetent to stand trial. Out of loyalty to their chief, they decided not to make any diagnosis.

When Dr. Duval had discussed this decision with Dr. Overholser, the Superintendent told him "he respected ... our diagnosis [but] we didn't need to disturb the practicalities of the situation by making it public, and we should just keep it to ourselves. So that's what we did so as not to embarrass our boss."[21]

Ezra Pound was found incompetent to stand trial, and he spent over twelve years in St.

Elizabeth's. By 1958, the public's mood had quieted.[22] People convicted of war crimes—such as Tokyo Rose who broadcasted for Japan—were being let out of prison. Dr. Overholser reported that Pound was incurably insane, but he was not dangerous. He added that it would be a needless expense to keep him in the hospital.

As for the government prosecutors, they dropped the indictment. Although their attorneys all agreed Pound's actions had been reprehensible, it was possible their case against Pound could not meet certain specific legal standards required to prove treason. Ezra Pound was released from the hospital.

It is obvious Dr. Overholser falsified his diagnosis and then effectively, if politely, muzzled his colleagues. Why did he do it? Actually, he was appointed as an examiner by the government, not

by Pound's attorney. His testimony did not support the view of those who were paying him. Perhaps he and Pound had mutual friends; perhaps he respected this man of unusual literary talent and felt that an exception should be made in this case. Torrey's comments get to the point: "Overholser had exaggerated Pound's symptoms and disabilities; when exaggeration under oath crosses an indefinable line it can be perjury. Some of Dr. Overholser's colleagues ... say such perjury was carried out with the best of intentions. As one of them succinctly summarized it: 'Of course Dr. Overholser committed perjury. Pound was a great artist, a national treasure. If necessary, I would have committed perjury too—gladly.'"[23]

So, how do we classify Dr. Overholser in this case? Not really a prostitute; he didn't do it for personal gain. Certainly not a hangman; he was helping Pound, not persecuting him. Not exactly a

junk scientist; he used (or misused) the best science of the day. Let us use the words of his colleagues; we'll have a category called "the well-intentioned prevaricator."

All of us think we know what is best, and at times, truth takes a back seat to "the practicalities of the situation." But this is ideology, not psychiatry. It's the kind of thinking that led roughly 10 percent of American psychiatrists in 1964 to diagnose Barry Goldwater as psychologically unfit to be president. And another 5 percent said he *was* psychologically fit. None of them had ever examined him; they were responding to a mail-in poll taken by *Fact* magazine.[24] It is an easy trap to fall into because who can argue with good intentions? As a recent study, aptly titled "Lying for Patients," reported, many doctors do it when they modify diagnoses to help the patient get insurance reimbursement.

And they always are able to justify this fraud by stating that they have the best interest of their patients at heart.[25] I've done it on occasion when I thought the cause justified the (shall we say) "exaggeration." Never in court, though, at least as far as I can remember!

But psychiatrist Robert Coles makes a very telling point about the Overholser-Pound case: "...We are once more reminded that psychiatry ... can serve the law poorly and that some of us will grant liberties to certain influential figures we certainly would deny other men and women who are presumably entitled to their fair share of this nation's 'equal justice under the law.'"[26]

Even in this country, psychiatrists may sometimes act more like hangmen than well-intentioned prevaricators. Consider the case of Grace Walden. She lived in a decaying flophouse

where you could rent a room for $8.50 a week. The building was across from the Lorraine Motel in Memphis. It was the building from which the gunman assassinated Dr. Martin Luther King, Jr., on April 4,1968. As she told me when I visited her in a nursing home almost 30 years later, “I heard the shot. I ran out the door and I saw a man running from the bathroom. He had something under his arm. I didn’t know what it was.”

Two months later, after James Earl Ray was apprehended at Heathrow Airport in London, Grace was taken to John Gaston Hospital. Two policemen brought her, acting on the complaint of her live-in boyfriend, Charlie Stevens. Grace had seen Ray’s picture, and she was telling people he was not the man she saw. Charlie and Grace both drank heavily and often argued. Grace thought Charlie complained because “he was so mad at me he wanted to put me away.” The hospital

admitting record indicated she had witnessed Dr. King's murder and was disturbed in anticipation of the upcoming trial. The examining psychiatrist said she had "suicidal tendencies.... She thinks she is a witness in Dr. King's murder trial."

At best, Grace would have made a problematical witness. Although quite bright and an avid reader, she was a street person. She had two or three marriages (she couldn't remember which) and lived with a succession of men. She was known to be a heavy drinker, although she insisted to me she had not drunk anything on April 4, 1968. She'd been arrested many times for a variety of offenses.

After a three-week stay at the Memphis hospital, she was transferred to Western State Psychiatric Hospital, 65 miles away. She was still there, committed involuntarily, when I first heard

of her ten years later. An attorney called me and asked if I would be willing to assist her group in a "very controversial" case. She told me Grace was confined incommunicado, but one of the lawyers just walked into the hospital and went to her room without asking anyone. Grace signed an agreement to have him represent her. By court order, the group had obtained all her Western State records. I agreed to review them to see if she still (or ever) met the standards for involuntary hospitalization.

Unfortunately, the lawyers were never able to get records of her treatment at John Gaston. They suspected the records had either been destroyed or were being kept secret. When I visited Memphis in 1996, I went to the record room of The Med (successor to John Gaston), equipped with the appropriate release forms given me by Grace's guardian. I was told the computers were down, but I could call in a few days. After several calls

which never were returned, I gave up.

Nevertheless, the Western State records were revealing enough. The admitting doctors there said, “She appears to be delusional, although she gives a very convincing story about her having seen the murder of Dr. King.” They diagnosed her as having a chronic brain syndrome (deterioration of the brain resulting in an impairment of her thinking) due to alcoholism. In the whole ten years of records I examined, there were no data to support this diagnosis. In 1996, I had the opportunity to review the reports of a psychologist and psychiatrist who examined her shortly after she finally got out of the hospital. Neither found any signs of chronic brain syndrome. Certainly, when I visited her, she was quite sharp for an 81-year-old woman. In fact, as early as 1969, a hospital doctor wrote “Non-psychotic.... Although she has only a behavioral

reaction, we may have to call it a psychosis anyway."

There were other, more ominous entries in her hospital records. Seven months after her admission to Western State, her doctor noted she was ready for discharge if only there were an "acceptable community placement." A year later, another doctor stated Grace could function outside in a boarding home, but there were "some legal complications in Memphis." Dr. Neale, the superintendent at the time, told the nurses they should allow "no one to see her or talk to her alone.... No information is to be given concerning the patient to anyone." He said she could still work in the hospital "but is never to be left alone." The written order said the nurses should hand this directive from shift to shift. This, despite the fact that her progress notes revealed that except for some stubbornness and outbursts of swearing, she

was cooperative and helpful to other patients. She spent much of her time reading in the library. I have never seen such an order come from the superintendent; occasionally such orders might came from a patient's psychiatrist.

By 1973, such warnings began to appear on the covers of her charts: "Nobody allowed to visit or read record." One doctor wrote, "I suppose her involvement in the Martin Luther King murder will support this prohibition by the Superintendent." And in 1976, another doctor suggested she be prepared for discharge, "but first check legal aspects of the case. Apparently patient still can't leave the hospital or go to activities in Memphis because of some legal complications."

By 1978, when the attorney sneaked into the hospital to get Grace's signature for him to represent her, Dr. Cohen had become

superintendent.

The policies had remained in place. Suddenly, there was a flurry of publicity, generated by the group of lawyers. Dr. Cohen responded that the hospital had been planning to release Grace for months, and they were trying to make suitable arrangements. Nothing in the records suggested this was the case. Indeed, if Grace was ready for discharge in 1978, she was ready years earlier, because her behavior had not changed. Even her official diagnosis remained the same. Dr. Cohen stated she suffered from "chronic brain syndrome due to alcoholism...." She had "brain impairments such as in a person who has senility."

I reported my findings to the attorneys, but I never had to testify. Doctor Cohen finally released Grace to a boarding home with the strict understanding she should not leave unattended—

whereupon the same attorney who had visited her in the hospital took her out to lunch and flew her to California, where she was evaluated by the psychologist and psychiatrist who found no signs of a chronic brain syndrome. After much legal maneuvering, April Ferguson, one of the lawyers, was appointed her guardian. Ms. Ferguson was more than a guardian; she was her friend. She took Grace into her home, and when it became apparent that this no longer was working out, she put her in a nursing home and visited her frequently until Grace's death, about a year after I visited her.

