

COMPETENCE AND INSANITY

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1. Are competence and insanity purely medical concepts?

No. In common usage they are considered legal concepts, because they represent specific judgments made by the courts. However, they also can be regarded as distinct medicolegal concepts. Although clinical data contribute to the determination of both competence and insanity, the determination also requires a knowledge of relevant statutes as well as a comprehensive analysis of both subjective and objective data. Such a deep level of analysis is not normally a part of clinical evaluation. Indeed, the standards for determining competence or insanity are multidimensional and somewhat case-specific. Relevant factors include:

- Applicable laws in the governing jurisdiction (e.g., “insanity” involves judgment of lack of criminal responsibility based on particular standard specified by statute)
- The act or decision for which a person is to be judged competent or incompetent, sane or insane
- Contextual factors defining the meaning of the act for that person at a particular place and time.

Basic Terminology Used in Determinations of Competence or Insanity

Burden of proof: The obligation in court of the moving party to demonstrate the existence of certain facts or to suffer loss of the proceeding.

Competence: The legal recognition of an individual’s ability to perform a task. The concept is not applied globally. Rather, it is directed at a specific category of demands.

Deposition: A form of legal discovery in civil proceedings in which the litigants may question potential witnesses under oath to discover the testimony that they are likely to present at trial.

Diminished capacity: The response of a criminal defendant requesting to be partially excused from mis-conduct on the basis of mental condition.

Expert witness: An individual permitted to present opinion in court on matters of fact that are beyond the expertise of ordinary citizens.

Imperfect self-defense: The response of a criminal defendant requesting to be excused for misconduct on the basis of a mental state of self-defense which is itself substantially influenced by a mental disorder or defect.

Informed consent: Authorization by a person who is free from coercion or undue influence, who has been given adequate information on the decision to be made, and who has the capacity to understand the information disclosed.

Insanity defense: The response of a criminal defendant requesting to be [entirely] excused for misconduct on the basis of mental condition.

Jurisdiction: The scope of a specific court’s authority. A court’s decision in a particular case sets precedent for all similar cases arising within the court’s geographic boundaries.

Standard of proof: The degree of probability to which factual assertions must be proven to allow a moving party to prevail in litigation.

Adapted from Group for the Advancement of Psychiatry, Committee on Psychiatry and Law: The Mental Health Professional and the Legal System (Report No. 131). New York, Brunner/Mazel, 1991, pp 181–186, with permission.

2. Do clinicians make determinations of competence and insanity?

No. Determinations of competence and insanity are made by the courts with the help of assessments by qualified professionals. Ordinarily, such assessments should not be made by a clinician who is treating the person to be evaluated.

3. What professional guidelines apply to combining the roles of treater and evaluator?

The following excerpts from the ethical guidelines of the American Academy of Psychiatry and the Law (AAPL) make clear that an attempt to combine the roles of treater and evaluator involves the clinician in both a **clash of perspectives** and a **conflict of interest**.

... the psychiatrist should inform the evaluatee that although he is a psychiatrist, he is not the evaluatee’s “doctor”... There is a continuing obligation to be sensitive to the fact that although a warning has been given, there may be slippage and a treatment relationship may develop in the mind of the examinee.

A treating psychiatrist should generally avoid agreeing to be an expert witness or to perform an evaluation of his patient for legal purposes because a forensic evaluation usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship.

4. Discuss the rationale behind the AAPL guidelines.

The reasons for avoiding duality of roles are evident. On the one hand, the empathic, subjective stance that the clinician takes to relieve the patient’s suffering and to promote growth is largely incompatible with objective evaluation. On the other hand, the distancing required to perform an objective evaluation, not to mention the loss of confidentiality, tends to undermine the therapeutic alliance. Therefore, when the treating clinician is asked to perform an evaluation for the

court, the appropriate response is to refer the patient for a forensic psychiatric evaluation. Likewise, when a forensic evaluation lapses into a treatment relationship despite one's best efforts to the contrary, the wisest response is to refer the patient for further forensic evaluation, especially if the plan is to continue treatment.

5. What is competence—or more accurately, what are competencies?

In **general application**, competence is understood to be the mental soundness necessary to carry out certain legally defined acts. A person is presumed competent unless it is shown that a mental disease or defect impairs his or her ability to understand the nature or consequences of the act in question. Competence is a matter of degree, but for most legal purposes it is the minimal rather than maximal standard of competence that must be met.

Moving beyond general descriptions of the elements of competence (e.g., “understanding of available choices, capacity to make those choices, and freedom from undue influence”) to specific **medicolegal applications**, the term has no single definition. Competence is selective and compartmentalized and must be assessed in relation to the decision or act in question: “Competent to do what, and in what context?” Thus, rather than focusing on a single, global competence, ask: “Which are the relevant competencies?” This specification is especially important in assessing the responsibility of organizations for negligent referral and treatment (*Klein v. Solomon and Brown University*, Supreme Court of Rhode Island, 1998) and is pertinent to the increasing trend for the courts to hold managed-care organizations responsible for such deviations.

6. Is the medicolegal application of competence complex?

Yes. Given the many factors that affect competence, the evaluator who goes beyond global assessments often finds that some capacities are impaired, but others are not. The evaluator must be alert for subtle, fluctuating signs of incompetence.

7. Distinguish between determination of competence and assessment of criminal responsibility.

Determination of competence in civil law means the individual is able to give (or withhold) informed consent to medical treatment and make contracts and wills. In criminal law, psychiatrists are asked to assess a defendant's competence to stand trial, confess, waive Miranda rights, or act as his or her own attorney. Psychiatrists also may act as consultants to probation officers or the courts for presentencing and in preparation of probation reports. A psychiatrist is asked to evaluate other areas of competence only on rare occasions: for example, an often neglected question is the defendant's competence to accept a plea bargain. A psychiatrist performing a competence evaluation must ask the attorney to specify which area of competence is in question.

