Forensic Psychiatry

A Lawyer's Guide

Vivian Chern Shnaidman

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Dedication

For my parents, Relly and Gideon Chern

Don't Skip This Foreword

This book grew out of my crazy idea that just as forensic psychiatrists need to learn basic law in order to be able to go to court and not make fools of ourselves, lawyers need to learn some basic psychiatry. I've been officially working as a forensic psychiatrist since 1994, but I started during residency, and if my friends are to be believed, I planned to be a forensic psychiatrist as far back as college or maybe even high school, before I even knew exactly the difference between psychiatry and psychology, when I took a sophomore honors English class called "Forensics" with the late, great Richard Sodikow at the Bronx High School of Science in New York City.

I was so fortunate to meet Elsevier's acquisitions editor Liz Brown at an American Academy of Forensic Sciences meeting a few years ago, and talked her into my idea on the spot. True story: a week later I broke my knee. It took me a year to get my official book proposal to her. She really liked it—only a week after that, she broke her ankle. It took another year for the project to really get off the ground. Leaving a trail of crutches, broken bones, torn ligaments, and frustrated physical therapists, Liz finally was ambulatory enough to head back to the office and pitch me to her team. Working with Liz Brown and my other editor, Joslyn Chaiprasert-Paguio, has been a pleasure, and after some of my experiences in the world of writing fiction, a true corrective emotional experience (I'll explain that for you later in the book), I could write a book a year for them, no problem at all! (Hint, hint!)

Many people plan their futures and then are surprised when they don't exactly work out as planned. I don't think I ever actually planned mine, but I am surprised how it worked out the way it did, and I have a great many people to thank. I need to acknowledge and thank them up front because I had to change all the names of the innocent in the book. You probably already know that mentally ill people are often quite litigious, and since I share their stories, albeit with details changed to hide their identities, I had to change the names of their attorneys as well. In this foreword I want to introduce my readers to the real-life people who taught me, who helped me, who shared their cases and their stories and their expertise, and who helped me to become the person who can write this book for you today. I have enjoyed this process so much; I have learned so much from all the lawyer interviews; I have laughed and cried from the absurdity of trying to deal with the insanity of the human brain in the structure of the legal system and then explaining it to lawyers who like to think in legal jargon. The whole process has had a tinge of the absurd, and I hope you will appreciate it and learn from it.

Richard Sodikow was not the only influential English teacher in my life. At Bryn Mawr College, Paula Mayhew let me write my Six Weeks Paper using psychology texts, which you will read about later in this book. Swarthmore Professor Emeritus Jeanne Maracek is probably the person who was most influential in my choice of psychiatry as a career. Virginia Mann taught me that young, female, and awkward was not incompatible with ambitious and brilliant. At the Sackler School of Medicine at Tel Aviv University, Dr. Alan Apter ran a psychiatry rotation so amazing that I never understood how the rest of my class could have chosen internal medicine instead of psychiatry. In my psychiatric residency at the Albert Einstein College of Medicine, full circle back to the Bronx, the late Dr. Tomas Agosin was such a powerful influence and educator that I cannot find the words to describe him without feeling his loss as if it occurred yesterday, even though it was over 20 years ago. I was fortunate to be trained in a fellowship at

the New York University Fellowship Program in Psychiatry and the Law with the people who invented forensic psychiatry, led by Dr. Richard Rosner, an act impossible to follow. I've also had the honor and privilege of working with and learning from many other internationally recognized forensic psychiatrists and psychologists over the years. Thank you to everyone who has taught me so much.

And now on to the lawyers. My first experience with law school was with Professor Michael Perlin, whose class at New York Law School I took during my forensic psychiatry fellowship. *The Paper Chase* it was not, but I loved that class! Law school was nothing like medical school. Professor Perlin is an international authority on mental health law and years later inadvertently contributed to the idea for this book when he suggested that I was naive in thinking that criminal defendants all over the country had the same access to competent counsel as defendants on the enlightened east and west coasts. I want to thank former New Jersey Governor—and attorney—Jim McGreevey, whom I met at a conference and who shared generously of his time and knowledge, as he does with the chronically mentally ill and drug addicted in New Jersey's jails and prisons. The many judges before whom I've testified as an expert, whose names probably don't belong here, but who have taught me so much and have helped me to become not only a better psychiatric expert witness, but also a better person, I cannot thank you enough. The appellate division judges, most of whom I've never even met, but who have reviewed and relied upon my reports and testimony and found them (i.e., me) credible and reliable, you have no idea how much that means to me, because as you lawyers say, *res ipsa loquitor*. The thing speaks for itself. I wasn't even there to convince you, but my words still spoke for themselves, and that means I did my job right.

Those are the big-shot people. But I really have to thank the little shots. The lawyers who are my friends, or friends of friends, people I've met here and there who agreed to be interviewed, who shared their cases with the full knowledge that I would change all the best details so neither the lawyers nor the clients would be recognized. People who gave freely of their time and expertise for my crazy project, who often thought that they had nothing to contribute or that there was not even a need for a book about forensic psychiatry for lawyers, because after all, they don't defend murder cases. For all of those amazing, ethical (yes—they exist!), and generous lawyers, thank you so much. But in order to protect their privacy and not let you figure out who's who in the book, I'm going to mix up their names with the names of all the other people who helped me in the commission of this book. I have to say commission, because anything that was this much fun is usually illegal.

Plenty of nonlawyers helped me throughout this process as well. The English language does not contain enough superlative adjectives to describe my assistant Sarah Casey, who makes it possible for me to do everything I have to do and still be around to talk about it at the end of the day. Without her not only would there be no book, our treatment patients would probably be feeling very uncared for, not to mention the dozens of lawyers, case-workers, judges, the Internet guy, and the water delivery man, who Sarah juggles so patiently and professionally. We outsource some work—you guys rock and without you, Sarah and I could not do what we do.

So many other people who helped directly or indirectly, with the book, with my career, or just with my life in general, thank you all. I am so lucky to have amazing friends, here in New Jersey and all around the world. I'm going to just list a bunch of names, and if I left you off, it was a mistake or a misprint. I'll get you next time. Laura Helper-Ferris, Sherry Meyer, Antoinette Errante, Nancy Cristoforo, Jonathan Bellush, Maggie Snyder Hamilton, Julia Van Pelt, Lawrence Greenberg, Adam Bierman, Sandra Bierman, Eric Saperstein, Rhona Melsky, Rupal Kothari, Ilona Bray, Barabara Silverstone, Stanley Silverstone, Cindy St. Martine, Cheryl Parker Davis, Jon Draud, Robert Levinson, Marlyn Quinn, Yelena Haimovici, Patti Epstein Putney,

Marija Willen, Debra Nathanson, David Kaplan, Don Cox, Sara Cox, Aaron Caruso, David MacFarlane, John Hartmann, Joan Van Pelt, Donna Vanderpool, Mary Foy, Marti Davis, Jessica Lique, Lindsey Beckleman, Joseph Nicola, Isabel Thomas, Steven Thomas, Christina Hardman, Julie Chapin, Tom Chapin, Heather-Rose Ryan, Danusha Goska, Sallie Stadlen, Isaac Fromm, Hanan Isaacs, and Stephanie Palo.

My friends out there in cyberspace, my college classmates of a certain age all around the world (you know who you are), my real and honorary family in the United States and in Israel, my sister Denny Chern Kelk, who shares my sense of humor, and my parents, Relly and Gideon Chern, who from birth insisted I have a degree in science to fall back on (so I found the only college in America where psychology was a lab science)—all of you helped me get to where I am today, some of you accidentally, I know.

Finally, my own family mainly drove me crazy, but according to Freud, as the reader will learn later, insanity is what fuels the writer, so you played your parts perfectly. My husband Michael, and my sons Barak, Matthew, and Evan, you all make me a better person. Thank you. I love you all in the whole wide universe.

Introduction

Forensic Psychiatry v. the Other Side: Why Do You Need a Forensic Psychiatrist, and Why Do You Need This Book?

Anyone who has ever been to court for any reason knows that people's behavior in front of judges is not always polite, decorous, or appropriate. We often attribute the anxiety, yelling, or tears to the stress of the high-pressure situation, and many times, that's all it is. But what about those cases that simply scream "crazy" from the very beginning?

Psychiatry is a branch of medicine that incorporates biological, psychological, and social information and constructs for assessing and treating patients. Forensic psychiatry is different. Forensic psychiatrists are trained to evaluate individuals for a third party. Unlike general medicine or general psychiatry, people involved with the legal system generally do not wish to consult a psychiatrist for help with their emotional problems. Of course, there are some applications of forensic psychiatry in which an individual will bring psychiatric information about himself to the court, and we will deal with those specific issues later. However, the first part of this book will deal with incidents and eventualities, which might require the expert testimony of a psychiatrist, and, most importantly, how to understand, interpret, and utilize the information the psychiatrist brings to the case. After all, your expert might look really professorial in his pinstriped suit, but if he does not really know what he is talking about, neither will you.

The second part of the book will discuss specific psychiatric symptoms, which might present themselves to a lawyer. This section is not intended to be a comprehensive course on psychiatry, which, after all, requires a four-year residency-training period following medical school. It is also not intended to be a course on landmark cases, or how to figure out what case law to summon up for your particular legal needs. Those books already exist. This book is different. We are going to focus on some of the most popular myths and presentations of insanity, discuss what they might mean, and how best to understand and interpret them, so that you, as an attorney, can identify what types of individuals might necessitate a call to a psychiatrist. We are focusing on the psychiatric needs of the individual who walks in the door, not the specific case, which is different than every forensic psychiatry book you will ever read or consult. I am going to show you how to let your assessment of your client drive your legal theory, instead of letting your legal theory drive your use of a psychiatric expert. Please pay close attention, because to my knowledge, no other psychiatrist or psychiatry book has ever taken this kind of approach before.

We will address how to utilize expert consultation and testimony in a legal case. Although the possible permutations are virtually limitless, a number of situations present themselves over and over and every lawyer should recognize them. For example, I once consulted in a case in which I reviewed the plea bargain agreement for a first-degree criminal offense. The first question was: "Can you read and write the English language?" The defendant's answer was "No." The defendant was then asked to circle the correct answers to each question, plead

guilty to the offense, and sign at the bottom of the page. Who advised the defendant to sign a document which he couldn't read? His own public defender! That case is currently on appeal for post-conviction relief. While the legal specificities are different in every state and province and in different jurisdictions around the world, the general principles are the same. At least in the English-speaking world, defendants are afforded a variety of protections, and one of them is the right to counsel. A counselor who does not understand his client's mental status, and thereby does not understand the true facts of the case, can commit grave errors without even realizing it.

In my experience, attorneys want to win. However, one of my lifelong mottos has always been: pick your battles. A prosecutor should realize that convicting certain types of mentally disordered people for crimes which these people did not even realize they were committing, is like shooting fish in a barrel. It might be a better expenditure of the taxpayers' time and money to convict the really bad guys. And this idea brings me to the final part of this book: Psychopathy, and Other Weird Things. The literature on psychopathy is extensive, and everyone seems to be interested in psychopaths. We will learn how to recognize psychopaths and how to understand and interpret their lies. We will touch on the subjects of malingering versus factitious disorders and the ever-popular defenses of dissociation (i.e., "Multiple Personalities") and amnesia. Whichever side an attorney represents, some understanding of these issues can prove critical in a legal matter.

We will begin by defining psychiatry and examining one (fictional) man's foray into the legal system.

Imagine that you are a public defender. You are assigned a new client. He's been charged with terroristic threats. He has threatened to kill the president and the president's wife and children—but not the president of the United States, which would immediately make this case a matter for the FBI, Secret Service, and the federal courts. He has threatened to kill the president of Congregation Beth-Mishugaim, a local synagogue.

The client's name is really Benjamin Goldstein, but he has informally changed his name to Mohammed Abu-Amy. His daughter's name is Amy, and somewhere he learned that one convention in the Muslim world is for fathers to call themselves by the name of their children, as in "father of whoever." Abu-Amy means Amy's father. Never mind that a true Muslim would never use the name of a daughter. Until recently, our friend Mr. Abu-Amy worked as a podiatrist in a three-doctor practice, but he stated he had amassed significant funds and he told his partners he wanted to take off some time to spend with his family. His family, incidentally, are members of Congregation Beth-Mishugaim, and his two children, 11-year-old Amy and eight-year-old Zack go to Hebrew school there. His wife, Jennifer, a convert to Judaism, drives a carpool. You know this information only third-hand—through the police reports and his wife's messages on your voice mail—because you are busy and just need to clear your desk. You get a copy of Ben's rap sheet and learn that he has no previous criminal charges, ever. His wife sends you his CV, which you scan, and think, maybe I should have gone to podiatry school instead. You don't understand how he qualifies for a public defender, until you learn that he recently donated all of his savings to a charity for Iraqi war orphans and that his house is heavily mortgaged. His wife Jennifer is a stay-at-home mom, and her Mercedes SUV is leased—chances are she will be losing that soon, unless her parents come to the rescue—which she tells you, is possible, but they will not help Ben with his legal fees because they still resent the fact that she married a podiatrist. After all, if she was going to marry a Jewish doctor, couldn't he at least have been a real doctor?

Let's stop right here. Does anyone notice anything strange about this story? Don't be afraid—the answer is yes, of course, this guy is crazy. The question now becomes, at what point in this process do we deal with the craziness?

The answer is that in most cases, nobody addresses the craziness at this point. You, the public defender, arrange a plea agreement in which Dr. Abu-Amy admits that he caused a public nuisance at his synagogue. He agrees to pay a fine and go to "counseling." Everyone's desk is cleared that day, and you go home to search the wanted ads for corporate law positions.

This story is fairly unremarkable. Many public defenders see cases like it every day. I taught a one-day workshop a few years ago, which I ambitiously called "Psychiatry for Lawyers." I worked so hard to prepare, and had four cases ready (we will meet them all later in this book—unlike this example, they are all real). At the end of the discussion period, as I struggled to explain what Fetal Alcohol Syndrome and Fetal Alcohol Effect were, and the difference between Psychopathy and Pseudopsychopathy (we will get to that later, too), one public defender in the back of the room raised his hand and said, sort of sarcastically: "I don't know what the big deal is. This guy is exactly like every single one of my cases." And at that moment, this book was born.

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Psychiatry v. Everything Else

What Is Psychiatry?

Psychiatry is a branch of medicine specializing in emotions and behaviors. Or, to directly quote Wikipedia: "Psychiatry is the medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. These include various affective, behavioural (sic), cognitive and perceptual abnormalities." In other words, psychiatrists deal with patients who are suffering from or exhibiting signs and symptoms of mental disorders.

The next question, clearly, is what is a mental disorder? This question is actually much more important than the first, because in order to have a doctor for something, we first have to define that "something." And this something is hard to define. Mental illness has existed as long as humans have existed, as far as anyone can tell. The Bible contains references to insanity. Many are vague and use the word "madness," although no one knows what the original meaning was. Clearly, as early in history as humans were capable of documenting their observations, they observed that some people behaved in ways outside the norm. King Saul was described as having had fits of euphoria alternating with black despair—certainly consistent with a modern view of bipolar disorder (more on this diagnosis later). The Talmud, the great body of literature expounding on the Jewish Law, the Torah, says that King David wondered why God would have created something as "purposeless" as insanity. Then David flees to the court of Achish the King of Gath, where he fakes insanity in order to save his own life. Implicit in this story is the concept that faking insanity bestows upon the faker social conditions and treatment different than that of a non-insane individual—the earliest known insanity defense. Thus, the Talmud decides that insanity can have a purpose after all. The Talmud also goes into great detail about legal decisions made while mad or insane. Interestingly, Maimonides, the philosopher and physician who wrote his own code of ethical behavior, finds that insanity covers so many different variations that it cannot be defined, but rather must be decided by a judge! We might say that Maimonides was the first forensic psychiatrist, even if he never did a fellowship, was not board-certified, and fell into the subspecialty via general family practice medicine.

