

**I. MENTAL ILLNESS AND OTHER
PSYCHOLOGICAL PROBLEMS
IN
CLIENTS IN YOUR LEGAL PRACTICE**

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**MENTAL HEALTH EXPERTS ROLES
AND
QUALIFICATIONS FOR COURT**

**Mental Health Experts: Roles and
Qualifications for Court**

**⌘ US Court system on all levels has seen a marked
increase in the use of MH experts**

**⌘ Vast sea of MH credentials, including hundreds of
academic degrees, licenses, certifications, etc.**

WHO TO CALL?

4

When to Specifically Call the Psychiatrist

- When medical concerns are raised
- Where the use of medication is an issue
- Where organic brain damage may influence the case

5

Psychiatry

- General Psychiatry
- Adult Psychiatry
- Child and Adolescent Psychiatry
- Administrative Psychiatry
- Addiction Psychiatry
- Forensic Psychiatry
- Geriatric Psychiatry
- Community Psychiatry

6

Education for Psychiatry

- A. General Psychiatry
- B. Training & Education
- C. 4 year Undergraduate Degree
- D. 4 years Accredited Medical School with
and M.D. or D.O. Degree

7

Education cont'd

- E. 1 year Accredited Internship
- F. 3 years of Training in Psychiatry at an
Accredited Training Program in
Psychiatry
- G. Specialists in Psychiatry, including
adult, geriatric, child & adolescent,
administrative, addiction, forensic and
community psychiatry

8

Education cont'd

- An additional 1 to 2 years of
specialized training (could be a
fellowship).
 - 2 years for child and adolescent
 - 1 year for the other subspecialties

9

Psychiatry Licensing

- Psychiatrists are licensed to practice medicine, not psychiatry.
- Examination is taken during medical school and after graduation to indicate, by passing the exam, that the person is licensed in a particular state or jurisdiction.

10

Board Certification

- The American Board of Psychiatry and Neurology (ABPN) certifies psychiatrists and neurologists [Gold Standard]
 - following completion of residency, training and a two part Board examination (a written test that must be passed and then an oral examination)
 - candidates may take the exam several times & some do until they pass

11

Forensic Psychiatry

⌘ 1) A forensic psychiatrist is a subspecialist who has had training and experience, not only in psychiatry, but also has a 1 year fellowship completed in the subspecialty of forensics by an accredited training program.

12

When to Specifically Call the Psychologist

- ⌘ To conduct a battery of psychological tests
- ⌘ To obtain more objective verification of diagnosis, personality disorder or presence of underlying conflicts that affect the case
- ⌘ To assess intelligence, especially in death penalty cases
- ⌘ To conduct neuropsychological testing to assess presence of brain damage and its impact on functioning

13

FIELDS OF PSYCHOLOGY

- Clinical Psychology
- Forensic Psychology
- Neuropsychology
- Addictions
- Family
- School/Academic

14

EDUCATION FOR PSYCHOLOGY

BA/BS – General Psychology
MA/MS/Med – Clinical/counseling psychology
PhD/EdD/PsyD/DA – Clinical psychology
– Counseling psychology

1 year predoctoral internship
1 year post doctoral training and/or a fellowship.

15

PSYCHOLOGY LICENSING

- Most are generic (some states license specifically in clinical/counseling, etc.).
- National exam and jurisprudence (written or oral).

16

BOARD CERTIFICATION

- American Board of Professional Psychology (ABPP) – 1947 (Gold Standard)
- Require minimum of doctoral degree plus 3 years post doctoral experience plus licensure in good standing
- 13 specialty areas (clinical, counseling, forensic, neuropsychology, children, family, etc.)

17

Psychological Testing

⌘ Who is qualified to administer psychological testing?

18

Testing cont'd

⌘ Not only someone licensed as a psychologist

☒ Clinical education & training in psychodiagnostics

- intelligence testing
- projective techniques
- neuropsychological
- other

19

Testing cont'd

⌘ What about non-psychologists who obtain special training in psychodiagnostics?

(i.e. family therapist who took courses)

(Dattilio, Tresco, & Siegel, 2007. Survey of State Boards and Provinces.)

20

Testing cont'd

⌘ Qualification involves education & clinical training in:

- administering
- interpreting
- scoring
- diagnosing

21

**HOW TO FIND
A
MENTAL HEALTH EXPERT**

- ◆ **Word of mouth**
- ◆ **Directories**
- ◆ **Universities/Medical Schools**
- ◆ **Telephone Books**

22

⌘ How do we know who's who in the zoo — who is legit and who is not?

⌘ Why do we need this book? How can it assist you?