Assessment of criminal responsibility (which may hinge on a determination of sanity or insanity) is different in kind from what is normally referred to as assessment of competence. When a question of diminished capacity arises in relation to criminal responsibility, it refers to a distinct set of faculties

such as formation of the intent to commit a particular act, appreciation of moral or legal wrongfulness, or ability to conform one's behavior to the requirements of law.

Questions of competence and criminal responsibility are treated separately in this chapter, as they are in everyday usage. However, the deep connection between the two (i.e., that lack of criminal responsibility by reason of insanity presupposes a generally or specifically disabled and, in some particular sense, incompetent mental state) must be understood.

8. How has the definition of competence evolved?

Classically, competence was defined mainly in terms of **cognitive awareness**. In 1960, in *Dusky v. U.S.*, the U.S. Supreme Court took this conception to its limit, and perhaps beyond, when it defined competence as “not only a factual but a rational understanding.”

As understanding of human psychology deepened, psychiatrists also took into account an **affective dimension**. That is, various impairments characterized by overwhelming affect, while not leading to psychosis, may restrict a person's sense of choice or hope for the future. Such conditions include full-fledged post-traumatic stress disorder as well as more subtle but nonetheless real syndromes of trauma response (e.g., pathologic grief and survivor guilt; see Question 12).

9. Distinguish between intrapsychic and interpersonal dimensions of competence.

The intrapsychic dimensions often are addressed first. Thus a forensic evaluation includes a mental status examination (both formal and informal) to look at the person's biologic and intrapsychic integrity, searching for disorders of cognition (e.g., delusions), affect (e.g., hopelessness), or volition (e.g., impulse disinhibition) that may constrain the relevant judgment or behavior. However, a person's competence to consent to treatment cannot be fully assessed without also considering his or her functioning in the interpersonal realm of relationships with the caregivers involved (see Questions 10–14). In the case of testamentary capacity (the competence required to make a last will and testament), interpersonal relationships are even more central to the assessment (see Question 17). Likewise, a person's state of mind at the time of committing a criminal act is often contingent on the interpersonal context, including the perpetrator's perception of self, the victim, and their relationship, as well as the *actual* relationship.

10. What is competence to give informed consent to treatment?

Competent, informed consent consists of three elements: **decision-making capacity**, **requisite information**, and **voluntariness**. Although all three elements usually are viewed as individual assessments, they are also a function of the patient-clinician relationship. The fact that information has been given does not mean that it has been received or retained. For example, information may be conveyed in an overbearing way or may be incomprehensible to a patient who is more visually than verbally oriented. Voluntariness may be compromised by coercive pressures, whether from clinicians who believe that they know what is best for the

patient or from an institutional culture that promotes cost-containment. Such deficits in information or voluntariness may overwhelm the patient's decision-making capacity.

Informed consent, therefore, is not a pro forma response to a checklist; rather, it is a **process of mutual engagement in decision making**. Thus, the competence to give informed consent includes the capacity to engage in a dialogue about benefits and risks and to apply the discussion meaningfully to one's present situation. This capacity may be either enhanced or diminished by the manner in which clinicians carry out their side of the dialogue (*Meador v. Stahler and Gheridian*, Mass., 1993).

11. When is a psychiatrist likely to be consulted about a patient's competence to give informed consent?

Consultations on competent, informed consent are requested in several types of situations. Two common ones are: when a general healthcare professional has a patient who refuses medical treatment, and when a mental health professional has a patient who refuses further psychiatric treatment.

12. Describe common pitfalls in the assessment of a patient's competence to give informed consent.

A common bias of clinicians is to obtain a consultation only when the patient refuses treatment, not when the patient agrees to treatment. Note that in terms of risk management as well as the patient's best interest, incompetent consent can be as much an issue as incompetent refusal. When a question of competent consent arises, a forensic psychiatric consultation is helpful.

It is also a mistake to try to assess competence to consent to treatment globally rather than in relation to the specific circumstances of treatment. Competence to consent to treatment, like competence in general, is not an indivisible concept. A patient may be competent to consent to treatment in most circumstances, but not to a particular kind of treatment or to treatment offered by a particular clinician.

For example, a man in severe congestive heart failure secondary to a surgically correctable cardiac condition refused surgery—despite his ability to recite the risks and benefits of the recommended operation. The patient revealed to the consulting psychiatrist that his wife had died 15 years earlier after what had been considered a minor, low-risk operation. The psychiatric consultation gave the patient an opportunity to work through the unresolved grief that impaired his competence to consent. Subsequently he consented and after surgery was grateful that his treating team did not “quit” on him, despite his initial refusal. He described the effect of the psychiatric consultation as “lifting a dark veil.”

13. Is assessment of competence affected by the examiner-examinee relationship and the circumstances of the examination?

Yes. Assessment of a patient's capacity to give informed consent may be biased by unrecognized fluctuations in competence resulting from the setting, time of day, variable medication, side effects, rapid changes in pathophysiology, or other factors. The examination may be performed when

the patient is at his or her worst or best. Furthermore, a person may be found falsely competent due to overidentification by the examiner, or falsely incompetent due to projection of the examiner's own despair. A breakdown in communication also can occur: for example, a patient who is frightened and not fluent in the examiner's language may respond with greater understanding to a visual model of the heart than to a strictly verbal description of a coronary bypass graft.