One could argue that being in the hospital probably prolonged Grace's life because she was kept away from alcohol and the dangerous life of the street. That would put a "well-intentioned" spin on it. But it is clear from the record that the doctors who collaborated with the "legal

complications in Memphis" were not acting in Grace's interest. They were hangmen.

Sometimes individuals attempt to use psychiatrists to handle those who give them trouble. Sometimes governments do. But when representatives of government attempt to use psychiatrists to deal with "troublemakers," the implications are even more severe. The State has enormous resources and power, and it is tempting for governments to use that power to curtail individual liberty.[27] The problem for psychiatry is not that the State may want to use psychiatrists for this purpose, but that it isn't always difficult to find psychiatrists who, either because of ideology, naivete, or personal gain, will allow themselves to be used.

Notes

1 In contrast with most names in this book, all names in this chapter are correct. Their names and cases have been

well documented in the public arena with the exception of Grace Walden. I publish the material about her with the permission of her guardian.

2 Packard E: Modern persecution or insane asylums unveiled: My abduction (In) Goshen CE: Documentary history of psychiatry: A source book on historical principles. New York: Philosophical Library, 1967, pp. 640-665

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4 Ibid.

5 Ibid.

6 Packard: Modern persecution.

7 Bloch S and Reddaway P: Psychiatric terror: How Soviet psychiatry is used to suppress dissent. New York: Basic Books, 1977

8 Ibid., pp. 105-127

9 Calloway P: Russian/Soviet and Western psychiatry: A contemporary comparative study. New York: John Wiley and Sons, Inc., 1993, p. 183

10 Bukovsky B and Gluzman S: A Manual on psychiatry for dissenters. (In) Bloch S and Reddaway P: Psychiatric terror, pp. 419-441

11 Committee on Nomenclature and Statistics of the American Psychiatric Association: Diagnostic and statistical manual

of mental disorders II. Washington: American Psychiatric Association, 1968, p. 42

12 Bukovsky and Gluzman: Manual on psychiatry

13 Bloch and Reddaway: Psychiatric terror, pp. 191-219

14 Ibid., pp. 187-191

15 Wernick R: The strange and inscrutable case of Ezra Pound. Smithsonian *26 (Dec.):* 112-127,1995

16 Torrey EF: The roots of treason: Ezra Pound and the secret of St. Elizabeth's. New York: McGraw-Hill Book Co., 1984

17 Ibid., pp. 1-17

18 Ibid., pp. 177-185

19 Carpenter H: A Serious character: The life of Ezra Pound. Boston: Houghton Mifflin Co., 1988, pp. 750-751

20 Torrey: The roots of treason, pp. 186-204

21 Ibid., p. 204

22 Wernick: The case of Ezra Pound

23 Torrey: The roots of treason, p. 218

24 New York Times, October 2,1964, p. 20

25 Freeman V et al.: Lying for patients: Physician deception of third-party payers. Arch. Int. Med. *159:* 2263-2270,1999

26 Coles R: How sane was Pound? (Book Review). New York Times, October 23, 1983

27 Szasz TS: Psychiatric justice. New York: The Macmillan Co., 1965, pp. 264-272

Chapter 13

Role Conflicts

Dr. Ruth Green didn't want any part of a court proceeding, much less having to testify at a deposition. Like most psychiatrists, she wanted to treat patients. She had to shuffle her schedule to make room for this appearance, and she anticipated a withering personal attack from the one of the attorneys. Nonetheless, she'd received a subpoena, and there she was.

Fortunately, she was not the target of a malpractice suit. She had a well-earned reputation as a skillful and caring psychiatrist. This case was about Sheila, one of her patients. Sheila was injured at work. While lifting some boxes at the factory, she "heard a pop" in her back and felt a

"stabbing pain." Despite medications, the back pain persisted. She couldn't sit for any length of time; on the other hand, long periods of standing or walking caused her to suffer. It was difficult to find a comfortable position in bed and her sleep was interrupted.

After some time, these problems seemed to bother her emotionally, and she was sent to Dr. Green who diagnosed depression. The causal chain was clear: injury—back pain—physical limitations —depression. Now, as Sheila's workers' compensation case came up, Dr. Green had to testify about the extent of the psychiatric impairment.

Although we discussed impairments in Chapter 4, I will tell you a little more about Sheila's situation in order to set the stage for the focus of this chapter—role conflicts and the difficulties of

being an impartial witness.

Sheila now depended on her adolescent daughter to carry an increasing load of the housework—a task the daughter resented. There was dissension in the house, aggravated by Sheila's irritability—one of the symptoms of her depression.

Because Sheila was now not working, finances were a problem. She applied for Social Security benefits as a disabled person, but she was turned down. Sheila had to depend on support from her parents and this, too, caused tension. If the workers' compensation award were large enough, her finances would stabilize.

Both Dr. Green and I agreed Sheila was depressed; where we differed was on the degree of the psychiatric impairment. She felt her patient was markedly impaired, while I felt she was mildly

impaired. Dr. Green thought the depression "had set in" and most likely was permanent. I felt that it was premature to form that conclusion; there were things that hadn't been tried as yet. For example, Dr. Green had tried only two antidepressants; there were several other medication adjustments which might help. Likewise, the whole treatment was oriented toward focusing on what Sheila could not do; there was no step-by-step encouragement for her to cope with the pain and try things.

Doctors can disagree. Dr. Green supported her conclusions reasonably and so did I. It was up to the judge to referee. As it turned out, he never had the chance because the parties settled the case out of court.

However, there were other aspects of Dr. Green's testimony which caught my attention.

According to her records, months after the start of the psychiatric treatment, Dr. Green submitted a letter to Sheila's lawyer stating that her patient had a 35 percent psychiatric impairment. Why did she do that? The data indicated the lawyer hadn't yet asked for this opinion. Dr. Green testified that "I felt it was in Sheila's best interest to submit an impairment rating at this point." Unfortunately she was never asked why this was in the best interest of the patient.

At another point, Dr. Green indicated that since the legal situation was one of Sheila's stressors, it was better to get the case behind her so she could move on. It probably escaped the doctor's attention that if the impairment was permanent—incapable of improvement—then what would she move on toward?

Shortly before her deposition, at the request of

the patient's attorney, the doctor submitted another impairment rating. This time it was higher —50 percent. This, despite the fact that her records indicated there was no change in Sheila's symptoms. Asked about this rating change, she said, "Frankly, I'm uncomfortable with changing my former rating, but I feel I was unfair before. I might have been a little too harsh. *I'm very concerned about Sheila, and my interest is primarily that her needs be addressed*" (emphasis mine). Asked about Sheila's needs, she responded that there was need to get out of the litigation, financial needs, and the problem with her daughter which must be diminished. On three other occasions during the deposition, Dr. Green repeated it was in the patient's best interest to have these three areas of need resolved.

Thus, Dr. Green has put the problem squarely before us. To whom did she owe primary

allegiance? She, herself, told us: Like every good clinician she owed it to the patient. She assessed what her patient *needed* and was trying to be as helpful as she could. In the technical jargon of forensic psychiatry, her role was that of the patient's agent. This is appropriate for a treating psychiatrist. But is it appropriate in the forensic situation? An impairment rating is not based on what the patient needs, but on what the patient cannot do. Two people with the same incapacity should get the same impairment rating, even if one is rich and needs less and the other is poor and needs more.

In contrast with the treating psychiatrist, the forensic psychiatrist should owe primary allegiance to the court and the legal process. With a few exceptions which I shall discuss below, there is nothing owed to the patient—or the defendant, or the plaintiff, or any of the litigants. But when

the treating psychiatrist is before the court, there is a conflict of roles. As Applebaum stated about forensic testimony, “When we allow therapeutic principles to creep into our thinking, we open the door to profound confusion over the psychiatrist’s role.” He went on to state that the work of the forensic psychiatrist should be “the pursuit of justice rather than health.”[1]

Does this mean Dr. Green was a prostitute? Not in my opinion. She was not selling her opinion to Sheila’s attorney in order to get more referrals. The last thing she wanted was more involvement in the legal process. Was she, then, a well-intentioned prevaricator? I wouldn’t say so. I have no reason to believe she knew she was distorting the data or lying about her conclusions in order to help her patient. According to her testimony and her reputation, she honestly believed (and she stated) that her role was to act in the best interest

of her patient. The problem was that as a witness, she was serving two masters—patient and court. Halleck[2] has referred to this as a double-agent problem which can cause role confusion. While testifying, Dr. Green was confused about her primary allegiance. As a witness, it should have been to the court.[3]

There is another reason that treating psychiatrists may have a conflict of roles when testifying. Patients expect their doctors to be on their side. Testifying to something that puts the patient at a disadvantage injures the doctor-patient relationship—a very important part of the treatment process. In order to avoid these conflicts, the treating psychiatrist should punt the forensic issue to another psychiatrist whenever possible.