⌘ Don't ask, don't tell policy

23

Some Attorney's & Jurist's Famous Last Words

⌘ I heard that he was good on the stand

⌘ Well, I just assumed he was qualified

⌘ I just needed somebody quick at the last minute

⌘ I used him before in another matter

⌘ She had a really nice presence on the stand

24

Moral of the Story

“Do your homework
so you know your cookie!”

25

II. Admissibility of Mental Health Expert Evidence

- Education
- Training
- Experience
- Prior Testimony and Qualification

26

CLASSIFICATION OF MENTAL HEALTH EXPERTS

- Licensing
- Board Certification
- Established Track Record

27

QUALIFICATIONS AND CREDENTIALING

- **Voir dire your expert before hiring him/her.**
 - Telephone interview
 - Curriculum vitae/website
 - List of prior testimony
 - Sample report in the area you are seeking an opinion
 - Professional references.

28

**Benefits of a Thorough
Voir Dire of Credentials**

- ⌘1) To educate the court
- ⌘2) To document the qualifications of the expert
- ⌘3) To expose potential areas of weakness
- ⌘4) To expose charlatans
- ⌘5) To protect the public interest

29

Benefits cont'd

- ⌘6) To protect your own integrity and that of your client

(ABA's Rule 3.3, mandates the avoidance of offering perjurious testimony regarding experts' credentials)

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Warning

⌘ Unfortunately, the field of MH is one of the biggest targets for ersatz degrees and bogus certifications

31

Forensic Experts' Training Should Include

⌘ An overview of forensic psychology/psychiatry/medicine and how this differs from other areas of practice

- overview of topics in forensic evaluations
- definitions of an expert ("More & more..." or one who shows special skill or knowledge)
- stages of criminal process

32

Training cont'd

⌘ Nature of forensic evaluations
⌘ Constitutional & ethical contours of the evaluation process
⌘ Competency to stand trial
⌘ Other competencies in the criminal process
⌘ Mental state at the time of the offense

33

Training cont'd

- ⌘ Sentencing
- ⌘ Other use of clinical evidence in the criminal process
- ⌘ Report writing in expert testimony, including participation in mock trials
- ⌘ Developing a forensic practice

34

Short Cuts

- ⌘ You can rely on board certification to consolidate this
- ⌘ Differences between licensing and board certification — **don't confuse them**

35

Short Cuts cont'd

- ⌘ Familiarize yourself with the Boards in each specialty:
 - psychiatry
 - psychology
 - counseling
 - social work
 - Nursing

36

Short Cuts cont'd

⌘ If the expert offers a Board other than what is recognized in the field, then use the question guides of Dattilio & Sadoff, 2007

37

Specific Credentials

⌘ Undergraduate training is important but, emphasis is on the terminal degree

⌘ Please state for the record your formal education beyond high school

Degrees and Areas Earned

- bachelors
- masters
- doctoral
- post doctoral

38

Specific Credentials: questions to ask

⌘ Do you possess an **earned** doctoral degree in the field of _____?

⌘ Is your doctoral degree earned from an _____ accredited program in _____?

⌘ If not, then in what area/field?

⌘ What is the title of your actual degree?
(*i.e.*, Ph.D., Ed.D.)

39

Questions cont'd

⌘ Did you complete a written dissertation for the awarding of your doctoral degree?

- case study
- original empirical research
- literature review

Title of study: _____

40

More Questions

⌘ Internship training?

⌘ Accreditation or approval?

- Length and duration
- full vs. part-time
- what was the content

41

and — more Questions

⌘ On what educational degree was the issuing of your license based?

⌘ Are you currently licensed "in good standing" in the Commonwealth of PA

Always Check!

⌘ What are states or providences

⌘ What board certification? Name of Board?

Know your boards!

42

What Makes an Expert a Forensic Specialist?

- ⌘ Unfortunately the term "training" is vague
- ⌘ Legitimate board certification in one of the designated areas
- ⌘ In lieu of board certification:
 - 100 hours (or more) of formal didactic training + experienced supervision

43

Always Check References

- ⌘ Who have they worked for previously?
- ⌘ How many cases have they done in the specific area that you are hiring them for?

44

III. MENTAL ILLNESS AND THE DSM-IV-TR

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45

DSM-IV-TR stands for the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition Text Revision, Published by the American Psychiatric Association, 2005, Washington, DC.

***The revision of the DSM is currently underway and is scheduled to be released in May of 2012.**

46

Introduction

This is the 4th Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems).

47

It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. DSM-IV must be usable across settings – inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care and with community populations.

48

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.

49

In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a “mental disorder,” “mental disease,” or “mental defect.” in determining whether an individual meets a specific legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.

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“When used properly, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination.”

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Finally, “The clinical and scientific considerations involved in a categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.”