14. What other factors can affect assessment of competence?

Medication side effects should not be overlooked as potentially treatable causes of impaired competence. For example, benzodiazepines have a negative effect on memory and can tip even non-Alzheimer's patients into a state of dementia that impairs competence.

Likewise, a patient who reasonably feels he or she has no choice but to accept managed health care's determination of benefits is being coerced and therefore is not giving informed consent. Even in the absence of overt coercion, an atmosphere of pessimism among hospital staff (exacerbated as it may be by managed-care restrictions) may subtly constrain patients' and families' sense of the range of alternatives they are able or even willing to consider. That is, people may disavow what they might actually want if they are conditioned to believe they cannot have it or should not ask for it. Elderly, chronically ill patients and patients of any age with socially stigmatized, chronic illnesses (e.g., AIDS, alcoholism, schizophrenia) are especially vulnerable to such demoralizing influences.

Thus, competence should be assessed in subjective as well as objective terms, in affective as well as cognitive terms, and as a function of the interpersonal and institutional environment as well as individual characteristics.

15. How are questions of patient competence raised in cases of alleged patient-clinician sexual contact?

It is now rare to hear the argument that a patient has given informed consent to sexual contact with a clinician as part of treatment. Not so unusual is the argument that the patient has consented independently to treatment and to concurrent or subsequent sexual contact. The issue, then, is whether the patient is competent to consent to what may be self-destructive physical intimacy with the treating clinician outside of treatment.

Note that when the patient does not have the option of seeing a different doctor or obtaining treatment from another organization, because of managed-care referral, the helplessness and horror the patient experiences and the resulting impairment of competence are magnified.

Questions of consent and of competence to consent often enter implicitly into civil litigation. The degree of damage, as suffered by the plaintiff or as perceived by a jury, often hinges on how competent and active the plaintiff was in initiating and maintaining the alleged sexual relationship. In addressing such questions, a thorough forensic evaluation of the plaintiff must recognize the complex interactions between character defenses and trauma in remembering and communicating.

16. What part does competence play in assessing the risk of suicide or violence?

Clinicians are asked to make decisions involving dangerousness to self or others in various contexts, including involuntary commitment and restriction of freedom during hospitalization. In such decisions, competence is an implicit if not explicit consideration. It becomes explicit in states where the criteria for involuntary commitment (in the presence of mental illness) include the ability to care for oneself as well as dangerousness to self or others. The decision-making process that leads to commitment is thus analogous to the seeking of guardianship on the basis of incompetence to give or withhold informed consent to treatment.

An often neglected and yet essential aspect of the assessment of potential violence is the assessment of the patient's competence to engage in a dialogue with the clinician concerning potential harm to self or others and measures to prevent it. Dangerousness in itself is so salient to clinicians that the equally important question of the patient's capacity to participate responsibly in monitoring his or her dangerousness tends to pale by comparison. The model of dangerousness presented below, in which competence appears as one dimension, illustrates a mindset useful in many areas of clinical decision making, such as addressing the multidimensional complexity of competence itself.

In cases where violence is both foreseeable and preventable, the problem generally is not one of insufficient legal authority to commit, but of inadequate training, poor professional judgement, or limited resources to carry out such a complex assessment.

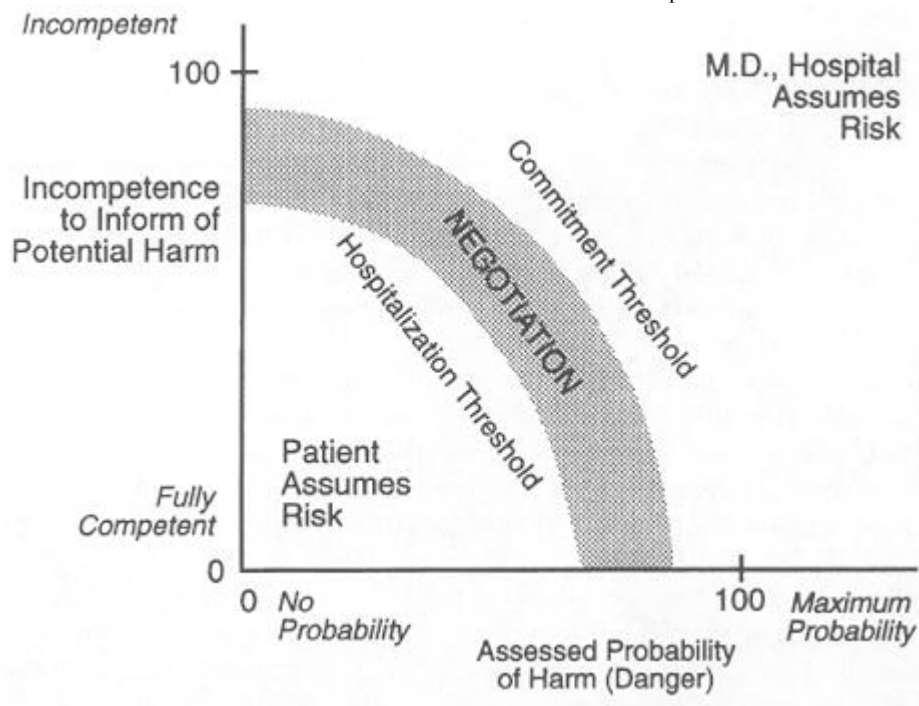


Figure Multidimensional assessment of dangerousness in relation to competence to inform. (From Gutheil TG, Bursztajn HJ, Brodsky A: *The multidimensional assessment of dangerousness: Competence assessment in patient care and liability prevention*. *Bull Am Acad Psychiatry Law* 14:123–129, 1986; with permission.)