Unfortunately, life is not so simple; separation

of treatment and testimony is not always possible. After all, it was Sheila, through her attorney, who raised the issue of emotional damage due to her work situation. She couldn't then duck and hide her psychiatric record. Her psychiatric history and treatment were relevant to the issue of the emotional damages she claimed.[4] Even if Dr. Green could have punted the forensic evaluation to another psychiatrist, she still would have had to release all Sheila's records—data which Sheila previously had every right to believe were confidential. That's the price one may have to pay for bringing a lawsuit-even if the suit is justified. We have already encountered that problem in Chapter 10, where I discussed how some women prefer to avoid claiming psychiatric damages due to sexual harassment, because it may open up an embarrassing Pandora's box when the defense attorney explores the woman's sexual history and

propensities.

So much for the problems of the treating psychiatrist who enters the forensic arena. What about the forensic psychiatrist who makes treatment recommendations? Gutheil emphatically stated that as a forensic psychiatrist, "You certainly don't owe a duty to other professionals who may be part of the patient's treatment team."[5] Indeed, frequently the attorney or the insurance company he or she represents specifically instructs the forensic psychiatrist *not* to make any treatment recommendations. Keeping the roles straight is the best way to avoid being partial to one side or the other.

Sometimes, however, treatment recommendations are unavoidable—particularly if the forensic psychiatrist must testify as to whether an impairment is permanent. In Sheila's case, it

was not enough for me to tell the judge it was premature to state the condition was permanent. I had to support that conclusion by talking about the possible use of other medications and about behavioral treatment aimed at getting her more active. But if I was helping Sheila out (by default), I never felt I had any allegiance to her. I wasn't doing it for her, but for the court.

I encountered another treatment situation when I was asked to evaluate Donald. As an adolescent, he seemed to lose interest in everything and everyone. He ruminated about such "philosophical" questions as the meaning of life, and whether people could control others through thought waves or other supernatural means.

When he was 19, he killed a cousin. He was blatantly delusional, and everyone agreed he'd

been responding to hallucinations. At trial, he was found not guilty by reason of insanity. I was not involved in his case at that point.

Donald was diagnosed as having paranoid schizophrenia. He was committed to a state hospital where he would stay until he was no longer actively psychotic and he posed no danger to anyone. The whole family was furious at him and refused to have anything to do with him. His uncle, who happened to be an attorney, said he could "rot in there for life."

Seven years later, Donald thought he was ready for discharge, but the hospital disagreed. According to state law, the hospital had to pay for an attorney to assist the patient who wanted to leave and for a psychiatrist to do the evaluation. Donald's attorney asked me to do the evaluation.

Looking through Donald's hospital chart, I

could see he'd made considerable progress in the hospital. He was working in the hospital kitchen, and he had free run of the grounds. He'd gone on several group excursions into the city accompanied by staff, and things went well. He reported no delusions. He regretted what he had done to his cousin, and he understood his parents' anger.

However, there were also negative features. Most of the time Donald seemed preoccupied with his Bible, which he carried around with him constantly. Every so often, he would mumble to himself. Could he be responding to inner voices? Because he had no family support and he didn't want to live in a group home, there was no reasonable placement for him on the outside. And a hospital psychologist noted that Donald seemed to become agitated whenever they talked about discharge.

When I examined him, I could see no overt signs of paranoid schizophrenia. He was able to talk about his psychotic thinking years earlier; he seemed to have a good perspective about it. He was a born-again Christian now, and his faith was stabilizing him. As for the muttering, he said he was not hallucinating; he was reciting Scripture. He didn't think the medication was doing any good, but he knew he would have to stay on the regimen as a condition of discharge.

In my report, I noted that this was a difficult call and the stakes were high. Was the Biblical preoccupation a remnant of his ruminations as an adolescent—a time when his schizophrenia was emerging? What if he panicked after he was discharged? Might he become delusional and kill again? What if he decided he should go off his medication? And where would he live? He had no family support. He did not wish to live in a group

home. I could not recommend that Donald be discharged at this time.

However, I did have some treatment suggestions for the staff. The doctor had him on a low dose of antipsychotic medication. I suggested it be raised. Then we could see if there were any loosening of his Biblical preoccupation. If so, this would suggest it was partly fueled by an underlying psychotic process. I also suggested the staff try to accompany him on visits to a group home and to the mental health center where his treatment would continue after discharge. Perhaps he would find a placement more palatable and the transition would be eased. In accordance with standard procedure, I sent my report both to the attorney who hired me and to the hospital's attorney.

One year later, the attorney asked me to

reevaluate Donald. His medicine dose had been raised. Now, although he still studied the Bible, he could also be seen reading secular bodks he obtained from the hospital library. The preoccupation had loosened. Equally important was that while on the hospital grounds, he had met several Christian missionaries. While they didn't enter the hospital, they did their work on the grounds with any patient who would listen to them. Donald was invited to attend their small church, and on occasion, a staff member agreed to go with him. The staff member's report about the group was quite positive; it was a warm and supportive environment. The church was willing to find him an apartment and help him get a job. They would undertake to see that he kept his doctor's appointments. Although certain religious groups believe that taking medicine shows a lack of trust in God, fortunately this group felt that

medicine and a belief in God were compatible. Since his medicine was administered intramuscularly every two weeks, compliance would not be a problem.

This time, while the hospital still maintained Donald was not ready for discharge, I felt he was. We each presented our views at the hearing, and the judge decided to release him with the provision that he comply with the outpatient treatment arranged for him.

A few years later, I happened to be in Donald's part of town and I ran into him sitting on a park bench. He was eating a sandwich and reading a novel. He told me he had a job and was doing well. He was seeing his doctor regularly. His faith was still very strong, and he felt supported by the members of the church. He was sad to be estranged from his family, but he accepted the fact.

The church was his family now.

Some of my colleagues might feel I stepped over the line by offering treatment suggestions while doing a forensic evaluation. In this case, I was clearly hoping to help Donald, and in a way, I was acting as his agent. However, as I thought about this situation, I concluded there was no conflict of interest. Even though I wanted to help him, the report I wrote opposed his discharge at the time I made the recommendations. While I was, indeed, assuming both a forensic and treating role, they were not incompatible.

As I mentioned above, it is not exactly true that as a forensic psychiatrist I owe nothing to the person I am evaluating. There are exceptions. I owe the person two things: acting courteously and honestly informing him or her about who is paying me, what my role is, and what rules govern how

my role is carried out. Generally, this means that I make sure the examinee knows the nature of the legal conflict and which side has employed me. I define myself as a psychiatrist and sometimes I must tell him or her I'm getting paid by the people on the other side—"but I call it exactly as I see it." Sometimes, the examinee will start right in pleading his or her case. I stop the person immediately and make sure he or she knows that nothing is off the record here. "Anything you tell me that I think is important the attorney should know, I will tell him (or her). And of course, if I testify, I have to tell the truth. There are no secrets in here." Then I double check to make sure the examinee understands.

Once in a while during the evaluation, the person will say, "I'll tell you, Doc, just between you and me..." I stop the discussion immediately and remind him or her that there is no "between you

and me." Often, he or she will think about that for a minute and then decide to tell me anyway. While I am trying to get as much relevant information as I can, I feel it would be unfair to trick him or her. And the best way to avoid unfairness is to let the examinee know with whom I'm consulting and what the rules are.

In my role as a potential witness, then, my primary allegiance as a forensic psychiatrist is to the court. However, I usually have another role, as well. I am a consultant to the attorney who has hired me. These two roles need not be in conflict. What I say when I testify has to be independent of the attorney with whom I consult. But as a consultant, I may help the attorney by discussing how the psychiatric findings might possibly impact on the case. I often point out that if I must testify about such- and-such, the other attorney may use the testimony on cross examination to

support his or her side of the case. The attorney to whom I owe allegiance is entitled to know what will help the case and what will harm it. The lawyer may decide not to put me on the stand.

You may recall the case I discussed in Chapter 3. Jim Thornton claimed his depression was caused by a work-related injury. His psychiatrist, Dr. Higgins, agreed with that position. Henry Bradley, the attorney representing the company, wanted me to look at Dr. Higgins's records and to say that Jim wasn't depressed. But he didn't want me to examine the patient, because I might agree with the diagnosis and Jim's attorney would know. I told him I couldn't give a diagnosis under those conditions.