52

The DSM-IV provides a multi-axial diagnosis, including the following:

Axis I – Clinical disorders and other conditions that may be a focus of clinical attention.

**Axis II – Personality disorders
Mental Retardation**

Axis III – General medical conditions

Axis IV – Psychosocial and environmental problems

Axis V – Global Assessment of Functioning (GAF)

53

Axis I includes primary clinical disorders such as psychosis, organic brain disorder, anxiety disorders, mood disorders, and adjustment disorders.

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Axis II includes personality disorders and mental retardation. Often, a personality disorder is not diagnosed because of incomplete assessment or without psychological testing. The personality disorders include the following:

- Paranoid personality disorder
- Schizoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Avoidant personality disorder
- Dependent personality disorder
- Obsessive-compulsive personality disorder
- Personality disorder not otherwise specified

55

Axis III includes general medical conditions (often related to the Axis I diagnosis). Such general medical conditions include infectious diseases, neoplasms, endocrine, nutritional and metabolic disorders, and immunity disorders.

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Axis IV. Psychosocial and environmental problems. These would include problems with primary support group. Problems related to the social environment, educational, occupational, housing, economic problems, or health care services. Sometimes, the person has problems related to interaction with the legal system or with criminal behavior.

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Axis V – Global assessment of functioning . This is known as the GAF Scale and ranges from 0 to 100. 0 is inadequate information and the lower numbers are the more serious, including persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene. As the numbers rise, the amount of impairment lessens so that at 100, the person is noted to be “superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

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DSM-IV-TR also includes chapters on disorders diagnosed in infancy, childhood or adolescents, including autistic disorders. It also involves organic disorders, including dementia and substance induced disorders such as delirium. The text also differentiates between psychotic and non-psychotic conditions. Often, there will be a term, NOS, which means “not otherwise specified.” This is used in certain psychotic conditions and also in personality disorders, where the individual does not meet all of the criteria necessary for the diagnosis.

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Dissociative phenomena: “The essential feature of dissociative disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception. The disturbance may be sudden or gradual, transient or chronic. The following disorders are included:

- a. Dissociative amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
- b. Dissociative fugue is characterized by sudden, unexpected travel away from home or one’s customary place of work, accompanied by an inability to recall one’s past and confusion about personal identity or the assumption of a new identity.”

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c. Dissociative identity disorder (formerly multiple personality disorder) is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. It is a disorder characterized by identity fragmentation rather than a proliferation of separate personalities. (Case example to be included here.)

61

d. Depersonalization disorder is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

e. Dissociative disorder not otherwise specified is included in which the prominent feature is a dissociative symptom, but the symptoms do not meet the criteria for any specific dissociative disorder. (Case example given here.)

f. Other DSM-IV issues are discussed under Personal Injury, including post-traumatic stress disorder and malingering.

62

**IV. VARIOUS USES OF
MENTAL HEALTH EXPERTS**

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63

PERSONAL INJURY – MEDICAL ISSUES

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64

From a medical-psychiatric standpoint, there are four aspects of personal injury:

1. The incident or accident.
2. Injury to the victim or plaintiff.
3. Impairment of function due to injury.
4. Disability to the plaintiff.

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In assessing personal injury, it is always important to determine any preexisting factors that may or may not be relevant due to the incident that led to the injury impairment and/or disability.

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Sometimes, for example, in sexual assault cases, the victim has been raped before and the question remains, does that earlier sexual assault or rape have any impact on the current injury to the woman? Some plaintiff's lawyers want to hide that fact because they don't want it to negate the impact of the current incident to their client. Other lawyers recognize that a person who has been raped before may be more sensitive to the assault and have a more serious injury or impairment because of the prior incident or incidents.

67

The mental health expert must have all available data on history, prior medical conditions that may or may not be related to the incident in question and the details of the incident, as well as follow-up treatment or symptoms exhibited by the plaintiff.

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Sometimes the expert does not get to see the plaintiff until several months, or even years, after the incident in question. It is ideal to evaluate the individual at the time, or shortly after the time, of the incident, and then have follow-up evaluations on a regular basis to note improvement or worsening of the condition.

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The diagnoses that are relevant in such cases include from the most severe, a traumatic psychosis, which means the person becomes psychotic or out of touch with reality as a result of the injury sustained when there was no evidence for previous psychosis, or perhaps only the slight evidence of predisposition or weakness in the individual's psyche that could lead to psychosis if properly traumatized.

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Next would be organic brain damage that resulted from the accident that led to impairment of cognitive functions and behavior.

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Next would be a diagnosable anxiety or depression that was not present prior to the accident in question.

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Perhaps the most often diagnosed condition following personal injury is post-traumatic stress disorder - 309.81. The diagnostic features state, "The essential feature of post-traumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1)."