Although forensic psychiatry was not officially practiced in Biblical times, we see that the roots of the differences in behavior and responsibility between the sane and the insane were documented as far back as those days. The word "forensic" itself means "in the forum," and the Forum was the location of legal proceedings in ancient Rome. The Hammurabi Code, the ancient law of Mesopotamia, had a special section reserved just for dealing with insane criminal defendants. The legal system throughout the world apparently has recognized since the beginning of recorded history that mentally ill

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individuals lacked the same capacity for reason as their non-mentally ill brethren. Only today is the insanity defense fairly rare and the concept of mental illness extremely hard for people to grasp. My goal in this book is to make it a bit easier to recognize the mentally ill, so that whenever a person who is less than psychiatrically stable crosses your threshold, you will know what to do.

The first modern mention of the concept of forensic psychiatry in the English-speaking world was around 1843. In that year, Daniel M'Naughten fired a gun into the back of Edward Drummond, who died five days later. Drummond was the secretary of the British Prime Minister, Robert Peel. Without the benefit of technology and the 24-hour news cycle, the mentally ill Mr. M'Naughten had mistaken Peel's secretary for Peel himself. M'Naughten's actual motivation for wanting to kill Prime Minister Peel remains obscure, but clearly, the motive was something crazy, because out of this murder, the modern-day insanity defense of both the United Kingdom and the United States was born. The other English-speaking and English common-law-based jurisdictions, Australia, Canada, and New Zealand, all utilize some versions of this law as well.

While the English system utilized certain aspects of insanity defense prior to the introduction of the M'Naughten Rule (or M'Naughten Rules, as it is sometimes called, since the court had boiled down the determination of sanity to five questions), this case is the first landmark case of modern forensic psychiatry. In part, the rule states that:

> *to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.* (original British spelling unchanged)

In the United States, before anything could be done about using insanity in legal matters, an attempt was first made to determine how often such a thing might be required. The first official attempt to acquire information about the frequency of mental illness came with the 1840 census, which had a category for "idiocy/insanity." By the 1880 census, seven options were available for mental illness: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. Today, those categories have been subsumed into other more official sounding diagnoses, and most modern psychiatrists would be hard-pressed to determine the disorders described by those archaic-sounding diagnoses. However, please remember that just because the name of something changes, the actual condition, symptoms, and clinical presentation do not change. Dipsomania then might be called alcoholism today, but it still exists.

Since those early beginnings, statistical data have been utilized in the United States to form diagnostic categories of psychiatric illness. The American Medico-Psychological Association, later to become the American Psychiatric Association, joined with the National Commission on Mental Hygiene to formulate and enact a plan to gather uniform statistics from mental hospitals all across the country. A psychiatric nomenclature (or

jargon) began to be developed. Later, following World War II, the United States Army and then the Veteran's Administration developed an even broader language of psychiatry to better classify, identify, and treat the disorders of soldiers. More or less concurrently, the World Health Organization (WHO) published the ICD-6 (International Classification of Diseases, Sixth Revision), which was the first ICD to contain a section on mental disorders. The ICD remains the publication utilized throughout the world for medical diagnosis classification, especially for the all-important billing codes. Eventually, the statistical information gathered from hospitals and the census became part of a standardized way of classifying mental disorders, and in 1952, the first DSM (*Diagnostic and Statistical Manual of Mental Disorders*) was published.

One of the early reviewers of this book was concerned that it would have no international appeal because the DSM is an American publication and its diagnoses are limited to the United States. In reality, psychiatry is psychiatry the world over. Moreover, the diagnostic criteria and codes of the DSM are part of the ICD, which is an international publication. Schizophrenia in New Jersey and schizophrenia in Timbuktu have the exact same diagnostic criteria. Furthermore, (like that—two legal jargon words in a row?) schizophrenia itself is indistinguishable in New Jersey and in Timbuktu—insofar as schizophrenia is ever indistinguishable from itself. The most interesting feature of psychiatric disorders and the thing that makes them so difficult to identify and explain is that they are all so unique. The general features of psychiatric disorders are common to every disorder in a category. The specifics of the illness occur only in the individual who suffers from his own unique version. This concept can be so difficult to understand that I will only mention it here and try to address it elsewhere, but it may really need its own book one day. Another way to explain this concept is that the features of the disorder—the delusions, the hallucinations, the poverty of thought, the autism, all of the things that make schizophrenic people look schizophrenic—are common to all schizophrenics. The delusions of control happen to all schizophrenics. But the details—how they are being controlled, who is controlling them, why they are being controlled, all of the coloring in of the disorder—are as unique to each schizophrenic individual as their fingerprints. It is the uniqueness of each mentally ill person's mental illness that makes the whole concept of mental illness so difficult to understand to people who are not psychiatrists. Even clinical social workers frequently have difficulty with diagnosis. I see this conundrum every day in my private practice. Therapists only know that patients are unhappy or dissatisfied, but somehow they are often unable to put the pieces together in a cohesive way. The therapists and the patients get lost in the details of the patients' lives and cannot figure out what the diagnostic criteria are. The reverse, of course, is true as well. I know plenty of psychiatrists who put people into diagnostic categories and ignore the details of the patients' lives that are so troubling to the patients. The best outcomes occur when the patient and therapist can communicate about the overall picture as well as the details, and when the doctor or non-MD therapist can figure out a diagnosis and a pharmacological approach, as well as understand the circumstances unique to the patient's life and design a psychotherapeutic treatment that will work for the particular individual. While this type of a treatment plan

seems intuitive and normal, you'd be surprised how infrequently it seems to actually happen. And this failure of providing individualized treatment is not necessarily the fault of the treatment providers. Insurance companies and even professional organizations increasingly demand "evidence-based" treatment protocols, based upon large research groups of subjects and not upon individuals.

To further look into this troubling paradigm, I interviewed a leader in this field, Dr. Eric Plakun. Dr. Plakun is the founder of the American Psychiatric Association's Caucus on Psychotherapy and a proponent of maintaining the biopsychosocial model in the face of immense pressure to shift to something he jokingly refers to as the bio-bio-bio model, a term possibly initially coined by another icon in the field, Dr. John Read, together with his colleagues in an article in 2009. In that famous piece, Dr. Read opines that the modern trend of mental illness is toward a paradigm in which everything is thought to be only biological, and any other influences, such as dysfunctional families, abuse, neglect, domestic violence, drugs, alcohol, or any other factor known to be causally related to psychosis is pared down to the role of a trigger or a biological influence only. Another outspoken such critic was an ex-president of the American Psychiatric Association (APA), which publishes the DSM. The late Dr. Steven Sharfstein was publicly critical of this bio-bio-bio model and also may have coined the phrase. Certain things are so good that lots of people want to take credit for them.

Whoever made up the bio-bio-bio model, in a recent article in the *Psychiatric Times*, Dr. Plakun remarks upon this trend toward this model, and identifies three misconceptions which heavily influence both the field of psychiatry and the general public in this regard. These are the following:

- Genes equal disease
- Patients present with single disorders that respond to single evidence-based treatments
- The best treatments are pills

Dr. Plakun's article explains why these assumptions are false, and a quick and dirty literature search reveals a whole world of information that shows exactly why and how he is right. In summary, no specific genes for specific diseases have been identified that are present in every case of every mental disorder; patients rarely have only one disorder, and when they do, many different treatment modalities (such as psychotherapy and exercise) are as effective, if not more effective, than medication, and medications do not always work, and if you read the fine print on any medication package insert you will find: "The exact mechanism of action is UNKNOWN." This previous sentence is a very gross summary, of course. We can write volumes on how and why the bio-bio-bio model is false. Another problem too is that our brains and our bodies are biological organisms. So while we may not really know anything about the biology of mental illness, at the same time, we know quite a bit. We know that neurotransmitters do mediate communication between neurons in our brains. We know that every single thing that happens in our brains and our bodies is a biological event. We know that without brain activity we die. The expression

"flat line" exists, and it does not refer only to cardiac activity. Brain death is a thing, and it is important in infinite variations in the legal system. We cannot separate mind and brain. But at the same time, we are not our neurotransmitters. And it is at this juncture that the faith-based people try to climb on board and derail the train, insisting that the soul is somehow in there with a life of its own. Who knows—maybe it is. But I am a scientist and until proven otherwise, while I do not deny the existence of a soul, I still believe there is a scientific explanation for personality, mental illness, and the interface of environment, genetics, stress, non-stress (i.e., good stuff), and everything else. There is some way in which the outside and inside world interact with each individual's biology to create each individual. And there is plenty of scientific evidence to support my statement. We know that identical twins who live substantially different lives end up with slightly different DNA. These differences are not in the parts of the DNA that code for hair, eye color, or which version of liver enzymes they have. Instead, the differences are in the telomeres—the parts of their DNA that were once thought to be "junk" DNA, that are now thought by many experts to be related to aging, prevention of oxidation, prevention of cancer, and a whole bunch of things that are still very minimally understood. We ("we" being the real scientists that work in laboratories, but I like to consider myself at least an honorary cousin-type member of that group) now have actual physical evidence that the environment changes our biology. The future is now. With this bit of knowledge in my back pocket, so to speak, I decided to contact an expert.

I wanted to directly speak to Dr. Plakun to see how he thought I could best explain these false assumptions about psychiatry to an audience of attorneys. When even psychiatrists do not seem to understand how we are being manipulated by the health insurance industry into providing inferior care for our patients, how can we possibly expect a court to ever order a true fair outcome or standard or care? I find this lack of parity a huge problem, so I figured I'd better contact an expert right up front.

Dr. Plakun was kind enough to take my call. He told me quite a few interesting things. His opinion underscores my belief that there is a lost generation of psychiatrists who do not know anything about psychotherapy. For the past 20 years or so, psychotherapy training has been absent from psychiatry residency training programs. Gone are the intensive hours of supervision, the process notes, the one-way mirrors, and the T-groups (I don't know if we ever really knew what that T stood for—possibly transference, possibly training, possibly something else). Gone are the hours of reading Freud in bad, flowery translation, the hours of watching videos of family therapy sessions, the processing of what happened in the community meetings on the "unit" (the long-term inpatient unit where the chronic schizophrenics lived, sometimes for years), and what happened in that meeting that triggered Anne-Marie's or Walter's need to get up and go to the bathroom at that exact moment. Those amazing hours spent thinking and talking about what we thought was going on in the minds of our patients, and what was going on in our own minds and those of our colleagues—all gone, as if none of it had ever really mattered. Now it's all medication, and all keeping people out of the hospital in order to keep costs down.

While the total amount of knowledge about the brain's biology has grown immensely, the individual psychiatrist's knowledge about the brain does not seem to have grown at all. The field of psychiatry has been so influenced by outside factors that the very things which drew so many of us into psychiatry—what makes people think, and what makes them think in crazy ways—has been abandoned for the much less interesting component of "how can we save the insurance companies money?"

Dr. Plakun pointed out a problem that we mentioned here right in the introduction—that so many people are diverted from the mental health system into the criminal justice system.

"I think it's a national tragedy," he told me. "The promise of the community mental health system in the sixties and seventies has fallen apart because of inadequate funding. People are diverted from an inadequately funded mental health system." He went on to tell me that what the emerging science is teaching us is that "William Faulkner was right… 'The past isn't dead; it isn't even past.' All the evidence is that early adverse experiences shape later psychiatric and medical outcomes." In other words, everything that happens to us as we develop from fetuses to babies to children into adults shapes our brains, bodies, and behaviors. Biology and psychology are inextricably linked; it is silly to pretend otherwise, and it is not therapeutic to treat patients as if their neurotransmitters are somehow functioning outside of their life experiences. While traditional psychoanalysis did not specifically include biological changes in the brain as mechanisms for psychopathology, we now know that experience changes brain biology. However, knowing that experiences change brain biology does not negate the effect of life experience, trauma, or any of the things that traditional psychoanalysis taught us.

And the body is not exempt from the brain's biological whims. For many years, psychologists have acknowledged and studied the brain–body connection known as the fight-or-flight response. When mammals, including humans, are threatened, an ancient survival mechanism is instantly triggered. The mechanism was initially proposed by one of the fathers of psychology, Walter Cannon, about a century ago. Cannon proposed that animals, including humans, react to threats with a general discharge of the autonomic nervous system, resulting in a release of a class of neurotransmitters called catecholamines, primarily adrenaline, (also called epinephrine), as well as norepinephrine (also called noradrenaline). These are released in the brain and in the periphery (the rest of the body). Catecholamines are produced in a pathway that includes other famous neurotransmitters, which you have no doubt encountered in your forays through the world of psychiatry: dopamine and serotonin. So we have just learned a few important things. First, that the fight-or-flight response, which starts in the brain and moves into the rest of the body, involves chemicals that work on both the brain and the body. Second, the main neurotransmitters responsible for the fight-or-flight, adrenaline and noradrenaline, which give us that "adrenaline rush," which we will discuss in several other places in this book, are also important in a pathway, something like an assembly line, with other neurotransmitters that are clearly implicated in ways which remain only partially understood in most mental illnesses, including depression, bipolar disorder, and schizophrenia (see Figure 1.1).

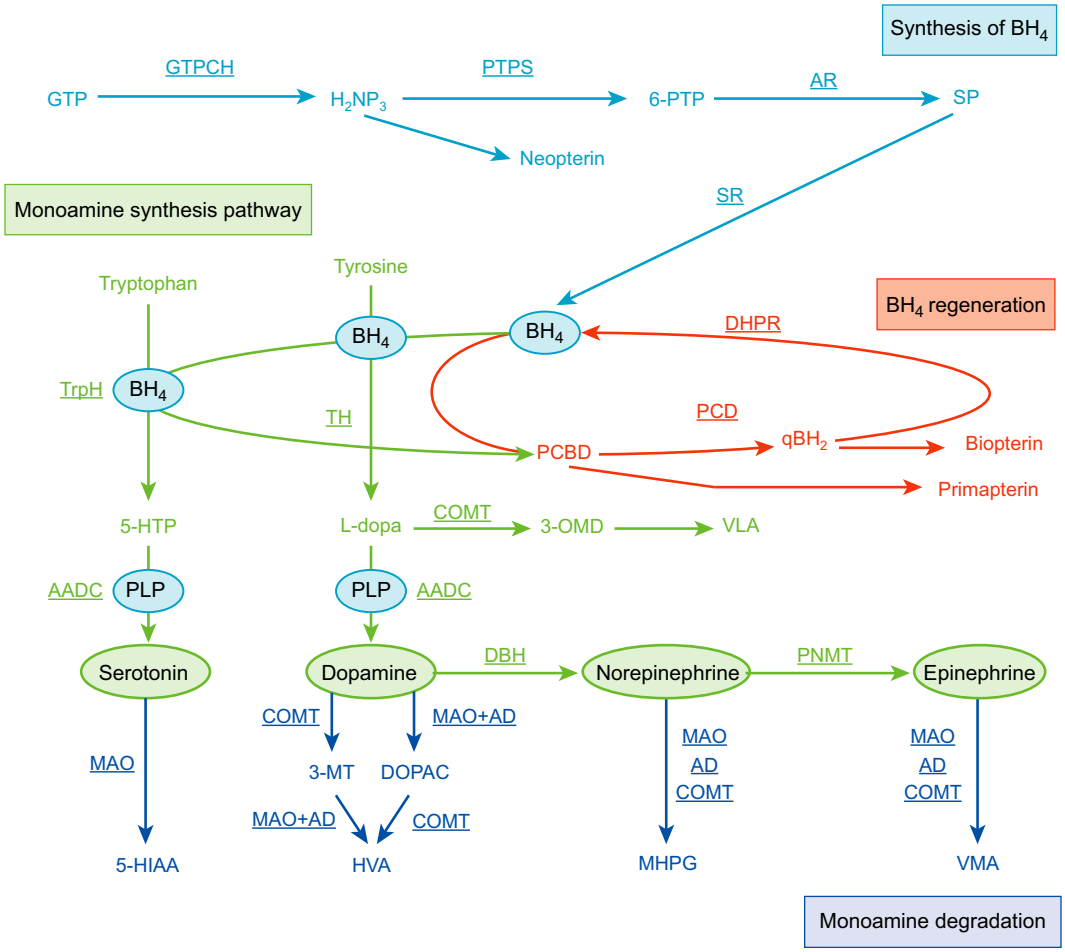

FIGURE 1.1 Pathways of catecholamine synthesis and breakdown.