Then, as a consultant, I told the attorney what I could do. I could tell him whether Dr. Higgins's office notes were consistent with the diagnosis of

depression. But I warned him that might or might not be helpful to his case. While giving him an alternative, I was also asserting the independence of my testimony.

The lawyer shifted his position and claimed that Dr. Higgins couldn't testify about what caused the depression because he relied only on Jim's reports in the clinical situation. I explained the difference between a clinical and a forensic evaluation, and I told him that a clinician (or any witness) can testify only on the basis of what data he or she has. If the doctor's opinion were the most likely alternative, it would meet the standard of reasonable degree of medical certainty. And I warned Mr. Bradley that if he asked Dr. Higgins if he were certain there were no other facts which were contradictory, the doctor might reply that he would be willing to reconsider his position if other facts were presented. In my opinion, consulting

with the attorney about what might help and what might hinder his or her case is appropriate, so long as the witness does not distort the testimony or mislead the court.

I also owe the attorney the opportunity to go over the questions he or she will ask me in court. This not only helps me to be better prepared, but it also allows both of us to make the best and most understandable presentation of the data and conclusions possible. It is not a matter of distorting the findings; it is a matter of helping the court understand them.

In addition to witness, treating psychiatrist (sometimes), and consultant, there are still other roles assumed by forensic psychiatrists. One of them is the role as a career person. We have allegiance to ourselves and our careers. There is at least a small part of us that wants to satisfy the

person who hired us. There is always some desire to get feedback that we have done a good job. Everyone likes to be thanked. Occasionally, when I step down from the witness stand and prepare to leave the courtroom, I find myself glancing at the attorney in whose behalf I was testifying. I look for some small sign—a nod, a smile, anything—to show me that he or she approved of my work. Of course I never get it, and I laugh at myself for having expected it. On one occasion, I did get feedback in the courthouse. While I was in the men's room, the bailiff entered and said, "Doc, that's the first time I ever understood what a psychiatrist was talking about." I'll take that kind of feedback anywhere—even in the men's room.

Allegiance to oneself and one's career can interfere with the way we reach our conclusions in the forensic arena. "I call it exactly as I see it" is all well and good, but the way I see it can be

influenced by my eye on my reputation. Let's go back to the case of Donald. The biggest problem with releasing him from the hospital was that he had killed someone. Suppose I called it wrong, and he got out and killed someone else—perhaps another member of his family. No one would then say I did a good job. On the contrary, my reputation (and perhaps my career) would be tarnished. I would be less than candid if I said this thought never crossed my mind. I was much relieved to stumble across him on the park bench and to learn he was doing well. And while I can't get into the minds of the hospital psychiatrists and lawyer who opposed his discharge, it is certainly possible that they didn't want to be the ones to take the risk and potentially the blame by releasing him. Maybe I took them off the hook.

However, it wasn't only my reputation I was concerned about. I had yet another role; I am a

member of society. I had an allegiance to society at large. While it was not primary, it was very much on my mind. I had an obligation to use my expertise to protect unknown persons who might be killed if I persuaded the judge to discharge him before I felt certain he was ready. This, too, came into my thinking.

Another role assumed by some forensic psychiatrists is that of advocate for social change. Usually, as Szasz[6] pointed out almost 40 years ago, when we testify, we act as society's agent, furthering society's values, such as marriage, racial relations, national interests, etc. For example, in participating in the commitment process, I was buying into our society's decision that some killers should be hospitalized with an indeterminate "sentence" while others go to jail—a decision based on sympathy for people who are ill. Many people—especially families of victims—

don't feel that way. The way we understand behavior and what we choose to do about it are significantly rooted in the values of the society in which we live. Recall the Soviet Philistines described in Chapter 12 who could not understand why a person with a job and an apartment would want to be a dissenter. And the Soviet hangmen who may have felt justified in distorting testimony in support of the Communist society. Allegiance to society and its values.

However, some witnesses follow a different star. Dissatisfied with some of society's current values, they may bend their testimony as they advocate for change. An expert may have a strong allegiance to a certain kind of ideology. For example, he or she may feel that all people should be held responsible for their actions regardless of their mental state. On the other hand, an expert may feel that no one should be blamed since

"criminal" actions are prompted by sickness or television violence or poverty. Sometimes a witness may distort testimony to promote such ideologies. Remember the psychiatrist who said he would perjure himself in the service of such a national treasure as the poet, Ezra Pound. Witnesses such as these are well-intentioned prevaricators. It may be tempting to use testimony in the service of a particular ideology, but this can undercut the primary allegiance to the court—presentation of honest opinions based on the best evidence available.

In my view, there are two acceptable ideologies in the courtroom. First, we must subscribe to the ideology of the justice system and the rules of the court. If you find this abhorrent, don't be a witness. Second, we must subscribe to the ideology of scientific evidence as data. We should supply the court with data and conclusions

based on the best specialized knowledge available. If we subscribe to an ideology which is junk science, if we act like the novices described by Soviet dissenters—parroting theories we have accepted uncritically because that's the way we were taught—we do the court and the litigants a disservice.

Possibly the most impassioned disagreement among forensic psychiatrists is whether we should participate in evaluating whether a convicted murderer is competent to be executed. At first blush the whole notion of this issue may seem silly. The perpetrator has been convicted and sentenced. He or she has been found psychiatrically sound enough at the time the offense was committed and sound enough to stand trial. What difference does it make if the murderer is sane or insane at the time of death? Certainly we don't want the convict to understand what is

happening in order to teach him or her a lesson!

Yet, for centuries, legal systems have required that the condemned person be able to understand what will happen and why he or she will be put to death. And it is required by the Constitution of the United States.[7] Among the reasons given for this requirement are the following: The insane person cannot participate with the attorney in the last-minute defense. The full force of the punishment is attenuated because the deranged convict doesn't suffer the worry of anticipating the execution. The condemned person doesn't have the capacity to repent and make peace with God.

It is not our role as forensic psychiatrists to argue the merits or drawbacks of the death penalty. Some favor it, some oppose it. These are ideologies, and each of is us gives allegiance to our own ideology. The controversy arises because we

are doctors, trained to help people, not to participate in their death. In my opinion, this is a role problem. True, we are doctors, and we should put our skills to work to help people. But in our various roles in the service of the court, we may be unhelpful—or even harmful—to a litigant. Even in the criminal process, we routinely testify about the state of mind of the defendant at the time of the offense despite the fact that this may put him or her in prison (hardly therapeutic) and even on the track toward the death penalty.

What happens in evaluations for competence to be executed is that we use our diagnostic skills in the service of the court, which is our primary allegiance. If we take the position we should primarily be the agent of the defendant (and life over death), we run the risk of falling victim to the same problem the treating psychiatrist has when called to testify— honest testimony may injure the

patient.

I believe those who say we should not participate in death penalty competency examinations are placing ideology as the primary allegiance— which is fine for them as individuals; they should stay away from this kind of work. “Although saving a life may be most consistent with traditional Hippocratic ethics, truth and honesty is the primary duty for a forensic psychiatrist.... If the facts are not favorable to the defendant, a forensic psychiatrist can refuse to become involved.”[8]

In forensic psychiatry, multiple roles are inevitable and they can cause problems. There is always the temptation to bend the testimony—sometimes unwittingly—to one or another allegiance. The notion of a totally impartial expert (in psychiatry or anywhere else) is a fallacy.[9] So

long as the psychiatrist understands these forces and chooses the court as the primary allegiance, problems of multiple allegiance can be minimized —but never completely eliminated.

Notes

1 Applebaum PS: A theory of ethics for forensic psychiatry. Journ. Amer. Acad. Psychiatry Law *25:* 233-247,1997

2 Halleck SL: The politics of therapy. New York: Science House, 1971, pp. 119-120

3 Modlin HC: The ivory tower in the marketplace. Bull. Amer. Acad. Psychiatry Law *12:* 266-236,1984

4 In re Lifschutz 467 P.2d 557, 567-569 (1970)

5 Gutheil TG: The psychiatrist as expert witness. Washington: American Psychiatric Press, Inc., 1998, p. 20

6 Szasz TS: Law, liberty and psychiatry: An inquiry into the social uses of mental health practices. New York: The Macmillan Co., 1963, p. 197

7 Ford v. Wainwright 477 U.S. 399, 405-410 (1986)

8 American Academy of Psychiatry and the Law: Additional opinions to the ethical guidelines for the practice of forensic psychiatry. Question # 13 (unpublished document), 1995

9 Diamond BL: The fallacy of the impartial expert. Arch. Crim. Psychodynamics *3:* 221-226,1959

Chapter 14

Which Conditions Count?