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Further, the DSM-IV-TR states, "The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2)."

74

"The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than one month (Criterion E) and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F)."

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Other diagnoses associated with trauma could be acute stress disorder, generalized anxiety disorder, or substance induced anxiety disorder.

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The defense against such mental conditions following trauma or injury would include the introduction of prior conditions that simulate similar symptoms such as bipolar disorder, anxiety disorder that preceded the incident in question and the conclusion that the person has had chronic symptoms even prior to the incident and that the incident may have slightly aggravated those symptoms, but not significantly so.

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The other defense that has been utilized is the concept of malingering, where one exaggerates the symptoms that one has in order to gain a favor from the court.

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“The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by extreme incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may represent adaptive behavior – for example, feigning illness while a captive of the enemy during wartime.”

79

Malingering should be strongly suspected if any combination of the following is noted:

1. Medical-legal context of presentence (e.g., the person is referred by an attorney to the clinician for examination).
2. Marked discrepancy between the person's stress or disability and the objective findings.
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed regimen.
4. The presence of antisocial personality disorder.

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Malingering differs from factitious disorder in that the motivation for the symptom production and malingering is an external incentive whereas in factitious disorder, external incentives are absent. Evidence of an intrapsychic need to maintain the sick role suggests factitious disorder.

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Malingering is differentiated from conversion disorder and other somatiform disorders by the intentional production of symptoms by the obvious, external incentives associated with it. In malingering (in contrast of conversion disorder) symptom relief is not often obtained by suggestion or hypnosis.

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Case Examples

1. Plane crash – Assessment of pain and suffering of the deceased passengers before death.

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2. A man was discriminated at work because of his race and was assaulted, insulted and threatened. He developed symptoms of stress disorder and sued the employer for not providing a safe environment. The examination by the plaintiff's expert clearly showed a linkage between the stress alleged and the symptoms presented. The defense psychiatrists emerged with two separate conclusions: One found the plaintiff to be malingering and to not have any psychiatric condition at all. The other defense expert independently found evidence for pre-employment bipolar disorder that, in his opinion, caused the symptoms and they were not due to the stress alleged by the plaintiff.

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It is better to put the conclusion in the subjunctive mode rather than the declarative one. That is, if the plaintiff's comments are accurate and based on the fact, then the symptoms, in my opinion, are related to the incident at work. (One cannot just take the plaintiff's word for what had occurred without further evidence.)

85

**IV. MEDICAL ISSUES
IN
CRIMINAL COMPETENCY**

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86

Competency is the most frequent assessment conducted by mental health experts in both civil and criminal cases. In civil cases, competency is an issue in several areas, including competency to testify, competency to write a will, competency to manage one's own affairs and, of course, is based on contract law.

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In criminal cases, the competency of the defendant is assessed in about a half dozen areas, including competency to give a confession or statement, competency to stand trial (which is the most common), competency to plead, competency to serve a sentence, and competency to be executed.

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The medical issues are primarily whether the person at the time of the assessment and the time relevant for competency assessment (i.e., at the time making the statement or the time of trial) understands the nature and consequences of his current legal situation. In competency to stand trial, one also must be able to work on a rational basis with one's attorney in preparing his defense. What medical conditions might keep a person from being competent in those situations?

89

Medically, one may have an organic brain condition that would prevent him or her from understanding the nature and consequences of his legal situation. He may not be able to work rationally with his counsel in preparing a defense because he may not remember what happened due to brain injury or an organic condition that was extant as the time in question.

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Competency is assessed in three different areas in criminal cases:

1. Past competency, i.e., was the person competent to give the statement he allegedly gave to the police (especially if it is not recorded either on an audiotape or videotape).

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2. Present competency, as in competency to stand trial or competency to maintain his ability during the stress of the trial, may deteriorate and become incompetent during the proceedings.

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3. Future competency, as in predicting whether a person in a hospital is ready to be discharged safely into the community. This may not be so much the issue of competency as it is the prediction of violent behavior or the absence of it because treatment has been successful

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Currently, when one is committed civilly to a hospital, it is because one is both mentally ill and a clear and present danger of harm to self or to others. The prediction becomes whether the person has been treated sufficiently, such that his danger to self or others has abated.

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Prediction of competency in the future also includes evaluation and assessment by professionals, including physicians, attorneys, judges, and police officers.

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Thus, the medical issues include psychosis, organic brain syndrome, mental illness, such as depression, anxiety or personality disorder. Mostly, personality disorders, which is the Axis II on the five Axis of DSM-IV, will not prevent a person from being competent to proceed in a criminal matter.

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One must consider toxic substances, either voluntarily ingested or involuntarily inhaled or ingested, that may affect a person's mental state such that he may become incompetent because of the effect of the substance on his brain or on his psychological processes.