17. Describe testamentary capacity.

Testamentary capacity is customarily considered the lowest level of competence. Even someone who has a guardian of person may have testamentary capacity, despite a rebuttable presumption that she does not. Making a will is considered to require a lesser degree of competence than entering into a contract, for example, in which case an adverse party seeks an advantageous position. However, clinicians who work with family dynamics may well find an adversarial relationship between the testator and another party or between two parties contending for the inheritance (in which case the testator must act as judge).

18. How do the principles of competence assessment apply to evaluating a last will and testament for testamentary capacity?

Familiarity with state statutes and case law is essential for framing the questions to be answered in the forensic psychiatric evaluation of testamentary capacity. Such questions emphasize functional as opposed to diagnostic considerations. For example, the Supreme Judicial Court of Massachusetts, in *Goddard v. Dupree* (1948), defined testamentary capacity as follows:

Testamentary capacity requires ability on the part of the testator to understand and carry in mind, in a general way, the nature and situation of his property and his relations to those persons who would naturally have some claim to his remembrance. It requires freedom from delusion which is the effect of disease or weakness and which might influence the disposition of his property. And it requires ability at the time of execution of the alleged will to comprehend the nature of the act of making a will.

Thus, contrary to the all-too-common stigmatization of the mentally ill, a person with schizophrenia cannot be assumed to lack testamentary capacity unless at least one of these specified functions is impaired. In this as in other areas, diagnosis does not by itself determine competence. At the same time, the evaluator must consider numerous possible sources of functional impairment. Often overlooked are impairments resulting from chronic, partially concealed alcohol use, early-onset organic brain syndromes, or drugs, especially pain-relieving drugs such as morphine, that may have subtle but real euphoric and/or dysphoric effects that alter judgment in relatively low dosages (by *Physician's Desk Reference* standards).

19. What kind of confusion may arise for the clinician addressing testamentary capacity?

With respect to testamentary capacity, as with other forms of competence, the treating clinician should refer the patient to someone in a position to make an objective evaluation. Especially when deathbed revisions of a will are at issue, the treating clinician's proper concern with relieving the patient's suffering precludes such objectivity. The clinician may confuse competence to consent to treatment with competence to dispose of property, each of which must be assessed independently. A treating clinician may either overestimate or underestimate the deceased person's testamentary capacity. Overestimation may occur if the clinician feels threatened by virtue of having already honored the person's acceptance or refusal of treatment, whereas underestimation may occur if the clinician's most salient memories are of the person in a confused rather than coherent state.

20. Is competence to stand trial equivalent to criminal responsibility?

No. The two assessments have different tests, different time contexts, and different purposes. A person is considered competent to stand trial if he or she understands the nature of the charges and is able to cooperate with counsel. The assessment of competence to stand trial is a **present-state** examination, whereas determination of criminal responsibility is **retrospective** and pertains to the person's culpability at the time of the alleged act. Although the criteria for culpability (see Question 26) represent a kind of competence at a deep-structural level, the two determinations are entirely separate matters in everyday practice.

Competence to stand trial usually is considered (subject to jurisdictional variations) the lowest level of competence in the criminal realm, because it is seen to require only a minimum of psychological functioning. However, notwithstanding the understandable desire to have defendants stand trial in a speedy, cost-effective way, the question of whether severely impaired clients have the capacity to assist counsel must be assessed on a case-by-case basis.

21. Should a clinician be trained in forensic psychiatry to determine competence to stand trial?

Yes. When clinicians untrained in forensic psychiatry become involved in competence determinations, essential distinctions may be lost. For example, in a prominent murder case (*New Hampshire v. Colbert*, 1992), the suspect was taken to a hospital emergency department. The clinician's finding that the alleged perpetrator was competent to consent to medical treatment was later equated in the courtroom with the suspect's state of mind at the time of the killings. Such extrapolations are clearly unfounded and unreliable. Moreover, when made by the treating clinician in courtroom testimony, they may be both unethical, because they involve a betrayal of the treatment relationship, and prejudicial, insofar as they unduly influence the jury by creating the impression that the accused must be guilty if the treating clinician is willing to testify against his or her own patient.

Of course, the clinician also should be trained to recognize medical conditions that can affect competence.

22. What other issues surround clinician testimony?

Offering testimony over an imprisoned ex-patient's objection may be considered a violation of professional ethics codes—from that of the American Medical Association to the Hippocratic Oath and the Nuremberg Code—governing duties toward captive patients.

Of course, the clinician whose testimony is compelled by court order must conform to the requirements of the law, but the clinician should clarify (through prior notification) the limits of his or her testimony. The treating clinician can testify only to fact: the primary focus on alleviating the patient's suffering precludes an objective, expert opinion. A referral to colleagues qualified to render an objective opinion may be helpful. Given such prior notification, the court usually is satisfied simply to receive the medical records in lieu of testimony.

23. Why should a person's competence to confess be assessed?

Competence to confess may be vitiated by mental disabilities produced by disorders such as psychotic depression, post-traumatic stress disorder, schizotypal personality, obsessive-compulsive disorder, and organic brain syndromes. After hours of hostile questioning, a person who is cognitively competent but made vulnerable by a major mental illness (e.g., schizophrenia, major depression) may come to "remember" committing a crime that he or she did not, in fact, commit. In Florida, for example, a schizophrenic man spent 9 years in prison for a double murder to which he had falsely confessed. False confessions typically are elicited by coercion and subsequent fear, combined with a conscious or unconscious need to be punished. False confessions also may result from false memory syndrome.