The Supreme Court's decision in *Kansas v. Hendricks*[1] sent a minor shock wave through American psychiatry, and state mental hospitals felt the tremor. Leroy Hendricks[2] was a pedophile, preying on both boys and girls. His criminal career[3] started in 1955 when he pled guilty to exposing himself to two young girls. Two years later, he was jailed for lewdness with a young girl. Three years after that, he was convicted of molesting two young boys. When he was paroled, he was arrested again for molesting a young girl. Subsequently, whenever he was released from prison, he was rearrested for further sexual misbehavior with youngsters, including his

stepchildren. And, of course, the record shows only those cases where he was caught! Finally, he was convicted of sexual encounters with two adolescent boys. After serving his sentence, a date for discharge was set. But this time was different!

In 1994, Kansas had enacted a law[4] stating specifically that people who, because of "mental abnormality" or "personality disorders," are likely to engage in sexual predation may be committed to mental hospitals. Hendricks was a prime candidate. He agreed he was a pedophile and that he could not control his behavior.[5] Attempts at treatment hadn't helped.

Why did the Kansas legislators enact a special law regarding pedophiles? The state already had a commitment law based on the criteria of mental illness and dangerousness. But in that law the legislators felt (possibly because the psychiatrists

felt) that pedophiles "do not have a mental disease or defect that renders them appropriate for involuntary commitment."[6] In other words, despite that fact that pedophilia is listed as a mental disorder in the psychiatric diagnostic manual,[7] as far as commitment was concerned, it didn't count. With the new law the lawmakers tried to "remedy" that situation; they made it count.

The staffs of state mental hospitals, the likely recipients of these committed pedophiles, were not happy. Even the Kansas legislators recognized that pedophiles often have "anti-social personality features which are unamenable to existing mental illness treatment modalities...."[8] But worse than that, repeated sexual predators with antisocial tendencies often are manipulative, are not very honest with the staff, and may prey on vulnerable mentally ill patients in the hospital. They may be

there forever, working the system and causing disruption of the unit. How does a hospital administrator ever decide to discharge such a patient and take the heat if another pedophilic act occurs?

The way the Kansas law defined "mental abnormality" is of interest to us here: "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses...."[9] In simpler terms, these people can't control themselves. In the Supreme Court's decision, mental illness which legally counts as an illness criterion for commitment is behavior which the person is unable to control.[10] The justices agreed that Hendricks's pedophilia was not under his control.

Is pedophilia a psychiatric condition? Or, more properly put, should pedophilia be considered a

psychiatric condition in the legal arena? It depends who you ask.[11]

While the Supreme Court ratified Kansas's position that pedophilia should be counted as a psychiatric condition, the Court has taken another route when the diagnosis is antisocial personality disorder (without pedophilia).[12] Terry Foucha was charged with aggravated burglary and illegal discharge of a firearm. Apparently he was on street drugs and had a psychotic reaction at the time of the offense. He was found not guilty by reason of insanity and was committed to a state mental hospital. Free of these drugs, his diagnosis was antisocial personality. Despite his track record, the doctors could not say whether he was still a danger to society.[13] But even if he were, the Court noted that many criminals have antisocial personalities, and the state controls their dangerous behavior not by commitment but by

other means, “such as punishment, deterrence, and supervised release.”[14] These people are not mad; they are bad. They go to jail instead of mental hospitals.

So there you have it: pedophiles can’t control themselves (at least in Kansas and several other states), while people with antisocial personalities could control themselves but they choose not to. Thus the justices decided that, for legal purposes, the former are counted as mentally ill while the latter are not.

But how did they know pedophiles can’t control themselves? Hendricks made it easy by agreeing that he “couldn’t control the urge.”[15] Most people don’t make it that easy. Yet, the linchpin in deciding whether a mental disorder counts as a commitable condition is precisely that: Could the person control him or herself? If the

opportunity to do something presented itself and the person did not do it, control is evident. But if the person took advantage of the opportunity, how are we to know if he or she *could have* exerted self-control if he or she wanted to? It is the old philosophical question of determinism vs. free will, and as Stone wrote, "The debate never has been resolved by psychiatrists; it is relevant to every question of volition and responsibility."[16]

The ability to control oneself is at the heart of society's definition of illness.[17] As Parsons[18] pointed out, a person is sick if he or she "can't help it." We can't expect the patient to get well by sheer willpower. Even if the person ate fatty foods, didn't exercise, smoked, etc., once he or she got the heart attack, that condition could not be changed by the patient deciding he or she is not sick. While the patient can decide to take measures to help the cure along, the sickness, itself, is beyond the

person's control. And generally, everyone agrees that the person can't wipe out the symptoms merely by choosing not to have them.

Partly this is due to the fact that most sicknesses are obviously biologically driven. There is a bodily derangement, and even if you deny it, the derangement is still there. But mental illness poses tougher problems, because the condition is recognized (diagnosed) by what the person says and does. Usually, there is no obvious bodily derangement to guide us in our thinking about whether the person could exercise control over the behavior.

Could we rely on psychiatric experts to help us determine which people are sick and which are evil? Consider the fiasco in the case of Comer Blocker.[19] Everyone agreed Blocker had a sociopathic personality. Today we call this

condition antisocial personality disorder. He was accused of first-degree murder, and he pled that because of this personality disorder, he was insane. (I couldn't help it; I was sick!) A panel of psychiatrists, including the Drs. Overholser and Duval, a former president and vice-president of the American Psychiatric Association, testified that sociopathy is not a mental illness. The implications of this opinion were that this man was in control of himself and he should be held responsible for his actions. Blocker was found guilty and sent to prison. One month later, in another trial, Dr. Duval testified that sociopathy was, indeed, a mental illness, and the defendant should be treated in a mental hospital. Why the change? There were no new findings about sociopathy. What happened was that the doctors met and decided to change their viewpoint.

Currently, the American Psychiatric

Association skirts this issue. The diagnostic manual doesn't even mention illness. All the diagnoses are called "disorders." Almost all imaginable mental conditions, from schizophrenia to smoking, are included as targets for psychiatric investigation and possible intervention. Some critics have condemned this type of array as "psychiatric imperialism."[20] Kendler doubts we will ever be able to agree on setting the boundaries of conditions which should count as disorders.[21] But the diagnostic manual cautions the reader that inclusion in the book "is not sufficient to establish the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect.'"[22] It wisely takes no position on whether people with these various disorders can control their behavior or not —in other words, whether they should count in any particular legal situation.

But where does that leave the psychiatrist who is on the witness stand? Johnny Blevins had a record of several arrests and convictions—forgery, burglary, assault with a deadly weapon. This time, he'd molested a young girl. Prior to the trial, his attorney sent him for a psychiatric examination. The psychiatrist diagnosed him as suffering from schizophrenia. The jury found him not guilty by reason of insanity, and he was sent to a state hospital.

Once there, all his signs of psychosis disappeared. Johnny bragged about "beating the system" by fooling the evaluating psychiatrist. When records arrived from other sources around the country, the doctors discovered that he had tried this ploy before, but it had never worked. The various doctors who examined him in the past all agreed that Johnny had an antisocial personality disorder—he flouted the law, was an

inveterate liar, had no respect for the rights of others, and was incapable of remorse for his actions.

The doctors in this hospital also diagnosed Johnny as having an antisocial personality disorder, and they added the diagnosis of pedophilia. True to form, Johnny proceeded to drive the staff to distraction. He was manipulative, demanding, threatening when he didn't get his way. He never actually struck anyone, but he did attempt to sequester several of the more vulnerable patients in order to make sexual advances toward them. The staff couldn't be sure whether he ever actually succeeded. Johnny just couldn't be trusted.

In order to beat the system, Johnny had to get out of the hospital. Having been found not guilty, once he was discharged, he would be a free man.

And Johnny knew the law. At the earliest possible time, he filed a petition for discharge, claiming he did not meet the standards for involuntary commitment. He was assigned a lawyer who called me to evaluate him.

After examining Johnny's records and meeting with him, I concurred with the diagnoses of antisocial personality disorder and pedophilia. I discussed the problem with his hospital psychiatrist. We both agreed that if he were discharged, he would likely be a danger to others again. The question was whether he was capable of controlling his actions. True, he had a mental *disorder* according to the diagnostic manual, but did he have a mental *illness*?