But there is another important piece to this fight-or-flight puzzle, which relates to Dr. Plakun's dire predictions about the interactions between early trauma and its effects on the mind and body. New scientific evidence strongly suggests that the fight-or-flight component of the autonomic nervous system is meant to be an emergency backup system. We are not meant to engage our fight-or-flight response on a regular, daily basis. We are not supposed to experience stress round-the-clock. Unfortunately, our modern-day, 21st century brains do not yet distinguish between a mountain lion on our cave-step and the bills piling up on our doorstep. Stress is stress, and when we cannot keep up with the Kardashians, or whomever we're supposed to be keeping up with, we feel stressed. We live by artificial light, we eat artificial food, we wear artificial clothes, and we take artificial medications. I am not asking anyone to stop doing any of these things, and I do not claim to know that if doing any of these things is bad for us. But I do know that our

bodies and brains evolved to their current state in a time when these artificial things did not exist, so to say that sitting in a chair in front of a computer screen for 12 hours a day is a stressor that our bodies, eyes, and brains are not really built for is not a stretch of anyone's imagination. I personally use my daily walk as a reward. Is that weird? I know quite a few other people who do the same. Walking as reward, in a world that defines itself by the day the humanoids climbed out of the trees and began walking on their two bottom legs.

So one night, I went to a drug-company-sponsored dinner, and I confess, I went there because I was scouting for talent. I need psychiatric help! I need another psychiatrist or a psychiatric nurse practitioner for my office! I'm too busy! You know what they say, be careful what you wish for! There was an awesome speaker, though, so going to that dinner turned out to be a huge bonus for me, even though I couldn't get the psychiatric help I needed.

The speaker was Jon Draud from Nashville, Tennessee, and he said a lot of really interesting things, but one specific thing really made me sit up and pay attention. He is the one who said that the fight-or-flight response was not meant to be on 24-7. Not only was the ongoing stress response bad for our brains, it was also bad for our bodies. Research was showing us that the constant secretion of catecholamines was actually causing medical illness in our bodies. Once we used to believe that medical illness caused depression and anxiety. Now it seems that depression and anxiety literally cause biological changes in the periphery—in other words, brain changes cause medical problems in the rest of the body.

Take-home lesson? We don't know everything, and we don't even know what we don't know. Let us be very, very careful before we allow our experts to call each other names.

We are now on the DSM-V, which was published in May of 2013. This Fifth Edition changed some names and diagnostic criteria. It invented a few new disorders (Binge Eating Disorder, anyone?) and dropped some other ones. Certain conditions seen daily in clinical practice, especially in the practice of forensic psychiatry (e.g., psychopathy, which also needs its own book, cutting or "self-harm," and pathological lying) are not DSM diagnoses. One can only speculate as to why not, but the fact remains that new disorders have not suddenly sprouted onto the face of the earth since the early days of the ICD-6 and the DSM-I. The only things that have changed are our way of understanding these disorders and our ways of treating them. Psychiatric disorders are now explained and categorized differently than they used to be, and undoubtedly when the DSM-VI comes along in another ten or 20 years, it will introduce even more changes to the official bank of psychiatric diagnoses. The DSM itself, via the American Psychiatric Association (APA), is attempting to trend toward a more biologically based understanding of mental disorders, but currently the science is still under development. As we discussed earlier, some critics call recent trends in psychiatry the bio-bio-bio model, a satirical play on the traditional biopsychosocial model, which was the traditional way of looking at mental illness for most of the last two centuries, and probably most of even prerecorded history, if the Bible and Hammurabi's Code are indicative of early mores. Despite recent problems

in the conceptualization of psychiatry and mental illness, the DSM remains important. While the actual diagnoses are basically made up, they all represent clusters of signs and symptoms that occur together in fairly predictable ways. While incomplete in some ways and overinclusive in others, the DSM gives all mental health professionals a way to speak the same language. Because the ICD is an international classification of diseases put forth by the World Health Organization, the DSM is utilized in many countries outside the United States. Therefore, this book is not limited to lawyers practicing in the United States—understanding psychiatry should be an international goal.

We psychiatrists know perfectly well that the diagnoses in the DSM are merely groups of signs and symptoms that frequently occur together. In regular clinical treatment practice, this knowledge is useful, especially when it comes to getting paid by health insurance companies. In forensic practice, however, these diagnoses become in some ways far more important than in clinical practice. I have seen many cases in which the diagnosis becomes more important than the symptoms. For example, we know that bipolar disorder is overdiagnosed. Bipolar disorder, once called manic-depression, is a severe, cyclical, psychiatric disorder, in which the sufferer can expect to take medications for a long time. The only absolute criterion for bipolar disorder is a history of one manic episode. The criteria for a manic episode are well and clearly defined in the DSM, and for a good reason—the disorder is very dramatic and requires ongoing clinical monitoring and treatment of the patient. While the etiology—the underlying causes—of bipolar disorder is not known—let me repeat—NOT KNOWN—we do have many theories about its inheritance, causation, and biology. There is definitely a biological component, and there are definitely at least some variants of bipolar disorder that are inherited, or at least some of the components of the disorder are inherited in some people. These facts are terrifically important in the study of mental illness, but they do not really have anything to do with treating any individual patients in any specific clinical setting.

So how come so many people are "bipolar" today? Two reasons—one sort of scientific, and one completely bogus. To understand how bipolar disorder became as common as the common cold, we have to first consider the topic of personality disorders. A personality disorder is defined in the DSM as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." One of these personality disorders is Borderline Personality Disorder, which is fully described in the DSM V on page 663. I will not go into the details here. The problem is that Borderline Personality Disorder is characterized by rapid changes in mood and affect. The disorder includes many other features as well, but in general, insurance companies do not cover treatment for personality disorders. Since I started my training in the late 1980s until today, millions of new "bipolar" patients have been discovered. Those patients would previously have been classified as borderline and sent to frequent psychotherapy, psychoanalysis, or inpatient borderline units. Those units and those treatments do not really exist anymore. And neither does that diagnosis—those patients are now all "bipolar."

Not surprisingly, many of the pharmacological treatments we use to treat bipolar disorder are the same as those used for borderline personality disorder. The reason I say that the similarity in treatment is not surprising is that the symptom pictures are similar. When we have similar symptoms, and we know now that biology is involved in some way, we are going to have similar treatments. However, this similarity is also the problem. We have plenty of scientific "evidence" classifying bipolar disorder as "biological." I put all these words in quotation marks because the health insurance industry, as well as the psychology lobby, still insist that personality disorders are somehow not "biological." And so now we are back to our previous conundrum—the problem of biology versus psychology—even though we have clearly established that everything we ever do, from typing a word, to having a hissy fit, to crying or sneezing or chewing gum, has a biological component. In reality, every day, new studies are published showing the relationship of certain personality disorders to certain chronic psychiatric illnesses, which are considered biological by the mainstream. These details are beyond the scope of this chapter or this book. What is important to know is that every time you think something or do something, something biological happens. The fact that we—we being the psychiatrists and neurologists and neuroscientists of the world—do not know the exact mechanisms by which thought and behavior occur is irrelevant. Science has progressed to the point that we absolutely do know that all thought, feeling, emotion, behavior, and action begins in the brain. The brain is a biological thing. Cut off its oxygen and glucose, and death occurs—no more thoughts, feelings, emotions, behaviors, or actions. Depending on where in the brain the oxygen and glucose loss occur, we see more or less impairment of these things. Cut off the fuel below the part called the brainstem and certain functions will continue—breathing, sweating, and heart beating. Cut off the fuel higher up, closer to the spinal cord, and those functions stop too. Cut it off higher, or in just one place (as happens with what is commonly called a "stroke") and only certain functions are impaired. The body of evidence that behavior and thought is biologically based is enormous. I once worked in a hospital whose neuroscience division had an ornate doorway featuring a massive mural representing the universe. The metaphor is perfect—so perfect that I used it on my website. Inside each human brain is an entire universe. Every single thing that we do is governed by biological reactions so complex that they are not yet even partially understood. Neuroscientists in laboratories spend entire careers trying to understand what happens when a molecule of neurotransmitter hits a receptor. There are lots of neurotransmitters and lots of receptors. We psychiatrists try to utilize the biological findings in a clinical manner, in order to help people live happier lives. We don't claim to understand the details of the biological mechanisms, especially as many of them have not even been discovered yet. But we know, far beyond a reasonable doubt, that brain and behavior are inextricably linked. Unfortunately, this little bit of knowledge has become a truly dangerous thing, resulting in this reductionistic bio-bio-bio theory of mental illness we discussed earlier—the idea that mental illness is a purely biological phenomenon that can be treated solely with the right combination of pills. Maybe a few patients can be treated with medication only—those few patients

with perfect lives, perfect relationships, perfect bodies, perfect psyches, and perfect SAT scores. I've never met any of those people, but one probably exists and she is doing great on Prozac, somewhere. For everyone else, there is the biopsychosocial model, like it or not. Our environment, our thoughts, our friends, our behaviors, our moods, what we eat, how we exercise, what we watch on TV, what we read, where we go, and who we know, all influence our brains, which then enact these influences in a biological way. Get it? See Figure 1.2.

FIGURE 1.2 A person being influenced by everything in the world, with neurotransmitters buzzing around in her brain.

Now, back to our overused diagnosis of bipolar disorder. In forensic practice, I have seen legal cases completely derailed by the issue of diagnosis. One case involved a true bipolar—a young woman who had a manic episode every few years. During one of these manic episodes, she met a man and had a child by him. She was unable to care for that child, especially when she entered her depressive phase and could not get out of bed, much less meet the needs of an infant. In that case, the father stepped in, took custody of his daughter, and moved away to another state. The mother was briefly hospitalized but then did not receive any follow-up treatment. She was relatively stable for a while, had a job, and even resumed visits with her daughter. But then she became manic again, which is when I was consulted by the court.

I saw that woman three times in about two years. The first time, she was in a depressive episode. She had just given birth to another child, who had also been removed from her custody by the state. She was tearful, anhedonic (unable to experience reactive joy), suffered from insomnia, loss of appetite, and all of the official signs and symptoms of depression. I was provided with only a little information about her past, but putting the pieces together (she was depressed, not stupid), I was able to understand how she had lost custody of her first child. I recommended psychiatric treatment and gradual reunification.

Time passed. I received another call from the case-worker asking me to evaluate this woman again. I agreed. This time, she was flagrantly manic. She was accompanied by the father of her new baby—a 24-year-old unemployed loser (my words). She herself was in her mid-thirties and college-educated. This time, I recommended psychiatric treatment again. Again, I wrote that the diagnosis was bipolar disorder. I included "most recent episode manic." I included all of the diagnostic criteria, word-for-word from the DSM, in my report.

After some time, the state wanted me to see her again. On this occasion, the woman was depressed. I do not recall what the legal situation was, but at this point I was asked to testify in a hearing. The testimony was over the phone. Note: When possible, please avoid phone testimony. While the judge and attorneys might think they are doing a busy psychiatrist a favor by not making her come to court for a 20-minute appearance, those 20 minutes will be far better understood in real life. How do I know? Here is the outcome of my 20-minute appearance: the judge turned to the young woman, patted her arm (I know this anecdotally; I have no idea how he could have gotten close enough to her to pat her arm) and said, "Don't worry, honey, you're not really bipolar." The judge (before whom I had previously and since testified many times) generally respected my psychiatric opinions. However, he was under the media-induced belief that bipolar means you are constantly agitated and upset. He was confusing bipolar disorder with personality disorders, acute reactions to stress, adjustment disorders, and a dozen far less serious psychiatric disorders that he sees in his courtroom on a daily basis. And for that particular woman, he was not doing her any favors. The only way she was going to regain custody of her children and live a normal life was by taking mood-stabilizing medications

indefinitely. To deny her an appropriate and correct diagnosis was to deny her appropriate and correct treatment, and ultimately, deny her children a healthy mother. I must say I never quite regained my previous respect for that particular judge.

Another example concerns a case in which I examined the defendant for her public defender. This example also brings up an important point: lawyers, steer clear of experts who only do evaluations for one specific side. In reality, an expert's expert opinion is far stronger if he or she considers every case equally and honestly. At least start by using an open-minded expert. When you pay for an opinion, the other side will know it.

So back to this case. In this instance, a 31-year-old woman had lost custody of her 10-year-old daughter. The father was completely out of the picture and had relinquished his parental rights and moved to another state. The mother had a long-standing history of psychiatric issues and substance abuse, as well as a total of 10 arrests (none for indictable offenses). At the time that I was asked to evaluate her, the mother was in an inpatient drug rehabilitation facility and also taking psychotropic medications. The daughter was in foster care.

The state's psychiatrist had opined that this woman could not care for her daughter because of her substance abuse, posttraumatic stress disorder (PTSD), and "rule-out bipolar disorder." He knew as well I as did that she was not bipolar. This particular psychiatrist does hundreds of cases for his state's Child Protective Services each year. He always writes exactly the same report and spends only about 10 to 20 minutes with the people he is evaluating (I know from speaking to hundreds of them). Often after he does an evaluation, the individual is referred to me anyway because his audience does not know what he is talking about. What really annoys me about him is that he is not stupid. He lies and knows he is lying. He spins information and gives partial opinions in order to always find that the parents cannot parent at the moment—in order to keep the work and the referrals flowing his way. He does not care at all about the fates of either the parents or the children, and his biases and apathy are obvious to me and to many of the case-workers who utilize his services, and often to the judges who end up sending the individuals for another evaluation. If he were merely incompetent, I would have more respect for him than I do for his sneakiness and manipulativeness.

Technically, according to the ethical principles of forensic psychiatry, our duty is not to the person we are evaluating—it is to the person who hires us and to the truth. But—and this is an important but—we are still human beings and still doctors. While we have to call it like it is, we are not supposed to lie. We are not supposed to invent a way to present this particular person in a way to support his lawyer's case. And we should still be polite and respectful to everyone we evaluate. (I spent almost 10 years working with sex offenders—it can be done. More on that later). Also, when we do evaluations for a child custody case, the evaluation is court-ordered, and we are doing the evaluations for the court. We are supposed to be impartial. I don't know how some of these experts decided that their opinions were supposed to always be that the parents could not parent and the children should always be removed. When an expert always has this opinion, the person paying for

the opinion should probably be suspicious that the expert has no actual forensic training (which is easy to find out—just ask for the doctor's curriculum vita).