24. Define false memory syndrome.

False memory syndrome often is engendered by overzealous clinicians who cross the boundary between clinical assessment and forensic evaluation—for example, in allegations of child sexual abuse during custody proceedings.

Patients who suffer from immature defenses such as hypochondriasis, conversion hysteria (somatization), splitting (dividing people into saints and sinners), and projection (misattributing to others all personal feelings that are unacceptable to oneself) are especially vulnerable to suggestion by the treating clinician. Such patients often attempt to figure out and then conform to the working hypothesis used by the treating clinician to guide treatment.

Memories—whether reported to a therapist, an attorney, or a courtroom—cannot be accepted as accurate without a careful forensic evaluation of their reliability. People in a state of emotional distress readily remember events that did not occur or forget events that did occur. The pressure to repress traumatic memories or to re-establish control by filling in the gaps in memory is too great for reported memories to be taken at face value. Reported memories may be accurate in general outline but inaccurate in detail or vice versa. They may be further distorted by suggestion and even coaching (by therapists, family members, attorneys, or law enforcement personnel) as well as by a need to maintain a close personal attachment by confirming the other person's construction of past events.

25. What other factors may affect memory?

The possibility of deliberate falsification of memory must be considered. The malingering offender who has not been treated is usually more transparent than the one who has had a chance to practice his or her act during treatment. For example, the forensic psychiatric examiner's finding of multiple personality disorder in an untreated examinee may be *prima facie* more valid than the same finding in a treated examinee. In addition to possible faking, malingering, or exaggerating, the examiner must consider impairments of memory resulting from displacement (to maintain psychic equilibrium), projection (to maintain self-esteem), or the effects of organic conditions, drugs, or personality disorders.

26. What is criminal responsibility in relation to the insanity defense?

State statutes may apply some variation of the following historical standards to establish criminal responsibility:

- The *M' Naghten* rule excuses a defendant who, by virtue of a defect of reason or disease of the mind, does not know the nature and quality of the act or that the act is wrong.
- The *Durham* rule excuses a defendant whose conduct is the product of mental disease or defect.
- The **American Law Institute test** excuses a defendant who, because of a mental disease or defect, lacks substantial capacity to appreciate the criminality (wrongfulness) of his or her conduct or to conform his or her conduct to the requirements of the law.
- The **Federal Insanity Defense Reform Act** of 1984 excuses a defendant who, "as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts."

Of these tests, the *Durham* rule is broadest in application, the *M' Naghten* rule narrowest. The permissive *Durham* rule, although important historically, is now used only in New

Hampshire and the Virgin Islands and is generally referred to as the "product of mental illness" test. The American Law Institute test represents an effort to find a middle ground by adding the element of volition to the cognitive standard established by the *M' Naghten* rule. The Federal Insanity Defense Reform Act, by removing the volitional element, essentially reverts to the *M' Naghten* standard. However, although specifying that the mental illness must be "severe," it retains the ALI's term "appreciate," thus allowing the primarily cognitive test to be interpreted as including an affective component.

27. How valid is the public concern that the insanity defense lets dangerous criminals go free?

Especially in the highly publicized cases like that of presidential assailant John Hinckley, the insanity defense is used by its critics as a symbol of the failings of the criminal justice system. However, it is not a cause of such failings. In an eight-state review, the insanity defense was used in only 1% of felony cases and was successful in only 25% of those cases. Indeed, from the point of view of public safety, it may be more effective to treat perpetrators in secure psychiatric facilities than to put them in prison, where they do not have the benefit of treatment and tend to return to the street sooner. In addition, they may become victims of predatory career criminals and/or (because they often are easily impressionable) imitate them. The high rates of recidivism among previously incarcerated offenders offer little comfort to critics who would abolish the insanity defense.

The reality is that, partly because of the widespread fear (promoted by sensationalistic journalism) of letting vicious criminals go free, the insanity defense is rarely successful in contested cases. Emotionally evocative characteristics of both victims and perpetrators reduce the likelihood that an insanity defense will be considered nonprejudicially. The Hinckley verdict was the exception, not the rule.

28. What other factors contribute to the difficulty in persuading juries to accept the insanity defense?

Insanity pleas are more frequently agreed upon by the prosecution and defense than contested. Largely out of public view, a stipulated "not guilty by reason of insanity" (NGRI) verdict is reached in many cases (more than 80% in one Oregon study) in which the question of sanity is raised. In other cases experts from the two sides agree that the defendant does not meet the jurisdiction's standard of insanity. In the small proportion of cases that actually go to trial—relatively well-publicized cases in which the experts disagree—the popular **stereotype of psychiatry as unscientific** is reinforced. Ironically, the fact that most cases do *not* go to trial (because of the high interrelater reliability with which most psychiatric diagnoses are made) leaves juries with the impression that psychiatrists always disagree. With this impression as a baseline and with two experts in front of them who disagree, jurors naturally tend to disbelieve the field as a whole and deliver a guilty verdict.

Besides having to overcome popular **stereotypes of mental illness** as either fiction or the paradigm of the incoherent "madman," the defense expert faces other difficulties. Prosecution experts characterize complex acts such as concealment as evidence of rational behavior, even when a deeper analysis reveals that such concealment is regressive behavior driven by psychosis. Moreover, defense experts

often are hampered by **limited funds**, which make it difficult to budget both a comprehensive forensic evaluation and the time needed for preparation of testimony to rebut a prosecution expert's negative findings. Finally, **gender- and relationship-specific stereotypes**, which predispose juries to deliver NGR1 verdicts for women who kill their children or for children who kill their parents, result in guilty verdicts for men who kill.