97

One has to consider such concepts as delirium from alcohol or other substances. Delirium is a condition of the brain that causes a person to be in an altered state of consciousness, either unconscious or not functioning at full capacity.

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One must also consider such concepts as hallucinations, which are the disturbances of the senses, either visual, auditory, taste, smell or touch, or delusions, which are fixed false beliefs more psychological than organic, but can be the latter.

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Sometimes, one has been operated on or has cancer or is on chemotherapy or other medications that might affect his judgment, his ability to maintain competency in working with his attorney.

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In summary, there are a number of medical, as opposed to psychological conditions that might affect a person's competency in criminal matters.

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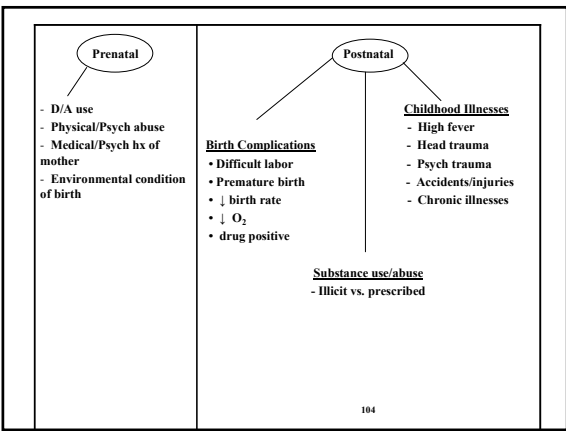
IV. MITIGATION

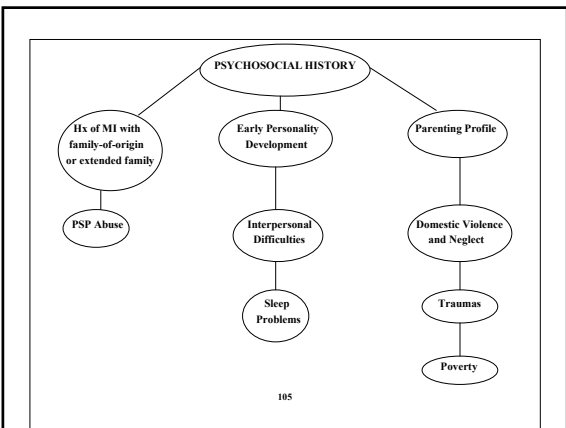
102

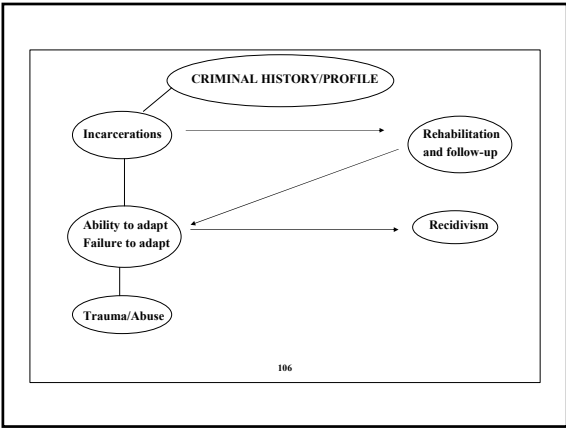
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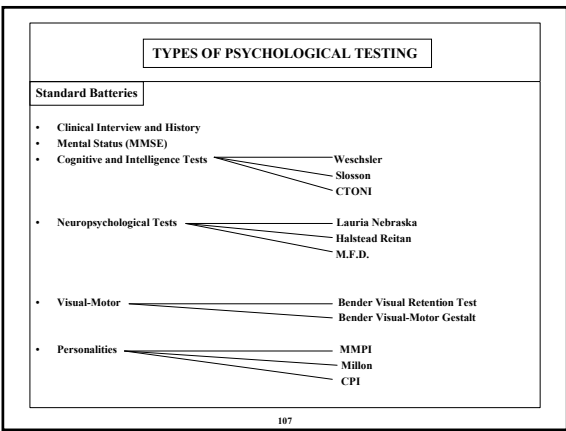
Range: From prenatal ————— incarceration