The case of this woman and her daughter ended up in termination of parental rights (TPR) proceedings. The state decided—or the judge decided, or what actually happened was that the judge agreed with the case-workers who decided—that it was time to terminate the mother's rights to her child. She was finally given a lawyer (the stage at which you get a lawyer differs by jurisdiction and type of case). Her lawyer read and reviewed all the psychiatric evaluations and did not think she needed another expert, since the reports were ambiguous enough about prognosis, and the mother had complied with all of that psychiatrist's recommendations. As I said earlier, the psychiatrist was not stupid and was not actually an incompetent psychiatrist, just sneaky and mean.

The case was in court and this psychiatrist—I'll call him Dr. Sneaky for now—was actually testifying for the state and for termination when the public defender realized she needed a new psychiatric evaluation. In the middle of his testimony, Dr. Sneaky realized he might have been a little too truthful in his reports, stating that this woman could be reunified with her daughter if she stopped using drugs and took appropriate psychotropic medication, because she was now doing those things. He had, after all, found that she suffered from substance dependence and PTSD, both treatable conditions (although he considered an additional dozen rule-out diagnoses just to keep his options open). Dr. Sneaky suddenly "realized" that the mother was actually "bipolar."

"She is bipolar, she has changes in her brain, and she will never get better!!" He was so proud of this statement that he wrote an addendum to his report, saying as much.

While Dr. Sneaky was writing his addendum and finding references for his outrageous statements, the public defender was finding me. Neither of us had ever seen a case like this one. The "references" provided by Dr. Sneaky consisted of every single page turned up on a Google Search for "bipolar disorder + biology." Some of the "references" were hilarious—flyers for international psychiatry meetings, cartoons, and book promotional materials. Naturally, there were some actual scholarly articles included, some of which were fascinating, but totally irrelevant to the case.

Dr. Sneaky returned to court prior to my report being finished, so I had the pleasure of reading his addendum, which read, in part, "The typical reader of this report will not understand what I am saying, since he is not a brilliant psychiatrist like me." No joke, but paraphrased into simpler terms we mere mortals might understand. I also had the honor, ironically just now inadvertently autocorrected into the "horror," of reading the transcript of his testimony saying much the same thing but in an even more obtuse and condescending way. I'm sure that if I had been there in person, I would have witnessed the veins bulging on his forehead.

In my review and evaluation, I learned that this young woman had completely turned around her life, and that she was psychiatrically stable and had been compliant with treatment for some time. I did not invent this information; it was all documented. All I did was put it together in a coherent way. Dr. Sneaky looked like a fool (especially after I tried

including all of his "references" in my report, only to give up in frustration at reference number 30, sub-reference k):

"At this point I decided not to waste the state's money in writing down every single abstract that Dr. Sneaky pulled off the Internet to support his bizarre statements in court. Approximately 10 additional abstracts were provided, all of which were reviewed but none of which has any bearing on this case."

I did not even have to go to court. The judge read my report, laughed Dr. Sneaky out of the courtroom, and gave the girl back to her mother. All I did was tell the truth. The moral of the story? A string of rule-out diagnoses helps no one and makes your expert look like a fool. Sometimes you really can't tell which diagnosis is more appropriate—often records are withheld, information is third-hand, and people are terrible informants. But with the right education and approach to forensic psychiatric evaluation, all the evaluators should come to the same, or similar, diagnoses. When they don't—someone is trying to suck up to the attorney who hired him. And a whole bunch of potential rule-out diagnoses are a big clue that your expert might be an expert in billing for his time, but not necessarily an expert in psychiatry.

In clinical practice, what does it matter what we call a diagnosis? The answer is, it depends. If part of someone's emotional struggle is a result of behaviors and perceptions that can change with appropriate therapy but not with medication, then that specific patient needs to understand that fact. Many times I have to tell a patient: "I don't have a pill for that." And what is "that?" "That" can refer to abusive relationships, lack of self-awareness, the expectation that "I deserve to be happy because I saw it on TV."

Now, if an abusive relationship results in depression (and there are many proposed mechanisms, including many biological ones) then I can treat those signs and symptoms of depression—to a degree. One example I encounter in my practice all the time, even though I was stunned the first time I heard this story, is that of the couple who divorces yet continues to live together in the same house. Their anger leads to divorce. So now, the wife, who used to be angry with her husband because he was never home and had a glamorous job in the city while she drove carpools most of her waking hours, has to get a job. (These are her perceptions, not necessarily the truth. Sometimes there is infidelity, or alcoholism, or something else, too. Or not. Sometimes she just thinks she deserves better. There are all kinds of stories). Anyway, now they are divorced but still living together. She is now more stressed. The husband is now less stressed, because he has no responsibilities to his family, other than the automatic paycheck withdrawals toward child support. He can come home for dinner with his family, like before. He does not need to help to clean up after dinner (like before). He can go out with his girlfriend on the weekends (like before?). Meanwhile his ex-wife is now more stressed than ever, juggling kids and what is usually a low-paying job (because she stayed home for years). She comes to see me because she is depressed. I have to tell her, there is no pill for making bad decisions. If you want a happy life, you have to move on. I tell them—but there is no way to engage in meaningful psychotherapy that will help this hypothetical woman to emotionally understand this situation, because as a psychiatrist I cannot afford to take a loss on every hour I spend with a patient—an entirely separate issue from what treatments work, but still an important topic for this book.

Why is health insurance important in the discussion of psychiatric illness? For a variety of reasons. Many psychiatrists do not accept insurance. I do (for now). While the American Psychiatric Association has battled for parity for psychiatric illness and treatment in Washington, there is no parity. If I visit my gastroenterologist (stomach and intestines doctor) for a 10-minute "intake" appointment, she gets around $300. Any procedures she might then choose to do are billed separately. Insurance pays her because someone decided that speaking to a patient for 10 minutes about recurrent diarrhea is somehow harder and more "medical" than speaking to the same patient about every single thing that ever happened in her life.

When a patient who never met me before comes into the office to tell me about her problems, I give her 45 minutes for an intake. Often that 45 minutes turns into an hour or an hour and a quarter, messing up my schedule for the rest of the day. I miss lunch. Other patients are angry at being kept waiting. But the difference is that the minute she steps foot into a psychiatric office, that patient's life become my responsibility. I get, from insurance and copays, about $150 for the intake appointment. She shares with me the most humiliating and painful experiences of her life. I was trained to take my time, to spend as long as it takes to get the patient to trust me, to understand her symptoms, her situation, and her family life—both family of origin as well as current nuclear family. All of these things are critical in understanding someone's symptoms, presentation, complaints, and diagnosis. Yet modern medicine has decided that this person's whole life is less important than her diarrhea. Ironically, stress is thought to be a major cause of gastrointestinal symptoms, and we know, from some of the things we discussed earlier, about catecholamines, fight-or-flight, and the effect of certain neurotransmitters on the body, that our brains can really make our bodies sick. Perhaps if patients could get appropriate psychotherapy from trained psychiatrists, their medical needs would diminish. (A whole dissertation waiting for the right person.)

I go into these details about the contrast between psychiatry and all the other branches of medicine to make a point, and the point is not that I wish I could make more money. I do wish I could, but I decided to continue taking insurance as long as I can so that I can help as many people as possible, at least a little. In my mind, I've decided that for me, I prefer to work super hard within the constraints imposed on me by health insurance, and help more people, rather than make more money helping fewer people. I am not sharing this information to show off, or to gain any kind of brownie points. I often think I'm being stupid by practicing this way! I'm sharing it so that you, the reader—the attorney who is going to encounter an untreated psychotic criminal, or a divorcing spouse who cries hysterically in the courtroom, or a repeat sexual offender who keeps being court-ordered to "counseling," or even the family of a suicide, trying to understand what happened and who are suing the doctor or the hospital—so that you have some framework in which to understand how the mental health system works. What I've described is the best possible outcome: a patient sees a knowledgeable psychiatrist, takes appropriate medication, and remains non-suicidal and out of the hospital, and possibly even capable of holding down a job and meeting his or her daily responsibilities.

The more frequent outcome is far worse. The best of the worst is when people complain to their family doctors that they are depressed. The family doctors throw some medication

at them, and hopefully it helps a little. Whether or not it helps, most people do not become suicidal or totally dysfunctional, so they continue to live their lives unhappily but at least minimally functionally. They experience back pain, fibromyalgia, headaches, migraines, and yes, diarrhea, and are appropriately referred to all sorts of specialists for those signs and symptoms. Usually those symptoms could be better managed by appropriate psychotropic medications and good psychotherapy, but since the good psychiatrists cannot support their families on what health insurance pays, only a few people have access to that sort of treatment.

In the poorer and inner-city communities, the situation is far worse. Medicaid (which includes ObamaCare) pays about $6 for a psychiatric appointment. You can imagine that the doctors staffing these public clinics are hardly the best. Getting a clinic appointment is close to impossible, anyway. Hospitals are pressured to not admit patients, and to discharge them the second they deny active suicidal ideation. Inpatient units change medications every day so that the insurance companies (and I include Medicaid and Medicare, both of which are privately administered) allow the patients to remain in the hospital. Although there is an extensive literature on psychotropic medications, and in order for a patient to just *begin* to respond to a medication can often take up to six weeks, hospitals are encouraged to try a different medication each day until they find one that works. If the medication that "works" (i.e., the medication that is given to the patient on the day he says he does not want to commit suicide) happens to be a new antipsychotic medication that is not covered by that patient's insurance—too bad. Discharge to the community, go to a clinic (first appointment in six months), and basically, keep your fingers crossed.

I am not writing a political critique—I am trying to write a book explaining psychiatry to the legal profession. But some insider information is important. Appropriate and adequate psychiatric treatment is a luxury available mostly to the people who need it least. The socioeconomic "downward drift" of the mentally ill is a well-established phenomenon. People who are severely mentally ill cannot maintain normal relationships. They cannot work at normal jobs. They often have other behavioral and personal mannerisms that make them look weird. So they drift toward the lowest end of the socioeconomic spectrum. These are the street people who talk to themselves while pushing shopping carts full of junk. They tend to be schizophrenic (more on that later). Sure, we can all think of rich neurotics, drug addicts, and downright wackos who make the news with their shenanigans or sometimes their extremely tragic deeds. The only thing that their existence proves is that mental illness can occur in all walks of life. It does not discriminate. But if you are not to the manor born, chances are you will end up in public housing once that chronic mental illness kicks in.

For the purpose of this book, I am including substance abuse under the general heading of mental illness. I will also include some neurological disorders with mainly behavioral manifestations. Clearly, different issues arise when dealing with what generally looks like a voluntary behavior (obtaining and using drugs or alcohol) and involuntary behavior (having a partial-complex seizure during which a person does something dangerous to another person). And while criminal acts while crazy are usually the most dramatic legal

manifestations of mental illness, most psychiatric involvement in legal cases occurs in far less dramatic situations. Divorces include a high degree of psychiatric issues. Immigration cases often require psychiatric experts. Child Protective Services cases and the removal of children from their parents are civil cases, not criminal. Testamentary capacity cases rely upon psychiatric expertise when often there was never any psychiatric involvement during the person's lifetime. I can think of many more types of legal cases with psychiatric nuances, and we will explore many of them throughout the course of this book.

One attorney whom I interviewed, Kelly Singh, does not actually practice law anymore. She works for a legal publisher and writes books on law for non-lawyers, sort of a parallel to what I'm doing here. She recalls her brief time working for an immigration law firm prior to attending law school, when her firm frequently consulted forensic psychiatrists. Kelly says they were "looking" for the psychiatric consultants to say that the clients had PTSD, but additionally, she always had more questions for them. Were the clients able to tell right from wrong? Did PTSD influence that ability? Were they suppressing some sort of guilt about what they had done or experienced in their country of origin, or were they self-medicating with drugs or alcohol, or was the whole legal process somehow damaging them further? Knowing Kelly, I'm sure she had, and continues to have, about a hundred times more insight and concern for those clients than the lawyers she worked for at the time, but she brings up some fascinating points. It is impossible to separate the forensic aspects of the legal case from the underlying psychiatric concerns of the human being. We must never forget that although we are dealing with a legal matter, we are also dealing with human beings when we bring psychiatric testimony to court.

With that idea in mind, let us catch up with our fictional friend.

When we last met Mr. Goldstein/Abu-Amy, he had paid his fine for harassing the president of the synagogue and had gone off to counseling, whatever that might be. Now, here is the interesting part. You know that Ben Goldstein, aka Mohammed Abu-Amy, did not lose his job. He voluntarily left his job because he was losing his mind. You defended him and kept him out of jail, and made sure he got "counseling." He should be better by now, right?

Even though you are an overworked and underpaid public defender, you are also highly organized and you know exactly where Ben/Mohammed's file is and that in it is a release of information to speak to his counselor. Intrigued by the situation, you find the form, fax it over (all on your own time, of course) and a few minutes later, you receive a phone call from a very cooperative and youthful-sounding Ms. Brandi-with-a-heart-dotting-her-i-Jones.

"Hi!" Ms. Jones chirps brightly. "I'm Mr. Abu-Amy's counselor. I got your fax. I checked with my supervisor and she said it was okay to speak to you." (This part is extra-made up. Usually Ms. Jones will decline to speak to you despite the release of information, because she once went to a training in which someone mentioned "therapist–client confidentiality," and although she does not really understand what it means, she fears getting into some indefinable sort of trouble if she speaks to you. But let's pretend that our Ms. Jones does understand the concepts of informed consent, release of information, etc., and is willing to talk).

"Hello Ms. Jones." Meanwhile you are thinking, Mr. Abu-Amy? His name is Goldstein. "I was wondering how Mr., ahem, Goldstein is doing in counseling."

"Oh, he prefers to go by Abu-Amy. Mohammed. He likes to be called Mo. And that's his civil right, you know. He can be any religion he wants and call himself anything he wants. It's in the Constitution." Ms. Jones sounds very sure of herself, despite having the voice of a 14-year old.

"Um, okay. So how is Mo doing?"

"Oh, he's doing great in therapy. Really talkative. Has some real creative ideas for a business. He was real depressed when he lost his job but now he is thinking about studying to become an imam."

"Is he—so you don't think he's mentally ill?"

"Mentally ill?" Ms. Jones laughs. "Ben is a pleasure to work with. He is always cheerful. He has great ideas. He even writes to the president once a week. He has so much self-esteem. I'm going to be closing his case soon. I just have to write a letter to the judge telling him that Mr. Abu-Amy is no longer in need of services."

I hope by this point you are appalled. However, while the facts and details are changed, this story is true. Seriously mentally ill defendants are virtually never referred for psychiatric treatment. They are referred to "counseling." The "counselors" are frequently very young, eager, and minimally trained individuals who staff the community mental health centers and other clinics where indigent and other poor patients are referred by the courts.

The judge in Mr. Goldstein/Abu-Amy's case, however, does not know any of these things. He knows that a guy who seemed to be a bit unbalanced was referred to counseling as part of his probation. The probationer successfully "completed" counseling. The probation officer, glad to have one fewer case on her roster, gladly terminates probation early. The case is closed, Mr. Goldstein/Abu-Amy is free to go, and he accompanies his wife, two children, two cats, one dog, and four goldfish from his east coast home to the midwestern state where his wife grew up and where his in-laws still live.