29. What is diminished capacity?

There are two kinds of diminished capacity:

1. An element of the charged crime is negated by showing that the defendant lacked the requisite mental state to be found guilty of the crime as charged. This defense, when successful, usually results in a conviction on a lesser charge rather than outright acquittal. For example, a person found to have lacked the mental state necessary to commit first-degree murder (i.e., premeditation) may be convicted of second-degree murder. For a person found to have lacked the intent to kill, the charge may be reduced to involuntary manslaughter.
2. A partial insanity defense that is not concerned with whether the defendant entertained a particular mental state is mounted. It addresses why and how the defendant was in a state of mind that precluded full responsibility for his or her actions. Again, reduction of charges is more likely than dismissal. This variant of diminished capacity resembles the insanity defense in that it provides a basis for extenuation (albeit a controversial one), even if all the elements of the charged crime have been proved. It often centers on impaired decision making resulting from post-traumatic stress disorder and its numerous offshoots, such as battered woman syndrome. It raises the question of both intrapsychic and interpersonal capacity. Typically, a person in an oppressive relationship believes options are limited. For example, a battered woman who kills her abusive partner may argue that sustained abuse left her feeling that "she had no other choice."

30. How is the claim of diminished capacity used?

In the current climate, the claim of diminished capacity is more likely to lead to just dispute resolution than the insanity defense. Given the limited applicability of the insanity defense and the odds against it prevailing in court, diminished capacity is used with increasing frequency as a flexible (if partial) alternative, filling the need for some assessment of a defendant's mental state as a factor in criminal responsibility.

Diminished capacity also is taken into account in the application of the new federal sentencing guidelines, which, after guilt has been determined, allow departure from otherwise mandated sentences if diminished capacity can be shown. Some states—for example, New Jersey—also have adopted this approach to sentencing.

31. Do considerations of diminished capacity form the basis for a claim of imperfect self-defense?

Imperfect self-defense is a prime example of the second variant of diminished capacity. To support a claim of imperfect self-defense, data about the defendant's state of mind at the time of the alleged crime must include the perception that the act was an act of self-defense. For example, a Vietnam war veteran who hears a truck backfire while he is arguing with another driver after a traffic accident may react as if he were under fire. Such a "false-alarm syndrome" may constitute the basis of an imperfect self-defense claim.

32. Are conditions such as battered-woman syndrome, rape trauma syndrome, child sexual abuse accommodation syndrome, and patient-therapist sex syndrome now recognized as legitimate bases for a defense of diminished capacity?

Expert testimony about battered-woman syndrome is admitted with increasing frequency in criminal cases. The courts also are grappling with the admissibility of other such syndromes. Descriptively, all of these labels have some basis in experience. Women are at serious risk of domestic violence, for example, and such abuse (like rape or sexual exploitation in therapy) has traumatic effects.

Nevertheless, reliance on putative abuse and trauma syndromes presents serious pitfalls both for the treating psychiatrist and for the expert psychiatric witness. Such diagnoses are not recognized in the Diagnostic and Statistical Manual–IV (DSM–IV) and do not take the place of other diagnoses. They raise questions of unreliability of evidence (including false memories), stereotyping, and stigmatization. Labeling people as victims does not allow for the enormous range of reactions to adversity of which people are capable. It is necessary, therefore, to evaluate each case individually rather than to assume an a priori syndrome.

For example, patient-therapist sex syndrome is merely a hypothetical, schematic construction. A victim of such abuse in fact may suffer from any or all of the claimed symptoms, but each individual case requires careful examination to determine which, if any, of the symptoms are present. Moreover, the presence of such symptoms is not by itself proof that the specifically alleged trauma in fact took place.

33. What other mental disorders affect criminal responsibility?

Psychosis, by whatever diagnosis or etiology, is the mental disorder that most commonly serves as a basis for an insanity defense. In addition, people with **organic brain syndromes** may fail to make the connection between actions and consequences. **Multiple-personality disorder** also needs to be ruled out.

Court decisions in different jurisdictions have been inconsistent about voluntary **intoxication** as an extenuating factor. In general, mental impairment resulting from either acute voluntary intoxication or chronic substance abuse may result in some degree of diminished capacity, but not in acquittal by reason of insanity. An insanity defense, on the other hand, may be successful in cases of involuntary intoxication, delirium tremens, idiosyncratic intoxication,

unpredictable variations in tolerance, or permanent psychosis (such as Korsakoff's psychosis) due to chronic alcohol use.

34. List the steps to follow in conducting a forensic psychiatric assessment.

There is no simple formula for conducting a forensic psychiatric assessment; the method of examination must be tailored to the person being examined and to the factual and legal questions at issue. Although a forensic psychiatrist may be asked to assess a person's *current* functioning (as in a disability evaluation), usually the request entails reconstruction of a *prior* mental state. Such an examination is akin to filling in a crossword puzzle; data from the events in question are merged with data from the present examination.

35. Are there general guidelines for performing a forensic psychiatric assessment?

The examiner must maintain objectivity, conducting the examination with an openness to evidence and an attitude of informed skepticism. A proper assessment is always an in-depth process and often an extended one. Typically, it includes multiple interviews of the examinee, interviews with others involved in the case, and review of other relevant data such as depositions, police and medical reports, and audiotape and videotape; when appropriate, site visits are made. If needed, the examiner may request additional specialized medical consultations and testing, such as a sleep/awake electroencephalograph, which may reveal an underlying seizure disorder. Such data are analyzed with a view toward internal coherence, subtle verbal and nonverbal cues, and corroboration of the examinee's story by other evidence.