In court, I testified that although these disorders are listed in the diagnostic manual, they are not generally considered to be illnesses—or at

least illnesses that meet the commitment standard. I maintained that if this person initially had been brought to the hospital for evaluation, he would have not been committed. This is not the type of person that psychiatrists count as commitable. In fact, in previous evaluations in other states, after being evaluated, he was not hospitalized; he was jailed. He was only in this hospital because he faked his way in. I agreed that if he were discharged, he would quite likely get into trouble again. Even if he were discharged on medication and with the condition that he be followed in a mental health center (mandatory outpatient treatment), he'd be gone in a week. And I was sure that secretly everyone would be happy if he left our jurisdiction and was off our hands. But I never said that in open court.

The hospital psychiatrist took the opposite view. His testimony focused not on the antisocial

traits, but on the pedophilia. He was attempting to treat this "illness" with medication, although he stated that there was not sufficient evidence of the medication's efficacy to merit approval by the Food and Drug Administration for use in such cases. He also focused on the patient's dangerousness. The judge decided that Johnny met the commitment standard and needed to remain in the hospital. Since the hospital psychiatrist said Johnny had a dismal prognosis, he would remain in the hospital for a long, long time. Instead of beating the system, the system beat him.

Of course, as in any case, there were factors other than those expressed in court. I wondered why the prosecutor had not sent Johnny for another evaluation—why she hadn't fought the insanity defense more vigorously. My hunch is that she weighed the possibilities. If he were convicted and sent to jail, he'd have served his sentence and

gotten out. But if he were committed to a hospital, he might languish there indefinitely. Indeed, there is evidence that some of the supporters of the law in Kansas which made pedophilia a commitable condition "had seen it as an opportunity permanently to confine dangerous sex offenders."[23] Not surprisingly, some of these supporters were prosecutors.

Which one of us was correct—the hospital psychiatrist or I? Was Johnny mentally ill? Could he have controlled his behavior? It was a matter of opinion, not science. Perhaps biology could solve the dilemma. In 1962, Diamond, a well-known psychiatrist, wrote, "Within ten years, biochemical and physiological tests will be developed that will demonstrate beyond a reasonable doubt that a substantial number of our worst and most vicious criminal offenders are actually the sickest of all. And if the concept of mental disease and

exculpation from responsibility applies at all, it will apply more appropriately to them. And further, it will apply equally to the vast horde of minor, habitual, aggressive offenders who form the great bulk of the recidivists." He went on to predict that science would force society to realize that these people "who now receive the full, untempered blow of social indignation, ostracism, vengeance, and ritualized judicial murder are sick and helpless victims of psychological and physical disease of mind and brain."[24]

While his timing was off, he may have been half right. In recent years, researchers studying violent juvenile delinquents[25] and adult murderers[26] have turned up intriguing biological findings. Even biological factors in people with antisocial personality disorders are being discovered.[27] Some time in the future, we may, indeed, end up knowing the array of factors (biological and

psychosocial) which can reliably predict criminality.

But what about the other half of Diamond's prediction? Will society treat all these people as mentally ill? Will they tear down the prisons and build more mental hospitals? Will people realize that there is no such a thing as sin, that no one is evil or depraved—that they are only sick and can't help themselves? Will offenders be excused from responsibility for their actions because scientists can confidently explain the causes of their behavior in biological and psychosocial terms? In short, will all illegal behavior be counted as mental illness?

I doubt it. Even if scientists were to decide that all offenders are ill and can't control their behavior, society wouldn't buy it. Society's sense of justice doesn't rest on intellectual formulations;

it rests on emotions.[28] In the case of those who break the law, the decision of what counts as illness basically rests on the tension between outrage and compassion.[29] If the jury (or the legislators) feel more outrage, they will conclude that this type of offender should have been able to exert self control—overcoming the biological and psychosocial factors.

The question of what counts as illness arises in a wide variety of cases. It is central in cases of disability, personal injury, and workers' compensation. If the litigant is impaired because of mental illness, he or she may get a substantial monetary award. If, on the other hand, the judge or jury decides the person could pull him or herself together if he or she really wanted to, there will be no award. Legislators, heads of government agencies, and those who design insurance policies grapple with the issue of just what kind of mental

disorder will count as compensable illness.

Bruce Adams was just about 50 years old when he applied for Social Security disability payments.[30] Although he had been hospitalized on two occasions for treatment of alcoholism, he continued to drink. However, he had stopped drinking about a quart of vodka daily; he now confined himself to six to eight beers a day (or so he said). He was examined by several doctors who found he had emphysema (from smoking) and cirrhosis of the liver caused by his drinking. Neither condition was serious enough to prevent him from working.

While Adams stated that although his condition would improve if he didn't drink and he'd have no problem quitting, he liked to drink. The doctors agreed he had no motivation to change. In fact, one evaluating physician reported

that during the examination, Adams asked him for barbiturates. The prospects for rehabilitation were virtually nil. The question before the Social Security judge was whether this type of alcoholism should count as a sickness; should Adams receive disability payments?

According to the Social Security regulations at the time (1970s),[31] alcoholism could be counted as a disabling condition if it resulted in a permanent damage to some bodily organ. Of course, liver cirrhosis might have filled the bill, but since the regulations also required the claimant to follow the advice of the physicians and Adams was unmotivated, the judge denied Adams's application for payments.

Adams appealed to the Federal District Court. The judge upheld the decision to deny the benefits, stating that although it was "hardly debatable"

that alcoholism is a medical disease, the real reason Adams could not work was that he enjoys drinking. “We are not convinced that simply because Adams wants to continue his drinking habits, this is sufficient to show a disability.”[32] In other words, Adams could choose to stop drinking and follow the doctors’ suggestions that he be rehabilitated, but he doesn’t want to.

Adams took his case to the Circuit Court. Once again, whether Adams’s alcoholism would count depended on the question of his ability to choose a different path. The judges said, “In the case of alcoholism, the emphasis should be placed on whether the claimant is addicted to alcohol and as a consequence *has lost the voluntary ability to control its use”* (emphasis mine).[33] This court felt that the Social Security judges hadn’t faced this issue squarely, and they sent the case back for review. I don’t know what happened in that

review, but I would like to have listened in when the judges grappled with the issue of determinism (sickness) vs. free will (volition).

What usually happens when people are forced to decide the unknowable is that they throw words at it. In my opinion, that's what the Social Security Agency did in 1998 when the new criteria forjudging alcoholism as a disability took effect.[34] In these new regulations, in addition to changes in behavior due to the regular use of alcoholism, the claimant had to have another mental disorder, such as cognitive loss due to brain damage, depression, anxiety disorder, personality disorder or deterioration of the nerves in the arms or legs. And not every personality disorder would count— only those which made the person seem peculiar or impulsive— but not antisocial personality. In fact, in a display of circular reasoning, some of the personality disorders were defined as illnesses by

stating that the behavior must be pathological. It seems to me that the framers merely shifted the dilemma of knowing if someone could control his or her drinking to other sets of behaviors where there might be more agreement that the person can't control the condition. Deciding determinism vs. free will on the basis of common agreement!

The Social Security regulations which tell us which personality disorders will be counted as illnesses do not necessarily apply to other legal situations. Each type of lawsuit may have its own rules; in fact, most of them don't have any guidelines with regards to whether a particular personality disorder counts. This was the issue when I testified about Alice Judson's problem.

Alice was 40 years old when she tripped over a box at work and broke her left arm in the fall. The doctor reset the bone, and healing seemed to

proceed well until the pains started. These were "burning pains" up and down the arm, sometimes accompanied by feeling her arm was too hot or too cold. Sometimes the arm was acutely sensitive to touch; on other occasions, she had less feeling than usual. The orthopedist diagnosed reflex sympathetic dystrophy and sent her to a pain specialist.

Reflex sympathetic dystrophy can occur unpredictably after an injury. It seems to arise because the injured tissue irritates the nerves in the vicinity which then set up a pattern that continues even when the primary injury has healed. "Sympathetic" does not refer to the patient's wanting sympathy (although, as we shall see, that's what the patient may have wanted) but to the sympathetic nervous system which is involved in producing the symptoms.[35]

The pain specialist concurred with the diagnosis. Unfortunately, medication and a series of nerve blocks did not alleviate the symptoms in Alice's case. Her doctor said she was 30 percent disabled and the problem was likely to be permanent. This would entitle her to receive workers' compensation payments. However, the doctor also noticed another problem; Alice had a tendency to cry, not from pain, but from the fact she could no longer do all the things she used to do —gardening, mowing the lawn, craft work, anything involving the use of both hands. Feeling Alice was depressed, the doctor referred her to a psychiatrist.