You think to yourself, good thing this lunatic is now someone else's problem, and turn back to the 7000 other case files on your desk.

2

Psychiatry v. Law

…We hold these truths to be self-evident:
That all men are created equal…

When our founding fathers included these words right at the beginning of the Declaration of Independence, the concept of all men being created equal apparently was so self-evident that it was not really mentioned again anywhere, except in hundreds of pages of amendments, which were required in order to recognize that certain groups might have been created equal, but certainly had not been treated equally. Blacks and women, in particular, had to get their own amendments for simple things such as the right to not be owned by another person (women too were once chattel), get an education, be allowed to vote, own property, and even have the same amount of money spent on their school sports teams as on the boys' teams.

The poetry of the Declaration of Independence seems (to me) to have been a bit more important to its creators than its actual truths. However, the Constitution left room for improvement, and over the years every special interest group has found its way into the laws of our country. Only one group has been relatively ignored—the mentally ill. I think that in order to understand why the legal system has ignored the mentally ill we need to consider this early premise of the Declaration of Independence. While this document is specific to our country, this concept applies to most modern nations. Some have more statutory understanding of disability and disadvantage than others, but in general, the concept of the rule of law is that law and morality are linked, and human beings are capable of making decisions based on their understanding of right and wrong.

Mentally ill people do not have the same understanding of right and wrong as people who are not mentally ill. Different mental illnesses have different consequences, of course, but in general, people who suffer from mental illness see reality differently than it actually is. Sometimes the differences in the way they see reality are irrelevant. A person who needs to wash his hands 50 times before eating probably is not going to engage in criminal behavior for this reason. However, when washing his hands 50 times makes him occasionally late for work, and he knows that this behavior is abnormal and cannot stop it anyway, and loses his job, we need to understand that something is wrong. Most employers would not have difficulty understanding that an employee on crutches would need extra time to get to work and that occasionally he might be late. The same employer, however, usually has no patience for an employee who has a hand-washing compulsion and is occasionally late for work. That employer usually is not interested in this psychiatric or "emotional" explanation. He wants the employee on time every day.

But that employee is not created equal. He is created with a brain loop that makes him repeatedly wash his hands. Unfortunately, we have no way of "proving" that loop. We have no

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imaging techniques, no blood tests, nothing standardized that can prove to the employer that Mr. Dirtyhands has a biological disorder causing him to be late for work. And telling someone that the disorder is emotional is even worse—then nobody would believe it. The "snap out of it" theory of mental health has always been alive and well, and remains so today. We therefore have two polar extremes—the bio-bio-bio model and the "snap out of it" model. The model to which I subscribe, and the one that is probably the true model, is the one we discussed in the previous chapter, where everything the biological organism encounters in its existence influences outcome. So the environment, events, people, relationships, education, food, drugs, chemicals, music, pets, stress, sports, and probably even the sunspots, all influence the biology of the brain, which is then expressed in emotions, mood, thinking, and behavior. Those things, in turn, elicit responses from everyone and everything around us, which then create specific new influences and stimuli on our biology, and so on, until we become the specific, unique biological creatures that we are, up to and including changes to our very DNA. Get the picture? Not only is no man an island (and no woman), but the interplay between biology and everything else is so intimately linked that we really cannot speak about biology and not biology as separate entities anymore.

Back to Mr. Dirtyhands. When I was a medical student doing my psychiatry rotation, different patients were brought in to talk to us about their disorders. Perhaps ironically, the sample patient for obsessive–compulsive disorder was a physician himself. A pleasant middle-aged man, originally from South Africa, he spoke in his precise accent about how he knew he was not actually running over animals or people on his way to work, but how he had to keep turning back to check. He kept leaving himself more and more time to get to the office, but he would imagine hitting more and more people and animals. He completely understood that he had a psychiatric disorder. He understood biology was involved. He understood he was inconveniencing many people by his behavior. He loved his career and his patients. He was not trying to avoid work; he was not trying to seek attention; he was not enacting some scenario to take advantage of anyone. He knew all these things because he had begun his treatment with a therapist. After years of talking about his conscious and unconscious motivations, he was worse. When we met him, he was eagerly awaiting the introduction of the first serotonin-specific reuptake inhibitor (SSRI) due to be released onto the market at any moment. He had done all the reading of all the available research and hoped that finally a medication might help.

I have no idea what happened to Dr. Animal-killer, but I hope he found relief. I use his example because he was the first person I ever met with obsessive–compulsive disorder (or, to clarify, the first person I ever met whom I knew had a diagnosis of obsessive–compulsive disorder) and he had obviously made a lifelong impression on me. I also use him as an example because mental illness did not impact his ability to tell right from wrong, although the mental illness did influence his daily life to an extreme degree. Despite his totally rational ability to know that he did not run anyone over on his daily drives to and from work, this fear, and the compulsion to check, interfered with his life in a huge way. Had he not been a doctor, but instead perhaps a factory worker, or even a doctor but in a different stage of his career, he

might have incurred legal difficulties, including, but not limited to, unemployment, financial problems, licensing issues, marriage problems, and even homelessness. I'm sure that you lawyers can think of many more possible legal consequences.

Today, we have medication that can treat obsessive–compulsive disorder, in many, although not all, people who suffer from it. Treatment now is fairly routine. People get better relatively quickly, although, unfortunately, some never do. But therapy is still important. Families are still ruined. People still refuse to comply with treatment, or insist that they know better, or want to understand their unconscious motivation even when you explain to them that we now know that there might not really be any unconscious motivation—that there is something called symptom substitution and that often when you treat one compulsion with psychotherapy, a new one, often completely different, takes its place. These are all real things that are known by people who work in the field. All are described, repeatedly, in the literature. Yet, patients do not always read the literature. They prefer to consult Dr. Google, who, as you may or may not know, is organized on a principle of how many links to web pages appear on other pages (I'm oversimplifying). For example, one day I was looking for a reference for a forensic report. I forget now what the actual topic was, but I bumped into a page called something like "SSRIs ruined my Life." The actual title was worse—it was the name of a specific SSRI antidepressant. Now, I write many prescriptions for that medication every week. It is a good medication. It has *saved*, not ruined, many lives. Yet, thanks to the magic of the Internet, I, a board-certified psychiatrist, saw that page prior to finding a page that could actually help me with whatever it was I was looking for. Imagine a person with no training or education searching for psychiatric information online. Huge Internet fail. Nobody is getting appropriate help via search engines. All you should be searching for when you have a psychiatric question is an *expert*. I will come back to this idea again and again, because time will run out while you try to figure out a legal theory of a case involving a crazy person, without knowing exactly what happened or what the craziness is really about. I have helped to keep many crazy people out of jail or from being sued by explaining their craziness to their lawyers and to the courts, and I am not famous or the chairperson of a department. To paraphrase one of the lawyers I interviewed for this book, I'm just a poor suburban psychiatrist.

Forensic psychiatry has applications in all areas of the law. Many books and scholarly articles have been written discussing the Landmark Cases. The purpose of this chapter is not to show you how well I can look up these references and list them here for your amusement, but rather to give an overview of the different types of legal cases that might require a psychiatric expert. For any legal issue which might include a crazy person whose version of right and wrong, or whose enactment of right and wrong might seem different than yours or mine, there is a landmark case and a whole bunch of other case law to support it. Finding those references and using them in court is your job—the lawyer's job—not mine. My job is to show you how this person's reasoning is not that of a fully psychiatrically intact individual.

Let us consider some of the categories and types of legal cases that might require a forensic psychiatric opinion. Many of the Landmark Cases arose from criminal cases. The biggies—the insanity defense, or Not Guilty By Reason of Insanity, has now been

supplanted in some jurisdictions by the new adjudication of "Guilty but Mentally Ill." Some jurisdictions now have mandatory psychiatric treatment in prison, making all convicts with mental illness (which tends to be a majority of them, as mentioned in the introduction) now Guilty but Mentally Ill. In the biggie category, we also have the Diminished Capacity pleading, which is not technically a plea, but a modifier. Both of these are affirmative defenses in the United States and in most English-speaking countries and have to be proved by the defendants. This distinction is important because a regular plea-bargain agreement often can result in a lesser sentence, still get the convict psychiatric treatment, and will cost the criminal justice system far less money to adjudicate. Still, it is important to be aware of these types of cases and how psychiatric opinions can be utilized. I learned while writing this book that in some jurisdictions, particularly in Scandinavia, it is the responsibility of the court to determine if an insanity defense would be appropriate, but once that distinction is made, the rest of the proceedings continue in a similar fashion to those in the English-speaking world. Apparently, with the popularity of international conferences and the shrinking of the planet, the similarities between the legal systems all over the world outweigh the differences in many important aspects. While the details are very different, the big picture ends up very much the same.

Arising from these criminal cases come what I call the accessories to the criminal cases—the Fitness to Proceed (also known as Competency to Stand Trial), again, a criminal issue, and then the question of how long must a person stay in a hospital as unfit for a crime for which he could never be tried? (These cases have different names in different jurisdictions, usually abbreviated by the number of the statute in that state or the name of the landmark case, like 730.20 in New York or Kroll in New Jersey).

Here the spin-offs begin. What about competency to represent oneself? Competency to plead? Competency to be executed? Each one of these questions is usually answered by a war of experts. Any lawyer who represents criminal defendants, or who prosecutes them, would be in a better position to do his or her job if he or she could determine the client's fitness without the help of an expert. With the right fund of knowledge, the attorney would know what to look for and how to ask the right questions of the expert, and how to inform the judge of what is really going on with each particular case. Instead of a war of the pinstripes, each of these cases could have a reasonable and calm meeting of minds. One court-appointed expert could make a recommendation to the judge, and the attorneys for both sides would be well-equipped to accept it because the case would no longer be about stopping it at the beginning but rather about the actual facts of each case.

Although from my perspective as a psychiatrist, there is some sort of mental abnormality present in virtually every criminal case, the law in the United States rarely considers mental abnormality when adjudicating criminal matters. My goal is not to change the system, but merely to make it possible for attorneys to understand the psychiatric information when it is presented, so I will move ahead to the next area where psychiatric information is frequently utilized—possibly more than in the criminal arena—that of civil matters.

Civil law ranges far and wide. I could not possibly begin to list every single civil matter in which a psychiatric opinion might be considered relevant. Many of these cases rely

on psychological opinions, and naturally I have my opinions about those as well. But to stick to the topic, I will try to cover some of the main categories that might require a psychiatrist's input.

Custody matters, other aspects of divorce, employment matters, immigration issues, bankruptcy matters, worker's compensation, disability, various types of other torts, testamentary capacity, personal injury… those are the few that I can list off the top of my head.

Immigration issues kept coming up as I interviewed attorneys for this book. I have done quite a few immigration evaluations and have even done presentations on how to perform psychiatric evaluations for the immigration courts at psychiatric meetings. Many lawyers and psychiatrists seem to be quite confused about how to include psychiatric testimony in their cases. I'm trying to avoid going into the nitty-gritty of the laws, which can change at any moment, but in general, there are two main ways in which psychiatrists can help: evaluation of an actual immigrant and evaluation of a United States citizen or legal resident. The statutes allow a variety of ways in which people can stay in this country if they can demonstrate some psychiatric factors, generally that they were abused in their own country, or that their removal would result in severe or unusual harm to a family member who has the legal right to be in this country.

I spoke to quite a few immigration attorneys in my preparations for this book. One of them, whom I'll call Rob Bernstein, told me that he usually does not get the opportunity to use an expert in his cases. When he does use an expert, he generally has to rely on a therapist or counselor, because his immigration clients do not have much money and are limited even when they seek treatment because they don't have health insurance. So even when they suffer horrific psychiatric problems, especially posttraumatic stress disorder (PTSD), they are unable to obtain adequate treatment. Rob says that he finds a great deal of resistance in most immigrant communities—at least the ones he serves—against seeing any kind of mental health providers, and that no matter how severe the psychiatric symptoms, seeing a doctor for treatment is an expense that these people cannot include in their budgets. So even though the bulk of Rob's practice is immigration law, including litigation, and even though cancellation of removal proceedings frequently require a finding of severe and unusual hardship or mental anguish, he recalls using a psychiatric expert fewer than eight times in a 25-year career. In that handful of cases, the written reports were extremely helpful, particularly since there is so little guidance in the law explaining what severe or extreme and unusual hardship really is. Rob, and I too, feel that we can recognize it when we see it (I think there is a famous saying about something else that sounds like that too). He taught me something I never knew before, which upset me for the rest of the day after I heard it. He told me that often he would speak to women who told him that their lives in Mexico had become unbearable, and they had to leave. When pressed, they had difficulty explaining exactly why and how their lives had become unbearable. Eventually they would confess that they had been taken "joyriding." Rob did not initially know the meaning of the term, and, until that day, neither did I. Sit down for this; it's horrible. Joyriding in Mexico is when a group of men abducts a young woman at gunpoint. They drive her around to every ATM and make her withdraw her life savings,

also at gunpoint. In between taking the maximum allowable number of pesos from every cash machine, they rape her repeatedly, and maybe beat her up repeatedly if they go for that sort of thing. If she had a car to begin with, she doesn't by the end of the night. She finds herself the next morning, broke, broken, and alone, in some unfamiliar place, possibly pregnant, or suffering from some sexually transmitted disease, and undoubtedly emotionally scarred for life.

I have no doubt that some skeptics would hear a story like this one and think that the victim made it up so she could stay in the United States. Get an expert. Would you know how to fake the symptoms of PTSD? Even if you look them up and memorize them, you probably wouldn't. Add in the time factor, the fear, the stress of being forced to go back, the stress of being in an evaluation with a total stranger, possibly with an interpreter… I think you get the picture. A good psychiatric evaluation can really assess whether or not the clinical symptom profile is consistent with this history. We cannot tell you whether or not someone's story is true. I have met lawyers who thought that a psychiatric evaluation could magically serve as a sort of truth serum—we could somehow see back in time into the jungles of Guatemala to determine who actually was hit with a machete. Nobody can do that. But what we can do is determine if the child who claims to have been abducted and who saw his father killed with that machete is exhibiting the signs and symptoms of a child who could have been in that situation. In the case of the kid I evaluated—absolutely. And in the words of another mother, who got her kid back: "At least in our village, everyone has a gun—or at least, a machete." I love immigration work because it is a window into the rest of the world.

Here is an immigration anecdote. This case was not my first immigration case, but it was my first time in immigration court. The case concerned a Cancellation of Removal, and the person who was theoretically going to experience severe and unusual hardship was the 15-year-old US-born daughter of a Guatemalan couple. They were a lovely family with two daughters, and my girl was the older one. She was small and adorable, a ninth grader who had been cutting herself since the seventh grade. She was in therapy at the local clinic. The school knew about her cutting and her eating disorder and was working with her and her family. She was a pretty good student but had dropped out of all the activities that she loved, although I remained unclear if she had stopped participating because she was not interested or if her family could not afford for her to participate in basketball, chorus, and some other activities. She told me she spoke Spanish with an American accent, and Quiché (her parents' native Mayan dialect), not at all. She was terrified of having to move to Guatemala, and more terrified about remaining in the States without her parents, who had arranged for the possibility of their removal by having their daughters live with family friends. This girl was not doing well emotionally already.