As noted in the AAPL ethical guidelines, "An evaluation for forensic purposes begins with notice to the evaluatee of any limitation on confidentiality." This so-called Lamb warning serves not only to set the stage for proceeding ethically with a forensic evaluation, but also to prepare the evaluatee for hearing a report of the results, as in the context of distressing courtroom testimony.

36. Can hypnosis serve as a useful check on the unreliability of an examinee's memories of key events?

Given the heightened suggestibility of hypnotized subjects, *under no circumstances* should memories uncovered during hypnosis be considered reliable, especially in criminal cases. Hypnosis decreases the examinee's autonomy; instead, strive to enhance autonomy—for example, by allowing a portion of the interview to be unstructured and associational. Confrontation has a place, but not to the extent that the examinee will say anything to decrease the anxiety induced by the interview. Advanced training in modes of forensic examination—including the recognition of countertransference, avoidance of accidentally conveying subtle cues and suggestions, creation of an atmosphere conducive to open communication, and use of unstructured interview techniques—helps to build expertise in data gathering and evaluation of memories.

37. How useful is psychological testing in the forensic psychiatric assessment?

In selected cases, psychological testing provides useful corroborative evidence, but only if it is used appropriately as an adjunct to—not a substitute for—forensic psychiatric examination. Because testing may disrupt the working alliance needed for the forensic examination, it should occur (when indicated) after, rather than before, the examination. Tests must be carefully administered by the examiner to minimize invalid results driven by anxiety, fatigue, reading difficulty, or misunderstanding. Moreover, test results require careful interpretation because: (1) a person's state of mind at the time of testing is not necessarily the same as the person's state of mind at the time of the events in question; (2) the results obtained in the forensic context may be invalidated by anxiety and confusion or by attempted manipulation.

38. Can dreams provide reliable data for medicolegal purposes?

Asking the examinee to communicate dreams (as well as memories, thoughts, and feelings) may yield useful data, but only in the context of a comprehensive forensic psychiatric examination by a psychoanalytically informed examiner with sufficient training and experience. By listening skeptically but carefully to everything communicated by the examinee, including dreams, the forensic psychiatrist gains the required entry into an examinee's internal reality. Dreams cannot be taken as a representation of literal truth; nor can the dream as communicated be assumed to be the dream as dreamt. Rather, one must listen to the dream as one would to any other communication: At what point in the examination was it communicated? Was it communicated spontaneously or at the examiner's inquiry? What associations preceded and followed it? What was the accompanying affect?

39. How might dreams be indicative of an examinee's credibility?

Dream communications may contribute to overall assessment of an examinee's credibility, because dreams are hard to fake. People are much more practiced at lying and exaggerating about waking events than about dreams. Specifically, after a genuine trauma (but not a fabricated one), dreams tend to progress from direct representations of the experience to more and more disguised versions. Likewise, the natural progression of emotional reactions in the wake of trauma typically runs from anxiety to depression, whereas a person who is embellishing may emphasize one reaction but not the other.

40. Does the presence or absence of dreams have meaning?

In DSM-IV, "recurrent distressing dreams" are listed as a possible diagnostic indicator of post-traumatic stress disorder (PTSD). Although vivid dream imagery is sometimes evidence of trauma, as in PTSD, it also may be a manifestation of an underlying hysterical personality disorder or simply a personal characteristic with no diagnostic significance. At the other extreme, the absence of dreams may be significant. For example, a man who had been in an airplane crash reported vivid dreams until the night preceding the anniversary of the crash, at which time he said that he simply felt terrified but had no dreams. Such a detail enables the examiner to explore further the impact of a major life event.

41. In what other ways are dreams helpful?

Even when dreams are not reported, it may be worthwhile to inquire about them, especially in the case of people who are not psychologically minded and, at the extreme, alexithymic. Both characteristics may occur as a result of trauma. When a person has difficulty with expressing feelings, whether for reasons of personality, trauma, or the public nature of the forensic examination, dreams may be a useful vehicle for exploring the examinee's psychic functioning.

42. How does countertransference affect the assessment?

An awareness of how your own reactions color assessment of another person is essential, regardless of your subspecialty (e.g., psychopharmacology) or mode or school of treatment. In psychoanalytic terms, this dynamic process is called countertransference. It operates primarily through the mechanisms of projection and identification. You may project your own competence or incompetence, either in general or in a particular relationship, onto the person being examined. Such projection, as well as overidentification, may affect the assessment of competence in any area discussed in this chapter.

43. What is positive countertransference?

Positive countertransference occurs when you assess an examinee uncritically—especially an examinee with whom you overidentify on the basis of similar demographic or personal characteristics—because you wish to see the examinee as healthy and self-sufficient. A desire to protect the examinee from distress may lead you to avoid exploring emotionally charged areas in which the examinee may be found incompetent. Likewise, a justifiable concern to avoid stigmatization may divert attention from areas of real incompetence.

44. What is negative countertransference?

Negative countertransference occurs when you find a person competent out of a desire to maintain control and to protect yourself and society from the person's dissembling—so that the defendant, for example, will not “get away with” the crime. On the other hand, you may inaccurately assess someone as incompetent because of failure to establish a communicative alliance for the purposes of the assessment. In this case, the denial of your helplessness to establish such an alliance may result in projecting the incompetence of the alliance onto the examinee.