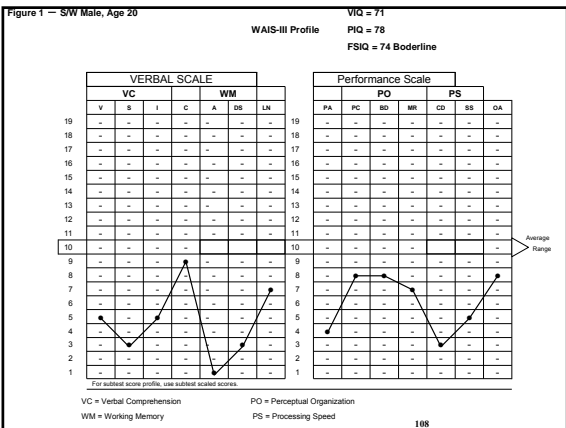
103











MMPI-2

? Cannot say
 VRIN – Variable Response Inconsistency Scale
 TRIN – True Response Inconsistency Scale
 L – Lie Scale
 K – Subtle Defense Scale
 F – Symptom Exaggeration
 F(b) – Detect Deviant Response
 F(P) – F Scale Inpatient who are mentally ill (infrequent)
 S – Superlative Presentation

HS – Hypochondriasis	SI – Social Introversion
D – Depression	A – Anxiety
Hy – Hysteria	R – Repression
Pd – Psychopathic Deviance	Es – Ego Strength
MF – Masculinity/Femininity	Mac – MacAndrew - ETOH
Pa – Paranoia	Ds – Dissimulation
Pt – Psychasthenia	Mp – Malingering
Sc – Schizophrenia	Sd – Social Disorder
Ma – Hypomania	Ss – Social Status

109

TESTS FOR MALINGERING

- WAIS-IV – Various subtests (i.e., digit span, memory scales)
- WMS-IV – Wechsler Memory Scales
- MPS – Malingering Probability Scale
- SIRS – Structured Interview of Reported Symptoms (psychopathological symptoms)
- MMPI-2 – Minnesota Multiphasic Personality Inventory-2 (LF&K, FB, URIN, TRIN)
- PAI – Personality Assessment Inventory (evaluates feigning)
- TOMM – Test of Memory Malingering (feigned cognitive impairment)
- VIP – Validity Indicator Profile (measures “suboptimal effort” rather than feigning)

110

MITIGATION REPORTS

- **Different from all other types of reports. Must always be done separately from any previous reports (i.e., competency, etc.).**

111

V. SPECIAL ISSUES

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112

**THE APPOINTMENT OF
MENTAL HEALTH EXPERTS**

- Attorney appointed
- Court appointed
- Client appointed

113

VIOLENCE AND MENTAL ILLNESS

- Violence Risk Assessment
 - Interviewing, psychological testing and appraisals,
and collaborative sources.

114

**V. SEX OFFENDERS
AND
SEXUALLY VIOLENT PREDATORS**

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118

DEFINITION

A sex offender is an individual who has committed a sexual offense that might involve sexual misconduct with a minor, or intentionally or knowingly engage in sexual intercourse, oral sexual, or digital sexual contact with an individual under the age of 18 years or, if above the age of consent, against their will.

119

PARAPHILIA

A common term for sex offending. This is a mental disorder or “abnormality” involving certain normative sexual arousal patterns that have caused distress or have led to overt behavior that violates the rights of others (i.e., pedophilia, ephebophilia, fetish, frotteurism, exhibitionism, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism).

120

Among some of the most common in our society today are:

- ◆ Rape
- ◆ Pedophilia
- ◆ Ephebophilia
- ◆ Images of child pornography on the Internet (non-contact victimization)
 - lewdness
 - indecent exposure

121

Sex Crimes and Megan’s Law

- Most states in the United States maintain a Megan’s Law component.
- Sexually violent predator versus sexual offender.
- Some states have a tier system (Tier I, II, etc.) (i.e., New Jersey)

122

Sexually Violent Predator

Two prongs:

Prong One – Mental abnormality (paraphilia or a personality disorder)

Prong Two – Predatory behavior

123

PRONG ONE - MENTAL ABNORMALITY

Most typical of Meghan's Law

- Involves pedophilia, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children for a period of at least six months or more – prepubescent is 13 years of age or younger.
- Person has acted on these sexual urges or the sexual urges or fantasies have caused marked distress or interpersonal difficulties.
- The perpetrator is at least 16 years of age or at least five years older than the child victim.
- Specifiers – sexual attraction to either males, females, or both, or limited to incest or exclusive type (attracted only to children) or non-exclusive type (attracted to adults and children).

124

PRONG TWO – PREDATORY BEHAVIOR

- Whether the offense involved multiple victims.
- Whether the individual exceeded the means necessary to achieve the offense.
- The nature of the sexual contact with the victim.
- Relationship of the individual to the victim.
- Age of the victim.
- Display of unusual cruelty.
- Mental capacity of the victim.
- Prior offense history, including criminal activity (i.e., including former sexual offenses).
- Whether the alleged perpetrator completed any prior sentences.