The cutting disturbed me. I treat a lot of cutters in my practice, and I can usually get them to stop with a combination of medications, therapy, and some other proprietary tricks, which I'm not going to share here just now. But I was not treating this girl, and at the time I was not really treating anyone; I was just doing forensic work. I called her therapist, who sounded about 14 herself and said to me, without a trace of irony (if she even knew what irony was): "She hasn't mentioned any concerns about having to leave the country, so I'm sure that's not one of her issues." I basically hung up on her because

I did not have time to waste. This ridiculous interaction exemplifies what is wrong with the delivery of mental health care in our country. It had taken me weeks to even reach this young woman, because she did not really understand what a release of information was, and did not understand that she had permission to speak to me about her patient (or "client," or "consumer," or whatever the euphemism of the day was).

When we went to court, the family's immigration lawyer asked that the young girl, I'll call her Elizabeth, wait outside the courtroom. Even the *lawyer*, not the most sensitive of individuals, understood that Elizabeth could not hear herself described as mentally ill and was at risk for self-harm and even suicide. So I described her. Her mother sobbed quietly, but not in an ostentatious way, because she was not seeking attention. She just felt horrible that her daughter was suffering. Then the Department of Homeland Security (DHS) attorney did an amazing thing, and not in a good way. I happened to be looking right at the judge, because, well, you're supposed to look at the judge when you are being cross-examined.

The DHS attorney asked me: "Don't all the girls cut themselves these days?"

I was horrified. Really. Horrified. What a stupid question.

"Of course not." I did not add, "What a stupid thing to say," but I think he could tell by my expression. And the judge's expression mirrored mine; I have no doubt. He looked disgusted.

The judge said something, I don't remember what. It was polite and judge-like, but it really meant something like, "You spineless twit, no, it is not normal for teenage girls to slice up their flesh on a regular basis. This young girl is sick, and this family gets to stay here so she can keep getting help." And they did. The last I heard Elizabeth and her family were doing very well. I hope she got out of that clinic and saw a real psychiatrist and a real psychotherapist. By my calculations, Elizabeth should have graduated college by now. I should probably find out.

My favorite case (I hate to call it my favorite because it was so tragic, but in terms of the detective work it required, it was challenging and interesting for me) was a case in which two dead people were essentially suing each other. In summary, one man with a known history of mental illness murdered another man and then committed suicide in an extremely violent manner. The estate of the murder victim then attempted to sue the estate of the murderer/suicide victim for wrongful death. The legal issue was whether or not this murder/suicide was a deliberate act. The state had previously opined on what constituted a deliberate act:

> *…[I]f the insured was suffering from a derangement of his intellect which deprived him of the capacity to govern his conduct in accordance with reason, and while in that condition acting on an irrational impulse he shot and killed [the victim in the case], his act cannot be treated as 'intentional' within the connotation of defendant's insurance contract.*
>
> *362 N.J. Super. 91, 827 A.2d 293*

The case was fascinating to me because the case law seemed quite obvious. I did not really think that an expert was even required. But the attorney who hired me

wasted months looking for a loophole. He had interviews, information from the family, medical records, police records, and he should have had common sense. But what he originally wanted me to do was to say that the antidepressant medication the man had been taking was responsible for the crazy behavior. Remember what I just told you a couple of pages ago, about wasting time on psychiatric defenses? That medication idea was that lawyer's "theory of the case." It had not even occurred to him that perhaps he might consult a forensic psychiatrist about the case to find out what had actually happened. I was able to read the voluminous case file and determine that the man had been mentally ill for many years, that he had told many, many friends and family members over the years that he planned to commit suicide and "take someone with" him. I even thought there might have been a hint of medical malpractice brewing there. Lawyers, please don't second-guess your psychiatric experts. Especially don't first-guess them. We don't hire you to do our legal work, and then tell you how to do it. I have no idea how to do a title search or even what statute to quote to the local township police department when a crazy patient keeps calling me in the middle of the night. I leave that to my lawyer friends. Please, if you have a case requiring a "derangement of intellect," let *us* figure out why the intellect is deranged. That's why you're paying us the big(gish) bucks.

Malpractice is another civil area that relies heavily on psychiatric input and not simply psychiatric malpractice. Once an incident occurs, the damage can range far beyond the physical, and often psychiatrists are called upon to estimate the extent of the resulting psychiatric or emotional damage to the victims (or the opposite, of course—to assess whether or not any emotional damage actually occurred).

Joe Frank is a trial lawyer. The vast majority of his work is medical malpractice defense work or professional medical defense work. He has never defended a psychiatrist but has defended psychologists and other therapists.

"Maybe psychiatrists are smarter?" he asked me. "Or maybe if things go amiss, the more frequent contact is with other forms of therapists?"

Joe has used psychiatric experts. "I've enjoyed that. I truly think psychiatrists are very smart people. It has always been stimulating to work on cases where there have been psychiatric issues. It is difficult for me as a lawyer because there is little objective truth in psychiatric situations. Wherever a psychiatrist is involved, it involves the interpretation of a mental state of an individual—what caused it, is there malingering, is there secondary gain—it strikes me as more of an art than a science. The ambiguity—there's so much ambiguity in the psychiatric evaluation of people. You can talk to people who supposedly have such great credentials, and the interpretation is 180 degrees different." Joe admits with glee that he has enjoyed cross-examining the plaintiffs' experts and digging into the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

He was also puzzled how experts could rely on the DSM but come up with different diagnoses. He has found that the most prevalent diagnosis where this issue arises is PTSD, an opinion shared by virtually every lawyer I interviewed for this book.

Joe has been repeatedly amazed that despite a book that tells you exactly what counts as a trauma, he keeps meeting experts who provide wildly varying interpretations of what kind of trauma is necessary and how serious does it have to be, to the point that he encountered a case based on an allegation of a false memory leading to PTSD. So that was the question he wanted me to answer in this book: "Can a non-event, but a believed event, cause PTSD?" Before I go there, I will share his case, because you have to hear it!

Joe's most memorable case with a psychiatrist, perhaps ironically, was a false memory case: Psychiatrists were involved primarily on the analysis of what, if any, mental health condition the plaintiff had. There was a psychiatrist defendant in that case, but he did not have much exposure to the defendant. Joe's client was a psychologist.

The plaintiff was a middle-aged woman, Maria, who was married to a prominent local businessman. They had several children. Through the course of her therapy with this psychologist, Maria started talking about childhood sexual abuse that had been perpetrated on her. Maria had lots of mental health issues, and there was lots of strain on the marriage. Her parents were also prominent people in the area. This area, by the way, is not my area, but somewhere far away from here, and of course the names and details have been changed.

All of these issues surfaced because Maria started talking with some of her adult children about what had happened to her in childhood, and her anxiety and worries carried over into intimate relations with her husband. Her children started looking into things on the Internet, and they discovered a false memory syndrome foundation. Then they told their father about this false memory syndrome. Everyone denied that anything could or would have happened to Maria in her privileged and happy childhood. Now, we know that some privileged people do have bad childhoods, but not Maria. At some point Maria separated from her family, and then she recanted her memories and said the abuse never happened and decided that something must have been done to her in her therapy to create those memories and beliefs.

This case went to trial and ended with a defense verdict. The plaintiff's claim was that the therapist made up the memories of abuse and then made her believe them. Her lawyers hired psychiatric experts who claimed that she had PTSD from this abuse, and claimed a whole variety of other diagnoses and problems.

My lawyer friend's psychiatric expert said that this woman did not have PTSD, and there was nothing in the therapy that had created false memories. She did not meet the clinical criteria for PTSD, but she did have some conditions that had led her to therapy. Nothing in the therapy had created false memories; the therapists were simply treating a historical perspective that she had brought to treatment.

The trial lasted six and a half weeks.

During the cross-examination of Maria's expert psychiatrist, Joe asked him what he had charged for his evaluation and testimony. This expert admitted that he had billed $250,000. The case went up to state Supreme Court twice. (I am in the wrong state, I know.)

Joe also described to me how while examining Maria she froze in place on the witness stand, in the presence of the jury, for five minutes while the judge tried to figure out what was going on. He had never had anything remotely like that occur in court before or since. Clearly the woman had issues. She had subscriptions. But she did not have false memory syndrome.

Later, Joe heard that the plaintiff's law firm spent a million dollars on that case, and still lost. You and I know that no malpractice insurance company ever spent that much money defending a psychologist.

Moving on from civil matters, there is what I call the "overlap" area of the law. Some states have the "Special Civil Part," or something similar. These courts deal with cases that seem to have one leg in the civil arena but the other in the criminal, although they are technically civil. In my state, these cases include Child Protective Services issues, in which the state can assume guardianship of children and eventually even take away the parental rights of individuals via the court. Also included under this heading are sex offender civil commitment cases, in which offenders who have served their criminal sentences can continue to be deprived of their liberty if they are found to be a continuing potential danger to society. In similar types of cases, adults might require guardians for a variety of matters—anywhere from guardians at litem (for legal matters) to financial guardians or payees for their disability payments, to medical representatives, to possibly other types of guardianship, which I have not yet encountered, but may very well exist.

The flip type of cases also exists. Some criminal cases are generally regarded as more civil in nature, such as traffic cases (even driving under the influence or driving while intoxicated), some types of child abuse or domestic violence cases, requests for restraining orders, and other cases, which fall under the purview of criminal courts but are often adjudicated in civil-like ways can also often benefit from consultation with psychiatrists, or include psychiatric information and testimony. I was involved in a case, which never went beyond the municipal court level—a mother was angry at her son and happened to be holding a shampoo bottle in her hand. She threw the bottle on the bed and it bounced and hit her son in the face. The boy's nose started gushing blood. (As a nosebleed sufferer myself, I can attest to the visual drama of such an incident, although they are rarely actually serious.) Although the divorce had been final for years, the custody issues were ongoing and extremely hostile. The mother ended up "sentenced" to anger management, which I provided in the form of individual therapy. She was extremely angry at the child's father for using this accident against her, angry at herself for accidentally injuring her son, but almost equally mortified that the shampoo bottle in question had been that of a well-known brand of dandruff shampoo, and the brand name had made its way into every single report. Not only did she now have an anger problem, but to add to her humiliation, her dandruff problem was now also a matter of public record. Undoubtedly, the inclusion of a real psychiatric evaluation in the ultimate adjudication of this case resulted in a much happier outcome for this moody adolescent boy. Courts tend to focus on the dramatic (the bloody nose), rather than on the actual issues (the completely unnecessary ongoing battle, which in this case was clearly repeatedly instigated by the father, over custody and

visitation of this child. Did I mention that the child's conception had actually been a case of date rape? Never prosecuted, of course—how does one prosecute something like that when the mother is a naive 22-year-old?).

Unfortunately, psychiatric opinions are not always sought, even when psychiatric issues appear obvious, and sometimes the results are disastrous. Attorney Natasha Delaney told me a story about a woman she was representing in a divorce case. Let's call her Rong. That's not her real name, but it lets me tell you an unrelated story about someone else named Rong, who had a complaint that her coworkers could not pronounce her name correctly: "My name is Rong. But they keep saying it Rong. That's wrong. It's Rong. So I told them to call me Jane." Psychiatry. Gotta love it.

Rong claimed she was unable to work, and soon Natasha learned why. Rong believed that she was being controlled by aliens, and that she was being paralyzed and was unable to leave the house to work, or really to do anything. Finally, Rong agreed to have a psychological evaluation as part of the custody dispute, and Natasha was very happy, thinking that now, finally, somebody would hear about these space aliens and all the other issues, and understand why the mother could not work, and not only arrange an equitable distribution of assets, but also get Rong some appropriate psychiatric treatment. But no such luck. The supposed psychological evaluation was some paper-and-pencil psychological testing, which anyone can "pass," because the most psychotic person in the world knows not to say that he or she has special powers, hears voices, or can move objects with his mind. The case was eventually resolved in Rong's favor, and the father had to pay for the kids' college, but although it went as far up as the state Supreme Court, not one person realized this case had a psychiatric component. And the appellate and Supreme Court decisions were actually published, but for some other matter of law, not because of the insanity component. I only heard about the case from the lower court attorney, and I do not know the names of the participants or the other legal issues—just the fact that the mother was extremely delusional and could not work because of her delusions, and that she was experiencing financial hardship because of that fact. The court eventually acknowledged her financial hardship and dealt with it somehow, but at no point did her craziness come into play. Imagine how much happier this family's life could have been had someone realized that the mother was mentally ill early in the game.

Another case had same divorce attorney for one of the parties, although I did not know that until later. I heard the story through one of my children, because one of the children of the divorce was a friend of my son's. Lovely local family, beautiful, bright kids. Attractive parents, by all accounts, always the model couple until suddenly the husband and father began acting strangely—cursing, lashing out, and even being violent. The wife and mother was shocked and dismayed, so she did what any right-thinking ignorant red-blooded suburban mother would do—she filed for divorce.

The husband was devastated. He loved his family. He missed his children. He did not understand why the court would not even permit him unsupervised visits. He did not really understand what had happened and did not understand right up until the day his brain tumor was diagnosed, shortly before he went into his final coma and died. Sadly, had

there not been all of the critical confidentiality and attorney–client privilege, my lawyer friend could have told me about the case and I could have blurted out, over lunch, "Brain tumor!" the way I do when I hear certain news stories, and perhaps the marriage and even the man might have been saved. But that too is another book for another day.

I tried to interview every single lawyer I know for this book, although many declined, citing confidentiality or fears of their employers. I spontaneously interviewed a college classmate at a mini-reunion brunch. She practices corporate, finance-based law in New York City, where everyone wears black, and nobody ever enters a courtroom. I'll call her Amanda. Amanda was sure that she would have nothing to offer me, anecdote-wise. But then she recalled an incident in which her firm had received some threatening correspondence from a former member of the New York Stock Exchange. Nobody in the firm actually knew what to do. She remembered that the individual had shown up at the office a few times and had to be escorted off the premises. He was clearly mentally ill and the law firm had no protocol, no plan, no nothing in place for dealing with threats or insane people showing up. She realized then that even in an ivory-tower type of work environment, mental illness could strike, and that it would be helpful to know something, or at least know who to ask for guidance. She was unaware, as most people are, that there is a whole field of psycholinguistics and threat analysis of written documents. Once we open the door to mental illness, it pops up everywhere. Another lawyer in a similar type of Wall Street firm, Laura Metcalfe, told me about a case that happened at her job. An employee kept complaining about things that the lawyers and paralegals were "saying" to her. Well, nobody was actually saying anything. This particular clerical worker was African American and a military veteran. Everyone agreed that she was both brilliant and beautiful. People had a real problem with understanding that she was also crazy. Every time she made a complaint, human resources took it seriously and investigated. Laura told me that nobody was aware of any possibility of referring this employee to any sort of employee assistance program. Nobody was worried that perhaps a military veteran might have a weapon, or that she might become violent, or that these things she was "hearing" people say were auditory hallucinations and not simply made up. Lawyers' minds don't work that way. The minute I heard this story I panicked, and I was glad to hear that Laura did not work there anymore! We keep hearing stories of school shootings, church shootings, workplace shootings, and everyone cries about gun control and racism, but nobody mentions mental illness. Whenever somebody does, the gun control people and the racism people jump down our throats, telling us how mental illness is an excuse, that there is "no evidence" that these people are mentally ill, and that basically, these violent crazy people should just "snap out of it" and act responsibly, or else go to jail or be put to death. People have a lot of political opinions about things that science disagrees with, not just in the realm of mental illness, but in the realm of everything—weather, medical disease, mental illness, what the definition of life might be—so all I can do in this book is to point out that psychiatry is a real branch of medicine, and that given some information and time, and access to the person in question, whether defendant, plaintiff, or the records of the dead, we can provide useful information that might help actual justice to be done.