45. What specific countertransference dangers should be watched for by the examiner?

The examiner who is retained by one party in a legal action may be susceptible to any of several typical countertransference reactions. It is relatively easy to recognize identification with the attorney (plaintiff, prosecution, or defense) who has retained your services. More subtle is the reaction-formation by which you identify with the opposing side. A most insidious (yet common) tendency, especially in response to an anxiety-provoking examinee, is to remove yourself to the safe ground of being the judge. Such detachment may take the form of false certainty in the face of confusing and ambiguous data.

46. What other factors may affect the assessment of criminal responsibility?

The assessment may be biased by “false sanity” resulting from the use of psychotropic drugs or from the setting in which the examination takes place. It is difficult to recognize psychotic states in examinees who have recompensated through medication, psychotherapy, tincture of time, removal from the stressful setting of the events in question, or placement in a structured medical or correctional setting. Conducting an examination in a jail or prison may either mask or induce psychosis, depending on whether the examinee experiences the facility as supportive or stressful. Other factors that may bias the assessment include a restricted emphasis on the appearance of the criminal act (e.g., planning, flagrancy, concealment, flight) without due regard to the psychological facts (e.g., people who are in the midst of a paranoid psychosis often flee or conceal without the requisite intent to obstruct justice).

47. Do special issues arise in the assessment of competence and criminal responsibility in children?

Yes. Common areas of competence assessment in children include consent to medical care, such as abortion, and emancipation of minors. In a clearcut instance of the interpersonal dimension of competence, the family must be included in assessments that involve a child or adolescent.

Age also is taken into account in the assessment of criminal responsibility. Age may be an absolute legal barrier to criminal responsibility, as in a state in which children under a certain age are considered incapable of forming the intent to kill. Age also may be a relative barrier in terms of a particular child's capacity to think and make decisions independently.

48. Does competence assessment play a part in product liability suits?

Yes. The forensic psychiatrist may be asked to review package inserts and warning labels or signs with an understanding of how people make choices about potentially dangerous products. Questions of cognitive awareness and affective maturity arise in assessing a person's capacity to assume the risk of using such a product. In the case of children, such questions commonly arise with respect to toys and playground equipment.

49. Do indigent defendants have a right to a court-appointed forensic psychiatric expert in cases in which mental status may be a factor in determining guilt?

According to the U.S. Supreme Court in the landmark case *Ake v. Oklahoma* (1985), indigent defendants have this right. There is no substitute for a forensic psychiatric evaluation in gathering and interpreting the data needed to determine criminal responsibility. Therefore, recourse to such expertise is essential to a fair trial in cases in which mental status may be relevant.

In practice, however, access to court-appointed psychiatric expertise often is restricted in ways that compromise both the expert's independence and the defendant's right to due process. It has been proposed, therefore, that any indigent defendant who shows a reasonable need for forensic

expertise be provided with a private psychiatrist of his or her own choosing who is paid for, but not controlled by, the state. At present, this entitlement must be advocated for, both in individual cases and at the policy level.

Note that the forensic psychiatrist must be aware of the dangers of performing an incomplete evaluation because of limited funds. If such a limited evaluation is unavoidable, it should be acknowledged in the psychiatrist's report and/or testimony.

50. How important is an understanding of ethical issues in the practice of forensic psychiatry?

Such an understanding is essential. The AAPL Ethical Guidelines for the Practice of Forensic Psychiatry consider much of what has been discussed in this chapter from an explicitly ethical perspective, with a view toward distinguishing between the methods of forensic and clinical assessment. In forensic psychiatric practice, issues of competence, consent, and responsibility frequently are intertwined with the ethical and epistemologic issues surrounding agency, autonomy, authenticity, and moral choice. Therefore, it often is useful to seek not only collegial ethical consultation with practicing forensic psychiatrists but also consultation with a trained ethicist for a transdisciplinary perspective.

51. What recent and forthcoming Supreme Court decisions are likely to affect general and forensic psychiatric practice with respect to the determination of competence?

Recent Supreme Court decisions in areas ranging from the Americans with Disabilities Act (ADA) to sexual harassment have emphasized the competence of both the plaintiff and the defendants in judging whether a plaintiff's claim or a defendant's accommodation response is "reasonable" (*Olmstead vs. L.C.*, 1999).²

* For further information on the cases cited here, including links to complete case texts, please see Dr. Bursztajn's website (<http://www.forensic-psych.com>).

- For plaintiffs, whether a claim is reasonable under the ADA is considered in terms of how competence-impairing a given disorder is with respect to social and work function. For defendants, the determination of whether an accommodation for a worker's disability is reasonable may involve raising as a defense the question of whether competent medical and mental-health care has been provided. The latter may have far-reaching implications for managed-care organizations.

- In cases of sexual harassment (*Oncala v. Sundowner Offshore Services, Inc., et al.*, 1998), the determination of whether an employee's perception was reasonable may rest in part on factors impairing the employee's competence to perceive reasonably. A company's competent preventive measures (e.g., in hiring, training, and supervision) and responses to harassment claims are available affirmative defenses.

- The importance of competence as a factor in health law is highlighted by a recent Supreme

Court decision bearing upon the standards for emergency care and transfer, which underscored the need for engaging in an informed-consent process with patients in cases where economic factors play a major role in influencing care (*Roberts v. Galen of Virginia, Inc.*, 1999).

- Finally, given the Supreme Court's reaffirmation of a "reliable and relevant" standard for all expert testimony (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993; *Kumho Tire Co. v. Carmichael*, 1999), it is likely that general psychiatrists wishing to subspecialize in forensic psychiatry will find it helpful to reinforce their training and experience with relevant psychodynamically informed perspectives (gleaned from the literature, colleagues, and so forth) regarding the varieties of "competencies," as applied to both the individual and the organizational environment.