125

- Whether the alleged perpetrator participated in available programs for sex offenders.
- Age of the perpetrator (Robost Factor).
- Use of illegal drugs or alcohol by the individual.
- Any mental illnesses, mental disability or mental abnormality.
- Behavioral characteristics that contributed to the individual's conduct.
- Factors that are supported in a sex offender assessment filed as criteria reasonably related to the risk of the re-offense.

126

Typical Measures/Appraisals for Sex Offenders and Sexually Violent Predators	
<ul style="list-style-type: none"> <input type="checkbox"/> Historical Clinical Risk-20 (HCR-20) <input type="checkbox"/> Minnesota Sex Offender Sentencing Tool-R (MnSOST-R) <input type="checkbox"/> Hare Psychopathy Checklist-R-2 (PCL-R-2) <input type="checkbox"/> Penile Plethysmography or Phallometry (PPG) <input type="checkbox"/> Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR) <input type="checkbox"/> Sex Offender Risk Appraisal Guide (SORAG) <input type="checkbox"/> Static-99 <input type="checkbox"/> Sexual Violence Recidivism-20 (SVR-20) <input type="checkbox"/> Violence Risk Assessment Guidelines (VRAG) 	
127	

<p>V. EQUIVOCAL DEATH</p> <p>PSYCHOLOGICAL AUTOPSIES IN</p> <p>CASES OF CRIMINAL HOMICIDE</p> <p>Frank M. Dattilio, Ph.D., ABPP Harvard Medical School</p>
128

<p>HISTORICAL DEFINITIONS OF</p> <p>PSYCHOLOGICAL AUTOPSY</p>
<ul style="list-style-type: none"> • The overall aim is to gather enough information about the circumstances of an individual's death to try to understand the reasons for suicide <p style="text-align: right;">Hawton et al., 1998</p> <ul style="list-style-type: none"> - More than 20 major psychological autopsy projects have been conducted in North America, Europe, Australia, New Zealand, Israel, Taiwan, and India <p style="text-align: right;">Isometsae, 2001</p>
129

AUTOPSY - To determine cause of death in medical cases when etiology is uncertain

- Used regularly and accepted as scientific evidence in clarifying forensic matters

EQUIVOCAL DEATH PSYCHOLOGICAL AUTOPSY

- Determine suicide or accidental death. Often used to assist medical examiners in death classifications when doubt arises.

WHY "EQUIVOCAL DEATH?"

130

TWO TYPES:

SUICIDE PSYCHOLOGICAL AUTOPSY (SPA)

- To determine the psychological factors that may have contributed to an individual's suicide.

EQUIVOCAL DEATH PSYCHOLOGICAL AUTOPSY (EDPA)

- Designed to expand and assist in actual determination of the manner of death classification (i.e., to rule out homicide or accidental death). Also, to assist the medical examiner's investigation in accumulating knowledge about the decedent in reconstructing one's psychological state at the time of death.

131

PSYCHOLOGICAL AUTOPSY (PA) FEATURES

• **EARLY STUDIES OF SUICIDE UTILIZING (PA):**

- Almost all identified a psychiatric disorder
- Depression was a frequent finding
- Alcoholism or illicit substance was common
- Some evidence of schizophrenia
- Additional risk factors include psychosocial problems

• Comorbidity of disorders was prevalent

132

WHAT ARE WE LOOKING FOR?

- Any information that might reveal:

- 1) Cognitions and perceptions of the decedent
- 2) Emotions and affect prior to death
- 3) Behaviors
- 4) Relationships
- 5) Medical history – including medications taken, prescribed or unprescribed, medical illness
- 6) Social pressures
- 7) Coping mechanisms
- 8) Alcohol or illicit substance use
- 9) Legal/financial problems

The gathering of this information is pivotal in investigating suicidal vs. accidental vs. intentional (homicidal) deaths.

133

THIS IS MOST CRUCIAL DURING CHARGES OF HOMICIDE, MURDER, AND MANSLAUGHTER.

WAS DEATH PREMEDITATED, ACCIDENTAL OR A TRUE CASE OF INTENTIONAL (DELIBERATE) HOMICIDE?

APPROXIMATELY 5 – 20% OF ALL DEATHS ARE EQUIVOCAL.