We see that in every type of case, and in every type of practice of law, we can encounter some sort of mental illness and the possible need for psychiatric consultation. Still don't believe me? Here is a case from a good friend, whose name, of course, has been changed, as have the details of the case. This friend is a patent attorney. I'll call him Dave Smith. Years before I even thought of writing this book, a group of us were having dinner and trying to one-up each other with our craziest work stories. Usually mine are the best, for obvious reasons (Bellevue Hospital Psychiatric Emergency Room and Sex Offender Prison are but two of the entries on my resume), but I still really like this one of Dave's.

A man came to Dave to file a patent on a new invention. The engineer's theory was that many people experience some problems with regularity of certain bodily functions. To conquer this issue, he invented a special toilet that could help. He wanted Dave to file the patent, although he admitted there were still some kinks to work out. When he built the prototype, the toilet's mechanism was so powerful that the designer actually fell off and was knocked unconscious while attempting to use it for its intended purpose!

The moral of this vignette is that lawyers should be aware that mentally ill people can be smart, can have crazy ideas, and can often be very litigious. Sometimes it is better to just say no. You might not want to take on a crazy civil matter for someone who may then turn around and sue you. Some of these individuals are like those gag candles that you can't blow out. And in many jurisdictions, the courts either have to give extra leeway to litigants who present as mentally ill or impaired, or just do it anyway, because judges are well aware of the tendencies of the super-crazy to turn around and then complain about the judges themselves.

Let's check in with our own crazy litigant, Mo, the former podiatrist.

Now it's two months later. The kids have adjusted to their new school and have made some friends. Jennifer found a job in the local library, two afternoons a week. She barely makes any money but at least it covers her mani-pedis. She and her husband don't have to pay any rent, and Ben, still calling himself Mo, has found a Muslim prayer group at a local university. With his curly dark hair and several years' worth of beard, he blends in with the worshipers, despite being two decades older. He has taken to sleeping in the downstairs rec room and skipping the family meals. His children avoid him. Finally one afternoon, his father-in-law tells him to get out. "I don't need no freeloading crazy Arab Jew in my home. You get out and stay out."

"I curse you and all of your descendants," Ben/Mo intones. He packs a few things into his backpack and sets off for I-80. That his father-in-law's descendants include his wife and children appears irrelevant to both Ben/Mo and to his father-in-law. Daddy-in-law has made one of the fundamental errors of people confronted by mentally ill family. He thinks, "I knew my daughter married an asshole." Not for one moment does this retired letter carrier think that perhaps somewhere there exists some treatment for his daughter's mentally deranged husband. He interprets Mo/Ben's behavior as "bad" and wants him far, far, away. And as Ben/Mo's contact with reality is growing more and more tenuous, he does as he is told and takes off. Of course, there could be another scenario in which he stays

and acts crazier and someone gets seriously hurt, but let's stick with the hitchhiking down Route 80 scenario for the purposes of this story.

As we can see, this made-up story is simply an exaggeration of cases that enter the criminal justice system every day. For each episode that causes the reader to think to himself, "Man, what a nut job," there is a legal way to obtain a psychiatric evaluation and get help for this mentally ill man, and to prevent his nuisance crimes from escalating into serious violent crimes. Yes, lawyers want convictions, but there are plenty of seriously evil and dangerous individuals out there who require much more attention—and prison time—than they are receiving, because the courts are so overwhelmed with the mentally ill. So what could Daddy-in-law—or anyone else along this path of insanity—know or do to help? They could understand a little something about the mental status examination.

3

The Mental Status Examination v. Common Sense

What is the mental status examination? Is it a test someone must pass? Must *you* pass it, in order to prove you effectively learned this material? Is it some sort of laboratory test? Are you getting panicked because I'm asking you to learn something new?

Don't panic. The mental status examination in psychiatry is equivalent to the physical examination in medicine. Instead of a stethoscope and a tongue depressor, we psychiatrists economize by just using our words. The mental status examination is not a psychiatric evaluation. You don't need to understand anything about psychopathology to do an effective mental status. However, the ability to assess whether the person's responses to a few simple questions are normal or abnormal will immediately confer on any evaluator a sense of serenity and competence and help you to understand which expert to call in at which stage of the game.

The mental status examination is very intuitive. Until now, when you've met someone who seemed to be "not right," you could always tell. You were, unconsciously, performing a mental status examination in your own mind. Whenever you meet a new person, you do the same thing. You assess the person's appearance, alertness, speech, thought content, etc. The only new thing I'm proposing you learn how to do in this chapter is to utilize a specific list, so that you don't miss anything that might be wrong, and learn a few key points to identify and document for later use. It's easy and fun, and soon you too will be able to do it practically in your sleep. The mental status examination itself is simple. It's the interpretation of the mental status and the diagnostic implications that require your expert. So when you call your expert, you can present the results of your client's mental status examination, and your expert will greatly appreciate the specific information.

One problem, though, is that people tend to confuse their observations with their conclusions. Please do not make this mistake. I see it in all branches of medicine; I see it in psychiatry; I see it in reports; I see it on accident reports and traffic tickets. An observation does not equal a reason or a conclusion. Remember any science lab from high school. You are now a lawyer, and all during science class you used to think, "This is a friggin waste of time; I'm not going to be a science major. I'm not going to be a *doctor*." Or maybe you did think you were going to be a doctor, but were "weeded out" in Biology 101. Or, you know, in that other way. In any case, you did take a lab science or two at some point in your life, and you are familiar with the concept that observations go in a separate section from conclusions. Now is not the time to mix them up.

There is a copyrighted test, the Folstein Mini Mental Status examination, which you can use for free. You can easily find it online, and print it, with instructions.

Forensic Psychiatry. http://dx.doi.org/10.1016/B978-0-12-802852-0.00003-7

This test has limitations, of course. It is a good screening tool, but primarily for dementia, now known as cognitive impairment. However, if you learn how to do a real mental status examination, you will then really know how to administer the Folstein, but at the same time, you will have no need to use the mini-mental status examination, because you will automatically do one in your mind whenever you meet any new person. We psychiatrists perform mental status examinations in our own minds with everyone we meet, whether we like it or not, and whether they like it or not. When I attended medical school, our professor of endocrine physiology told us once that we would eventually know which doctors the children in the elevator were going to see based upon how they looked. We all laughed. But the truth is, eventually your knowledge and experience becomes such an integral part of you that you can look at an elevator-full of clinic patients, see their endocrine abnormalities as expressed in their features and body types, and know which specialists they will be consulting. The same thing with the mental status examination. You just do it.

Here Are the Things We Evaluate in the Mental Status Examination

Level of Consciousness

Is your client awake? Is he alert? Is he oriented to time, place, and person? If so, we document: awake, alert, and oriented to time, place, and person (you will find this notation abbreviated as "AAO×3"). If he is not awake, alert, and oriented to time, place, and person, and he is not drunk or on drugs, then you need to call a medical doctor before you call me. If he is, move on to the second part. Just note that if someone is not aware of which jail he is in, or he does not know your name five minutes after you first introduced yourself, do not automatically assume that he is disoriented. A few days ago, I wrote the wrong date down the whole day, over and over, on reports and prescriptions. Probably I was wishing for Friday to come, but thinking it is the wrong date does not automatically mean I was disoriented, so evaluate these bits of information with common sense as your guide. If someone is unconscious, that should be obvious. It is also a medical emergency! Important note: someone who refuses to answer your questions is not "unresponsive." Medically, unresponsive means unconscious. Please don't call me to tell me that your client is unresponsive when he simply does not wish to speak to you. He might still need an evaluation, but he does not require a call to 911!

Appearance

What does your client look like? Is he clean, dirty, or disheveled? Does he look much older or younger than his stated age? Is he missing teeth or limbs? What is his apparent race or ethnicity? This part gives you information about how the person cares for himself, but it also gives you information about whom exactly it is you are talking about. In other words,

if I document that Mr. So-and-So is a 60-year-old morbidly obese bald man who looks far older than his stated age, and the psychologist's report says that the same Mr. So-and-So is a skinny black teenager who should be playing for the NBA because he is almost seven feet tall, then obviously one of us is describing the wrong guy (or maybe one of us needs new glasses). Make sure the client you are describing is the one you are calling about. I have seen many, many incidents where records got mixed up because different individuals had the same name. I have then seen doctors perjure themselves in their roles as expert witnesses, swearing under oath that a particular individual was gravely dangerous because of a historical event that never happened. At that point, descriptions really help. Physical descriptions also tell you something about how the person has been living, how he takes care of himself, and possibly if he has medical or physical issues that might contribute to his current situation.

I need to insert an anecdote right here to prove that this type of mix-up can really make a difference in people's lives. If you don't care about people's lives, think about the taxpayer's dollars, since by some estimates it costs well over $100,000 a year to keep someone in prison every year, and possibly over twice that to keep him in a civil facility for sexual predators. In the case I'm referencing, two individuals had the same name. It wasn't John Smith, but it might have been, because I am sure there were at least 30 more men incarcerated in New Jersey at the same time with the same name. I would not have been surprised if there had been 50 more, and if two of them had even had the same date of birth (random statistical fact about randomness: when 25 people gather in a room, there is a 50% chance that two of them will have the same birthday.) One man was a sex offender with a fairly run-of-the mill history of intrafamilial offenses. The other man was a psychopathic criminal, not a sex offender, but a true bad guy. However, if one were to add the crimes of the psychopath to the crimes of the incest offender, the incest offender would suddenly become an incredibly dangerous sexually violent predator who would fit into the category of "needs to be locked up until the funeral home van comes to take him away."

What happened in this case was exactly that—some records from an internal prison offense got mixed up for the two cases. One involved our pedophile who had done something stupid, like missed group therapy. The other involved this psychopath of the same name who had served another inmate a ham, cheese, and ground glass sandwich. The psychiatrist who reviewed the records somehow did not notice that these were two different men (with different inmate numbers, different ages, different crimes, different histories, coming from different prisons, and of different races). He wrote a report in which he swore that the pedophile was a danger to society because of his horrendous psychopathic acts (primarily the delicious meal which resulted in the death of his colleague, since incest offenders rarely reoffend as long as they are kept away from family situations with similar potential victims). When someone pointed out this error to the consulting psychiatrist, he insisted on going to court and swearing under oath that he was correct. The word I learned in my training for what he did is *perjury*—feel free to tell me if there is another one. I got to be the defense expert in that case. Please, before you tell me that he was a pedophile and

should be left to rot in his own poop, remember that you guys are the lawyers who swear to uphold the law that includes the part that everyone is entitled to a fair defense. I only swore to first do no harm.

Demeanor/Attitude

Is your client cooperative? Uncooperative? Belligerent? Anxious? Guarded? This part is descriptive, but also provides information about whether or not you need to get a professional evaluation. This part, interestingly, can also provide some information about the evaluator. I will give some examples later.

Psychomotor Behavior

Is the person agitated? Does he or she demonstrate psychomotor retardation (i.e., is he or she very slow at everything he or she does?) Do you observe any strange physical mannerisms—head bobbing, writhing, jitteriness, fidgetiness, even nail biting? All can give clues to a person's internal emotional state and to whether or not they have a psychiatric history or are being treated with medication. Long-term treatment with certain psychotropic medications can cause movement disorders, although five percent of schizophrenics who are untreated develop movement disorders anyway, and people with no psychiatric histories can develop movement disorders too. And there is of course an observer bias—I remember once watching a man cross Ninety-Sixth Street in Manhattan and saying, "Poor guy, he has Tardive Dyskinesia" (the movement disorder that people get after many years of treatment with antipsychotic medications) and my husband saying at the exact same second, "Poor guy, he has Parkinson's," because tardive dyskinesia and Parkinson's are basically the same disorder, just with different causes of dopamine depletion. Psychomotor behavior can provide clues as to whether a person is intoxicated or in withdrawal from some substance, or give us information about a movement disorder characteristic of psychiatric illness, medical illness, or other problem.

Remember, when you are observing psychomotor behavior, that you are just noticing behavior, not interpreting it. People so often think they know the reason for something when all they really know is what they are seeing. I was once in a car crossing the George Washington Bridge (GWB), which goes from New Jersey into Manhattan. Anyone who previously never heard of this bridge by now is definitely familiar with it after the "Bridgegate" scandal of 2013, when New Jersey Governor Christie may or may not have been the person who ordered lane closures on the first day of school in Fort Lee, the town where the bridge is located, as revenge for Fort Lee's mayor not endorsing him in the gubernatorial election. Now that you have identified the bridge, imagine a younger me sitting in the passenger seat of one of those mid-nineties Jeep Cherokees, the ones with the gold trim. A gigantic truck comes up behind us and smashes into us for no apparent reason.

Fortunately, it was not my first rodeo—I had previously been the passenger in another vehicle in which I broke the passenger door window and the windshield with my head when another car hit us from the side (different driver). I mention this thrilling experience

only because we are going to talk about head injuries later in this book, and I like the idea of foreshadowing, like in fiction. The point of the story is that when we sorted ourselves out, pulled over to the side of the road (not an easy feat on the GWB), contacted the police (also not an easy feat in those days when cell phones were not quite ubiquitous) and stopped—or paused in—thanking God that our then very young children were somehow not with us in the backseat, which was completely caved in and covered with glass (to this day I do not know why they were not). We were shown the police report, in which the truck driver gave his version of why he had hit us: "He (the driver) did not know where he was going."

Think about this statement for a moment: "He did not know where he was going." While it sounds innocuous, from the perspective of a psychiatrist, it is incredibly grandiose and on the border of psychotic! We can discuss all the possible implications later, but for this section, we can assume that something in the actual or assumed driving style made the truck driver believe that the driver did not know where he was going. It is possible that the driver observed something—an erratic maneuver, a hesitation, or a change in speed—something. I was there, and I did not observe it. But instead of describing what he saw, he drew a conclusion: "He did not know where he was going." The police who investigated the accident, therefore, rightly concluded that the truck driver made up some reason for his own inability to control his vehicle. He was found to be at fault, we were not found to be at fault; thank God nobody was hurt, case closed. Had the truck driver invented an actual observation (or possibly made an actual observation), the police might have come to a different conclusion in their investigation. So always be very careful to describe what you observe and not what you conclude from your observations. The conclusions will come much later in the process. They are not part of the mental status examination.

Speech, Thought Form, and Thought Content

Speech is critical. Through speech we assess the person's thought form and thought content, the two things that can tell us if a person is psychotic or not. Is your client's speech logical and coherent? Does he or she make sense? Is he or she speaking too quickly for you to follow his or her train of thought, or does his or her train of thought seem to be constantly going off its rails? All of these factors have their own special psychiatric names. We'll define them later so you can look them up when you read a psychiatric report. But in the meantime, you should use your judgment. If you think that the person is speaking abnormally in any way, whether because he or she is verbalizing "word salad" (mixed up words that have no apparent logic or order), pressured speech (speaking way too quickly and impossible to interrupt), or that the thoughts he or she is expressing make no sense, either because of the way he or she expresses them, what he or she is expressing, or both, then it's time to call in the shrinks. We call this problem with thinking a thought disorder, and it is really the only requirement for many mental illnesses. People who are not suffering from some sort of mental illness do not have thought disorders. So when you identify, through someone's speech or writing, that there is something wrong with that person's thinking, it is probably time to get a professional opinion.