Dr. King, the psychiatrist, said Alice was suffering from Major Depressive Disorder, and it was in a causal chain from the work injury. He tried a variety of medications over a period of almost a year, but the depression didn't seem to

change much. Alice cried in the office, she expressed wishes that she could die (but she denied she'd ever kill herself), and she was the picture of dejection. Dr. King tried to get her to become more active by doing things that didn't involve her left arm, but she didn't try them. Instead, she just stayed in the house. The doctor attributed this to the lack of interest in anything, which sometimes accompanies a significant depression. He felt she had a 50 percent psychiatric impairment which was likely to be permanent.

The defense attorney asked me to do another evaluation. Through most of the evaluation, Alice supported her left arm with her right hand. She certainly looked downcast, and she cried from time to time, especially when she described how the pain prevented her from doing the things she used to do. Gently, I told her to stop crying so we

could proceed. She carefully placed her left arm in her lap and wiped her eyes with the right. Then she resumed holding the injured arm, and she said, “After I cry it out, I feel better.” She said she used her right hand to steady the left arm because “otherwise it hurts.” This essentially incapacitated both hands for much of the time. She winced when she described her symptoms.

Alice reported she did virtually nothing during the day. Often she spent the day in her nightgown, sitting and thinking or watching television. “But I don’t really watch. I turn it on so the noise keeps me company. I can’t concentrate enough even to remember what’s on.” However, later in the interview, when I asked her what was happening currently in the news, she was able to tell me. When I asked her about meals, she said that her friend, Jean, brought food over. Alice was able to warm things up in the microwave. She had not lost

weight.

It turned out Jean did more than bring food over. Good friend that she was, she cleaned the house twice a week, and she did Alice's banking and kept her accounts. She sometimes spent an afternoon with Alice. Alice told me there was no conversation because she was too depressed to talk, but it was nice to have Jean just sit with her. Jean also took her to her doctor appointments.

Alice's brother was also helpful. Because she was no longer working, he helped her out financially. Sometimes he would come over on a weekend. He'd watch sports on television and she would sit on the couch. "Just to have someone in the house," she said. Other relatives would call to find out how she was, but she never called them. It all sounded very gloomy.

Usually when I go to court, the other witnesses

and I must wait outside the courtroom until it is our turn to testify. In that way, we won't shape our testimony on the basis of what other witnesses say. For some reason, that rule wasn't invoked in this hearing, and I had the opportunity to hear Alice present the same story to the judge. I observed how another woman, presumably Jean, held her lightly as she took the stand, and again jumped up to help her back to her seat when she finished testifying.

When I was called to testify, I said that in my opinion Alice did not have a depressive disorder, although she was unhappy. I went down the criteria one by one. True she felt sad much of the time and showed little interest in things, but her appetite was adequate, her sleep was reasonable except when her arm hurt her, she did not complain of loss of energy. She complained of pain and loss of the use of both hands. Although she

said she couldn't concentrate, she did remember the news she saw on television. She felt no guilt. The wish not to be alive didn't rise to the level of a significant suicide thought. In my view, there were just not enough features of a major depression to support that diagnosis.

The judge asked me if her crying when she testified didn't indicate depression. I told him that many people cry when they feel sorry for themselves. I pointed out that although she claimed not to hold conversations at home, on the witness stand she answered questions quickly and clearly. And she was able to concentrate on the line of questioning.

Alice had adopted the role of a sick person and those around her were supporting that role. She was a very expressive person, and that expressiveness evoked unusual amounts of

sympathy from others. For example, I asked why she needed the other woman to support her when she got on and off the stand. At home alone, clearly she could walk. And why did she need to incapacitate her right hand when the left arm could be supported in a sling?

Alice and those who helped her were locking themselves into a permanent situation, but was she mentally ill? Obviously what she was doing—consciously or unwittingly, I couldn't tell which—was a feature of her personality. I could have even diagnosed a mixed personality disorder, but would it have implied that it was under her control? Could she act differently? Would she act differently if the support of others were withdrawn? Fortunately, I was never asked these questions. My role in the hearing was to speak about the diagnosis Dr. King gave her, not to make a diagnosis of my own. I described only what she

and her associates were doing with each other, and I left it to the judge to decide if that was a psychiatric impairment—illness. The judge decided it was, and he awarded her compensation.

I agree with Stone. Psychiatrists can not tell whether behavior is totally determined by biological and psychological factors (sick) or could be altered if the person wanted to (not sick). It is a dilemma that defies solution. Nothing in our psychiatric training equips us to make that distinction.

Judges and juries solve this problem by using *common* sense. Subtly prompted by outrage or compassion or indifference,[36] they decide that this kind of person should be able to exercise self control while that kind of person can't be expected to do so. And like it or not, that is what psychiatrists do also. But, as I did in the case of the

antisocial Johnny Blevins, we tend to follow the general trend of the way the group of psychiatrists practice, as if that provided us with more knowledge about the determinism-free will dilemma.

However we're supposed to testify on the basis of *uncommon* knowledge, as I noted in Chapter 2. Unfortunately, the laws are written in terms of illnesses rather than disorders, and so we're stuck and we do the best we can. It would be better if the laws were written so that the psychiatrist would know which disorders society wants to count, as the regulators did in the 1998 revision of the Social Security guidelines—and which, I should add, the Kansas legislators did when they decided to count pedophilia. Then, we could describe the behavior and whether it fits with the diagnosis that society, through its legislators, have decided to count. This, to me at least, makes sense because

counting something as illness in a particular legal context is a societal function, not a psychiatric one.

Notes

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2 The cases of Hendricks, Foucha, Blocker, and Adams are accurate as described in the referenced court records.

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31 20 C.F.R. §404, Subpart P Appendix 12.09 (1975)

32 Adams v. Matthews, p. 732

33 Adams v. Weinberger 548 F.2d 239, 244 (1977)

34 20 C.F.R. §404, Subpart P Appendix 12.09 (1998)

35 Calliet R: Soft tissue pain and disability (3rd. ed.). Philadelphia: F. A. Davis, 1996, pp. 46-51

36 Bursten: Beyond psychiatric expertise, pp. 142-166

Chapter 15

Should We Throw Out the Baby?

In the early 1990s, the Council on Psychiatry and Law of the American Psychiatric Association was charged with the task of considering the many criticisms about the quality of psychiatric expert testimony. They reported, “Some criticism, to be sure, is ill-informed, stemming from a misunderstanding of the role of the expert witness in court. Much of it, however, comes from knowledgeable commentators who are disturbed by aspects of psychiatrists’ conduct on the witness stand.”[1] Now, almost ten years later, as I have discussed in this book, the situation hasn’t changed all that much. The reputation of our

profession must still bear the stains of prostitutes, junk scientists, ideologues and others who present distorted testimony. Should we bow to the critics and agree that psychiatric testimony must be excluded from the courtroom?

Of course, the critics present only one side of the story—unfortunately the most dramatic side. There is another side which must be considered. In many legal situations, psychiatric testimony is needed to give the judge or jury information that lay people don't have.[2] Psychiatrists are licensed physicians who must live up to the profession's standards of practice. When a malpractice suit is before the court, only a psychiatrist can testify about whether the defendant deviated from the standard. In cases where a plaintiff alleges he or she was psychiatrically injured—in an accident at work or on the road or elsewhere—a psychiatrist can inform the court about the seriousness of the

injury, what caused it, and whether it is likely to respond to treatment or will be permanent. When a contract or a will is challenged because the person who signed it is alleged to have been so mentally ill at the time that he or she didn't realize the nature of what was being signed, a psychiatrist might be able to throw some light on the person's mental state when the signing took place. When someone is charged with a criminal offense, he or she may plead insanity. A psychiatrist may be able to help the jury understand the defendant's mental state at the time the offense was committed.

All of these needs can be met only if we psychiatrists have a sound basis for our testimony. Psychiatry today is very different from the psychiatry of the early 1960s when I first trained.[3] During those years, psychiatrists were divided by various theories—ideologies, if you will. It was a case of medication *vs.* psychotherapy,

psychoanalysis *vs.* behavior modification *vs.* a "common-sense practical approach" laced with advice-giving. In tune with the spirit of the times, there were those who felt that mental illness was a product of an unjust society and others who thought that if we could just have enough money to treat patients (often called "clients") in the community, we could go a long way toward solving the problem of psychiatric disorders.