134

REFERAL: QUESTIONS TO BE ANSWERED

ESTABLISH DATA BASE - This is the backbone of the autopsy process

- 1) **Copious Review of Crime Scene** – Photos vs. visiting actual crime scene if possible.
- 2) **Relevant Documents:**
 - Police reports
 - Medical autopsy reports (or coroner's reports)
 - Toxicology reports (especially serology stats if illicit substances were used)
 - School records
 - Prison or probation/parole records
 - Court documents/transcripts
 - Mental health records
 - Medical records
 - Drug and alcohol records
 - Employment history/job reviews

135

3) INTERVIEWS

ETHICAL NOTE:

Interviewer must clarify his or her role before hand to the interviewee

- Live or telephone
- Relative of the decedent
- Witnesses to the death scene
- Former spouses
- Friends
- Co-workers
- Employers
- Neighbors
- Probation/parole records
- Mental health professionals

136

KEY FACTORS

INTERVIEWS

- Should take place at informant's home or neutral setting
- Forewarn informant regarding length of interview
- Start with open-ended followed by close-ended questions
- Excessive note taking should be avoided
- Tape recording is acceptable and allows for flow
- Informants often report benefiting from the interview
- Interviews should not be therapeutic

STRUCTURE OF THE INTERVIEW

- Assess for psychiatric disorder
 - Strict adherence to DSM can underestimate
 - Make diagnoses that seem clinically relevant
- Assess for personality disorder
 - Can be difficult for informants b/c focus tends to be negative
- Assess life events and problems
 - Create a chronological sequence of events

137

COMMUNICATING SUICIDE

- The absence of communicating intent does not mean low risk
- If explicit statements of intent are included then one-third to one-half of victims told family member(s) and/or health care professionals during final few months
- Suicide is often a surprise because communication of intent is often not temporally close to the act
 - Prevents interference or sense of hopelessness

138

ETHICAL CONSIDERATIONS

- Autopsy usually conducted 3 to 12 months after suicide to allow for bereavement
- Approach informant by letter and then by phone
- Informants should be fully informed and written consent should be obtained
- Integrity of deceased should be respected
- Provide referrals for family members that may need psychological or psychiatric treatment

139

PROXIMATE CAUSATION

- Legal Liability (employers, mental health care)
- **Substantial Factor Test:** Liability will be limited to those cases in which the defendant's conduct was a substantial factor in producing the suicide
- **"But for Test":** Injury would not have happened *but for* the defendant's negligence
- **Foreseeability:** Recovery will be denied because the suicide was an unforeseeable consequence of negligent injury
- **Mental Illness:** Recovery will be allowed if the decedent did not know the nature of his or her actions

140

CASE OF AN ACCIDENTAL SUICIDE

- Contacted by Defense
 - Alleged Defendant was Victim's Boyfriend
- Deceased – 40 y/o, SWF, shot in mouth – wrapped in bed sheet
- Victim was not wet despite rainy weather all evening
 - Police found firearm positioned between seats
 - Blood was pooled on the front passenger seat with bits of pink human tissue stuck to the dashboard of passenger's side
 - Alleged defendant appeared to be under the influence of ETOH

141

- Left side of alleged defendant's shirt was soaked with what appeared to be blood
- Victim's blood was on right side of defendant's face
- X-ray of victim's skull showed small objects inside of skull – shotgun pellets
- Suspect charged with DUI and firearm violation
- Police ran check on suspect and victim and found that they shared the same address, as well as victim's criminal history
- Medical autopsy determined cause of death was gunshot wound to head
- Suspect was detained, mirandized. He waived his right to legal counsel

142

MATERIALS REVIEWED

- Forensic pathology report on victim
- Autopsy report, including cause of death, pathological diagnosis, and opinion on manner of death
- Specimen reports
- Laboratory findings
- Toxicology reports, including volatility and blood screening for various substances
- Hospital examination reports (previous)
- Emergency room records
- State Police homicide investigative reports
- Hospital witness statements
- Prison and probation records on victim for prior criminal offenses

143

INTERVIEWS

- Family-of-origin of the victim (refused)
- Defendant
- Biological brother of defendant
- Forensic pathologist who performed autopsy
- Several of the victim's friends
- Investigating State Trooper
- Toxicologist

144

RISK FACTORS

- Depression – Hx of depression and stress facing incarceration
- Substance Abuse – Hx of heroin use, snorted cocaine heavily, use of ETOH frequently

Toxicology report indicated that the victim's blood (IVC) value of 0.17% ethanol, with a vitreous of 0.20% ethanol, and urine value of 0.23% ethanol. Blood alcohol was actually lower because of the absorption phase of the substance (due to time screen was conducted) – post absorption phase of alcohol use. Blood (IVC) = positive for cocaine 97mg/ml (significant). Conversion of cocaine and ETOH yielded cocaethylene (95 mg/ml) = substance was more psychoactive and potentiated to a greater affect.

- Inferior Vena Cava

145

ACUTE STRESS AT TIME OF DEATH

- Financial difficulty
- Possible criminal incarceration (state)
- Substance abuse
- Relationship problems
- Housing problem
- Theft
- Diagnose with breast cancer (not confirmed)

EMOTIONAL STABILITY

- Emotionally unstable at time of death
- Self-destructive life style
- Estranged from her family-of-origin

146