However, the past few decades have seen an explosion of empirical research. Ideologies still exist, and speculative theories still find their way into testimony, but the scene is changing. The newer technological tools, such as imaging of the brain, biochemical and genetic studies, and epidemiological research are replacing untested and untestable theories. Diagnostic categories are being refined so that there can be greater agreement about the condition of the person being

evaluated. Researchers are studying the efficacy of various treatments and are producing data to help us gauge the likelihood of our patients' improvement. With the prospect of better understanding the way our biology interacts with the environment, we can expect the empirical basis of psychiatry to expand at an ever-increasing pace.[4] Like every other field of medicine, there is a long way to go, but psychiatry has covered a great deal of ground in the last quarter century. We can meet the Daubert standard of a scientific basis for our testimony—to a reasonable degree of medical certainty.

So here we are: Do we get rid of psychiatric testimony because of the multiple opportunities for distortion and instances of abuse of the privilege of testifying as an expert witness? And if we do, are we not also depriving the justice system of the possibility of gaining sound and specialized

information where it is needed? Should we throw out the baby with the bath water?

In my opinion, we should not. As Weiner stated, "To suggest that the possibility that some will prostitute the profession is a reason not to become involved in the courtroom setting is analogous to suggesting that because some psychiatrists have sex with their patients we should never trust any psychiatrist to be alone with a patient."[5]

This leads to the next question: Can we improve the performance of those who wittingly or unwittingly distort their testimony? There are several possible approaches: training in evaluation of research, training in the legal issues, mentoring, and peer review. All of these have their virtues and their limitations.

The problem of junk science might be

confronted by teaching psy- chiatrists-in-training to distinguish between good research and poor, and to know how to draw a valid inference from the research findings as they apply to the legal case at hand. Would it help if psychiatrists were trained in statistics and research evaluation during their residency period? Perhaps so, but maybe not. Clinical psychologists study statistics and do research in order to get their Ph.D. degrees. However, when on the witness stand, they, too, may purvey junk science based on unvalidated information.

Another approach might be to educate psychiatrists-in-training about a few basic legal principles of testimony, such as the meaning of "reasonable degree of medical certainty," or the undesirability of speculation. They might be exposed to how the special requirements of expert testimony differ from those of lay witness

testimony, as described in Chapter 2. However, we must heed Stone's warning not to produce quasi lawyers.[6] When we testify, we are psychiatrists operating in someone else's field. It is important to know the layout of that field, but it is more important to be knowledgeable about the substance of our testimony—the *psychiatric* opinion and the data on which it is based.

Stone has raised a cogent concern about those who specialize in forensic psychiatry (and I am one of them). He fears that as such specialists get more involved with learning about the legal aspects, they may lose touch with psychiatry—which, after all, is what we testify about.[7] In 1984, he pointed out how those who testify are tempted to bend their ethics when they are "cajoled by the lawyers, dazzled by the media spotlight, and paid more than Blue Cross and Blue Shield allows."[8] Today, managed care pays even less, and I see

more and more psychiatrists opting for the more lucrative and less managed field of forensic psychiatry. Perhaps five or more years as a practicing psychiatrist (after residency) should precede admission into forensic training programs. And the forensic psychiatrist should continue to have some activity which brings him or her into ongoing contact with clinical psychiatry. Continuing educational activities should be heavily weighted toward psychiatric rather then forensic subjects. We should be psychiatrists first and forensic second. However, most of the depositions I review are given by clinical rather than forensic psychiatrists. And there's still plenty of junk science.

Two types of consultation could be available to colleagues who become involved with legal testimony: mentoring and peer review. Mentoring is a consultation to help prepare the testimony.

Peer review is an educational experience which goes over testimony that has already been presented in court.

Mentoring presents special problems involving confidentiality. The psychiatrist who will be a witness in the case has access to information about the litigant which is not yet a matter of public record. He or she does not have the right to disclose to the mentor details of the case which could lead to the identification of the litigant. However, if the mentor makes the issue of confidentiality clear (already an educational process), the consultant can discuss the *type* of case—workers' compensation, insanity defense, etc.—and orient the witness to the relevant legal issues. The mentor can point out potential pitfalls, such as role conflicts and testimony based on speculation or ideology. The potential witness can be directed to printed sources of information

relevant to the particular type of case, such as those reported in a recent issue of *Psychiatric Clinics of North America.*[9] Even psychiatric aspects of the case can be discussed, so long as the discussion is general and no identifying information is given. I have sought such consultation from colleagues on quite a few occasions. For example, one litigant was diagnosed by another doctor as suffering from brain damage. However, the behavior he exhibited didn't fit well with my understanding of what brain damage can do. After reviewing several articles on the subject, I became convinced that the diagnosis was incorrect. Without mentioning any names, I described the behavior to a colleague who suggested that the symptoms fit better with a diagnosis of anxiety. He recommended some articles I might read. My mentor would have no way of knowing whom I was talking about unless

the case came to trial, in which case the information would be in the public domain. All of us can use such consultation from time to time.

Of course, not all who undertake the mentoring will benefit from it. Years ago, I was approached by a young colleague whose patient claimed to have been sexually harassed on the job. My colleague was about to be to be deposed by the company's lawyers. We spent approximately two hours together going over the parameters of testimony in such a case. I told her about the pitfalls of a treating psychiatrist on the witness stand. We discussed the fact that while her patient said she was harassed, the doctor could not state definitively that the harassment took place. We went over the patient's current psychiatric symptoms, and while we could connect them to harassment if it did occur, the psychiatric injury was modest. I directed her to some papers

describing womens reactions to sexual harassment in the workplace.

After the deposition, the colleague phoned to thank me for my help. She was exuberant, but much of what she told me was contrary to what we had discussed. She'd told the lawyers that she knew her patient well and that her patient wouldn't lie. And because of the harassment, her patient's condition had deteriorated significantly. My colleague must have thought she was being gracious when she thanked me for helping her patient! Even with mentoring, all the knowledge in the world may fall prey to the role conflicts described in Chapter 13.

Peer review comes after the testimony has been given. Since the information about the litigant is now in the public domain, confidentiality is not an issue. A task force of the American

Psychiatric Association has developed a resource document outlining guidelines which a peer review committee could follow when discussing the testimony with the psychiatric witness.[10] The American Academy of Psychiatry and the Law has set up such peer review sessions twice yearly, but it does not seem that at this point there are widespread opportunities for such review.[11]

Both mentoring and the peer review process are limited by the fact that those who testify must volunteer to take advantage of such education. Not all witnesses have a sincere desire to seek the educational benefits. Prostitutes won't bother with this process. Ideologues will argue with the reviewers. Hangmen will avoid review like the plague. Well- intentioned prevaricators can always justify their opinions. However, peer review could be helpful to those who wish to improve their skills as witnesses.

While we can expect continued progress in the establishment of an empirical research base for our opinions in court, and we can take steps to improve the competence of those psychiatrists who testify, we will always have an imperfect system. But then, litigation and trials are also an imperfect system. Remember, the courtroom is an arena of persuasion, not of truth. Lay witnesses may lie, jurors may be biased, judges may nod off during the proceedings, attorneys often seek strategic advantages in their legal combat in order to mislead the jury.

Why does society put up with all that? Because society needs a mechanism, however imperfect, to settle disputes. And by the same token, often the court needs the specialized information psychiatrists can give—with all the warts and all the beauty marks that come with expert testimony — to help resolve the dispute being litigated.

Stone has also expressed concern that the adversarial legal process nudges the forensic psychiatrist to try to view the proposed testimony in terms of the needs of the referring attorney instead of what the psychiatric data show.[12] There is always the temptation to keep one's eye on the attorney instead of on the psychiatric issue. This is the double-agent conflict discussed in Chapter 13. In my view we can be a consultant to the attorney so long as we realize our first allegiance is to the court and we continue to assert the independence of our opinions.

The adversarial legal process is a fact of life, and so long as psychiatrists participate in it (and I believe we should), we must accept it and try not to be swept away by it. And what is the alternative? Will the court hire one impartial expert to speak for the profession? Where will we find the "impartial expert" who satisfies everyone?

No, the saving grace of the adversary system is that sometimes—only sometimes—distorted testimony can be rebutted by the presentation of sound testimony to a reasonable degree of medical certainty. And that's all we can ask for in an imperfect world. We must not shoot for utopia, because every time we do we end up with unintended consequences.

Notes

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