Anxiety

Is the person very anxious? Is the anxiety beyond that which we would expect from someone involved with the legal system? Does he or she tell you he is anxious? You can ask, if you want. Is he or she shaking? And, is the shaking a result of anxiety, or is it physiological (a result of alcohol withdrawal or from a movement disorder or a benign essential tremor? You might have no idea, but if you are concerned, get a professional opinion).

Phobias

Is the person terrified of something beyond any rational explanation? Psychiatrists ask about phobias. You can always ask, especially if you are looking for some sort of psychiatric hook for your case. Many people have phobias they never mention. I find them a lot in my adult attention deficit hyperactivity disorder (ADHD) patients as an incidental finding, after they already know and trust me. I suspect that many people are embarrassed about their phobias and never mention them to anyone, especially men. I'm sorry if that is a sexist statement, but here is a typical clinical scenario in my office: two parents bring in a child for diagnosis and treatment. The child ends up having ADHD. I treat the child and he gets much better. A few months later, the father slinks in. He explains that his childhood was very similar, with the same struggles and academic and emotional issues. In fact, he has the same problems at work. We figure out that he has always suffered from ADHD. I treat him. He gets better. On one of his visits he mentions his fear of flying, public speaking, or the dentist. Now we treat that. Sometimes we uncover some other phobia as well. But it often takes a long time, and it stays secret between him and me. Phobias are not like ADHD. Nobody wants to talk about them. But if a phobia somehow resulted in some sort of crazy or quasi-criminal act, you might want to learn about it and use it in your case. A phobia can even rise to the level of psychosis (see above and below) so if you happen to elicit one, even if it seems to have nothing to do with your case, a psychiatric opinion is a good idea.

Obsessions

Does the person have obsessive thoughts? Does he or she repeat himself or herself far too many times for the thought to make sense? Does the person appear stuck in a loop about something? This symptom can make it virtually impossible to work with this type of client. What presents as an obsession may in fact be a neurological symptom called perseveration, so if you get someone who constantly repeats herself, you might need to check with a professional. We will discuss the differences between psychiatric and neurological disorders later, but this stuck in a loop thing, whatever its causation, can make working with the client torture for any attorney, billable hours or no billable hours. At some point you will need to obtain actual facts from your client and act upon them, and somebody who keeps going over the same noninformation without getting to the point is not going to be capable of "rationally and factually assisting in his or her own defense," or his or her own case, even if it is just a house closing or a will-writing.

Compulsions

A compulsion is a behavior that is repeated to excess for no apparent reason (to the observer). The person who has a compulsion is usually aware of the fact that he or she is behaving inappropriately, but not always. However, if your client's crime or other legal situation is a result of an obsessive–compulsive disorder (i.e., a hoarder whose house becomes a fire trap, or a parent who follows his child around out of some abnormal fear leading to obsessions and compulsions) then uncovering and perhaps treating this disorder can be helpful to your case. There are shoplifters (kleptomaniacs), whose crimes are a result of mental illness; there are people who can perform complex actions as a result of something called partial-complex seizures. These conditions are rare, but do occur. If in doubt, get an evaluation. You don't have to use it, but especially if you have questions about something weird with your case, you should find out.

Suicidal or Homicidal Ideation or Intent

This part should speak for itself, but unfortunately it does not. Often people lie about wanting to kill themselves in order to obtain better treatment or to try to get out of their criminal charges. Suicidal ideation, intent, or attempt should always be evaluated by a psychiatrist in order to assess if it is real or not. Clearly, an individual who is authentically suicidal must be evaluated and treated. Sadly, many suicidal individuals will not share these thoughts or plans with anyone. Also, people who are severely suicidal rarely bother to commit crimes against property. Why should they? Where they think they are headed, property is useless.

Homicidal ideation, intent, attempts, and plans can be even more difficult to assess. In general, homicides are not treated as the result of mental illness, although far more of them actually are triggered by abnormal thinking than the law acknowledges. Cases adjudicated Not Guilty By Reason of Insanity are rare. Some states now have the adjudication Guilty but Mentally Ill, which basically convicts a defendant but ensures his placement in a psychiatric unit in prison. The important thing when you see your client is to assess if he or she is still homicidal in any way. Homicidal ideation is a psychiatric emergency. While the courts would prefer to stack up convictions of attempted homicide or terroristic threats, I promise you that a sane person would usually prefer not to kill anyone. If someone's paranoia is spurring his or her homicidal ideation, that person needs help before you do anything else. Murder-suicides are among the most heartbreaking cases that we forensic psychiatrists ever see, and they are always a result of some kind of mental illness.

Hallucinations

Hallucinations are sensory experiences that originate in the brain. We generally ask about auditory and visual hallucinations—that is, "Do you ever hear voices or see visions?" The truth is that people who are truly hallucinating rarely know that they are hallucinating. Visual, olfactory (smell), and tactile (feeling) hallucinations are usually the result of organic

disorders, such as brain tumors, intoxication with substances, or during or after certain types of seizures.

Auditory hallucinations are the typical hallucinations of psychotic disorders. A voice telling the person what to do, called a "running commentary" on the person's behavior, is pathognomonic for schizophrenia (pathognomonic means it is characteristic of a specific disease). One way we can often tell if someone is hearing voices is by observing his or her presentation. If the individual pauses before answering, seems to be listening to something, nods or shakes his head but not in obvious response to what you just said—all of these signs suggest that the person might be "internally preoccupied" or, in other words, listening to voices. The voices of psychosis seem to be outside of the person's head. People who say "I hear voices in my head" might have some sort of psychiatric disorder, but they are not hallucinating. Also—a hint—don't tell them that real voices are experienced as outside of one's head. We don't want to create good malingerers (see the chapter on malingering).

Hearing voices is a clinical area fraught with confusion, doubt, uncertainty, and clinical messiness. Patients say they hear voices and everyone panics. Clinical social workers freak out, stop treatment, and refer to psychiatrists, even when the patients say they are hearing the voice "inside my head, and it seems to be my own voice." I still see a patient every three months who gets an antidepressant and a sleeping medication. That woman has been with me for a few years. When she initially presented, she was what is known professionally as a hot mess. She had been in a truly horrible motor vehicle accident. Not only had she been traumatized emotionally and physically, she was left with severe post-concussion syndrome, as well as a multitude of neurological problems. But the one thing she was most afraid to tell me about was the auditory hallucinations. I think it took her close to a year to come clean. I knew she was suffering, I knew she was depressed, but I don't have a magic instrument with which to get inside her brain and know what's happening there. Finally, after she began to trust me, she confessed. I asked at every single appointment if she ever heard voices or saw visions—every single appointment, which at the beginning of treatment, took place at about two-week intervals.

"I do, sometimes." She could barely get the words out without tears, even though her depression was much better. "When I'm falling asleep. That's why I'm so scared to fall asleep. I think I hear someone in the room, or the house." She took a deep breath and sat back, waiting for me to call 911 and send her to the mental hospital.

"Only when you're falling asleep? How about when you're waking up?" I asked her.

"I don't think so. Just as I'm drifting off to sleep. Is that really bad? Does it mean I'm schizophrenic?" All the color had drained from her face, and her breath was coming in short shallow gasps.

"I'm not laughing at you," I assured her. "There are these things with super-fancy names. They're called hypnagogic and hypnopompic hallucinations. One is as you're falling asleep, and the other one is as you're waking up. Hearing voices as you fall asleep and hearing voices as you wake up. Totally normal. Not pathological. Not psychotic. They don't require treatment. Definitely not schizophrenia. I wish you had told me before! Is this what was upsetting you all this time?"

Well, talk about a miraculous treatment breakthrough! The next week she got a job, which she still has. Now she is on the three-month plan. She still takes medication, but her mood is so much better. She is happy. She looks 10 years younger. She has a bounce in her step. All because she was brave enough to tell me that she heard voices as she was falling asleep. Not every sign or symptom that exists in psychosis necessarily means that the person is psychotic. Be very careful when someone tells you he is hearing voices. Even if you think he is lying or malingering, even if you think he is telling the truth, or if you are not sure, then please get a professional opinion. The reality might mean a great deal for your client and your case. In my patient's case, she was thrilled to be able to live a normal life and not be crazy. People do not develop schizophrenia from head injuries, but it is possible to develop things that look like psychosis from head injuries, and if she had, her lawyers needed to know about it. She was so panicked about her symptoms, though (as are many people who are actually injured in their personal injury cases, as opposed to the ones in it for the money—just an observation from my side of the table) that she was afraid to say anything. And once she said it, and learned she was not actually crazy, she got her life back. A miracle cure, in a way. Perhaps her lawyer's cut was a bit less than it would have been had she been more injured, but her outcome was a whole lot better. I'll always root for the better outcome. And to clarify, she was my treatment patient, not a forensic evaluation, although of course my treatment notes ended up on her lawyer's desk, as they always do, and for free.

Intelligence

We estimate intelligence based upon the way the person speaks to us, their fund of knowledge, their educational achievement, formal scores on intelligence quotient testing, and our gut instinct. None of these methods are foolproof, of course, and that is why we document intelligence as "estimated to be average." Often we get a result on a written test (administered by a psychologist), which contradicts our clinical impression. Low written test scores in combination with a clinical impression of intelligence can be the result of many things, but often it is a result of the person either having a learning disability (reading or writing), not speaking English well, or being so depressed, psychotic, or intoxicated that he or she is unable to comply with the testing requirements. Sometimes people malinger (fake) stupidity on these tests because they think it will help their legal cases.

The opposite situation—when someone scores well on a written test but later presents as not very bright in person—usually suggests that the person is malingering stupidity in person, or has some sort of physical problem interfering with communication; for example, he or she is deaf or hard of hearing. Psychiatric illness that arises after the written intelligence test but before your clinical interview can also result in people presenting as less intelligent than they are. True cognitive decline is usually a result of some sort of organic disorder and should be investigated medically and taken seriously. Pseudodementia (fake dementia or fake cognitive decline) occurs when a person is so slowed down from depression or another psychiatric illness that they present as intellectually or cognitively

impaired. The person is not actively faking, but just does not have the energy to think. Usually when their depression is treated, their intellectual and cognitive ability returns.

Cognitive Functioning

Cognitive functioning is related to intelligence but is not exactly the same. Cognition means the act of thinking. Everyone thinks, but some people think more intelligently than others. So really intelligent people can have impairment in their ability to think, and really dumb people can have no impairment in their ability to think. This concept might be confusing, might seem to some as hair-splitting, might often be irrelevant, and might be crossing over into the realm of neurology more than the neurologists would like. However, we should mention here that there are certain questions that we ask on the mental status examination that are more concerned with cognition than intelligence.

We ask about words and word finding. In a formal examination, I would point to my watch (I know, young people don't bother with watches; they just use their phones) and say, "What's this called?" The answer, of course, should be "a watch," or even, from a very old person, "a wristwatch." "And what's this part?" "The band." Point to a pen (again, with the advent of the Electronic Health Record, a disappearing relic) and ask, "What's this?" The person would say, "A pen." "And what's this part?" "The cap." Any mistakes or difficulties with these things indicate problems in either thinking or in verbal expression. If you know the person has had a stroke, for example, you cannot assume that it is the thinking that is messed up. All you can assume is that somewhere in the circuit between seeing and expressing an answer, there is a glitch. The glitch may be in the thinking, or it may be elsewhere. All these tests, in fact, may actually be giving you a wrong answer because of a glitch elsewhere in the system. It is up to the examiner to figure out what the problem really is. That is why it is a mental status examination and not a score.

Other types of things we can do are to ask the person to follow a written command, that is, close your eyes, put this pen on the table, etc., copy a drawing, or, my favorite, draw a clock. The clock drawing gives us a wealth of information, mostly neurological, and is probably too technical and complex to interpret here right now. But if you think you have a neurologically impaired individual in your office, and you want to convince a psychiatrist or neurologist to come take a look, ask the client to draw a clock. This clock, of course, needs to be a traditional clock, not a digital clock, so perhaps this amazing tool for uncovering and understanding brain dysfunction will be abandoned before long. But a good messed-up clock is worth its weight in gold. A clock can tell you if part of the brain is not functioning at all and which part of the brain it is. To explain how I know this will take a few more chapters, but for now, trust me. Your expert will be amazed when you fax him a drawing of a messed-up clock innocently drawn in good faith by your client.

Attention and Concentration

Attention and concentration are two terms that are actually slightly different, but clinically present as very similar. For the purposes of anyone other than a neuropsychologist, these

terms both refer to the person's ability to notice and understand what is going on around him or her. There are many different ways to test attention and concentration. For the attorney, it is just important to recognize that if a person is so distractible that he or she cannot stick with the conversation, further evaluation is warranted. Making an actual diagnosis of a psychiatric disorder is rarely only a question of attention and concentration, as these traits can be abnormal in a wide variety of disorders.

Insight

Insight is one of the most crucial components of the mental status examination, but is also a relative feature and can mean different things for different people. Insight refers to a person's knowledge about himself or herself. It can refer to a person's understanding of his or her own mental illness, knowledge about personality or personality traits, knowledge about one's behavior, or simply the understanding that he or she needs to take medication to help with a problem. Insight can be a fluid and relative concept, but it is always relevant to legal cases in some manner. In general, identifying whether or not the person's insight is intact relative to the issue being considered by the court is the most critical in forensic cases. If you, as the lawyer, think your client does not "get" what he or she is facing right now, get a psychiatric opinion. The concept of insight is so important in psychiatric-legal matters that we will have a whole chapter on it later.

Judgment

Obviously, most criminals demonstrate poor judgment. The question that the psychiatrist can answer is whether this poor judgment is part of some psychiatric disorder or whether it was part of the proverbial "choice" that each individual is thought to have under the law. Therefore, stating that someone's judgment is "impaired" is fairly meaningless when performing evaluations for the courts. The court needs to know why the person's judgment is or was impaired. Was it a result of intoxication, head injury, psychosis, intellectual disability, or simply that poor choice? If you, the attorney, cannot figure out this part, we can help you. Some psychiatrists and psychologists use certain rote questions to evaluate judgment. A famous one is, "If you see a letter lying on the ground next to a mailbox, with a stamp on it, what do you do?" The traditional "right" answer used to be, "Put it in the mailbox." I don't know anyone who has asked that question in a clinical setting for a long time now. Not only do we rarely mail letters anymore, we have all been taught, "if you see something, say something." A person who says he or she would do nothing, or would call the police, is not necessarily paranoid. He might simply have watched too many shows about terrorists, or perhaps lived in a country where envelopes routinely explode. So we have had to reconstruct our pro forma questions into more of an evaluation of past, present, and future behavior in a variety of circumstances. One crazy answer does not mean someone is crazy, and the "right" answer does not mean someone is sane.

In summary, the mental status examination is the basis by which we evaluate someone's psychiatric status in the moment. We make decisions about competency, need for

psychiatric hospitalization, and often treatment with medications, based upon a current presentation. Other decisions, like decisions about dangerousness, placement, whether or not someone can be rehabilitated, and many others, require far more information for an accurate assessment. Just as a medical doctor takes a history and does a physical, we also do both. Psychiatrists are the ones who can figure out what the history and mental status examination, taken together, really mean for your client and your legal case.

I said I would give some examples about how the mental status examination can give you information about your evaluator. I will discuss how to use your expert—and how to abuse the other guy's expert—later in this book (since I want to keep you reading until the end). But I want to give one example here, because it fits in with the whole concept of the mental status examination.

I am frequently asked to be the second-opinion evaluator. Someone will get a psychiatric evaluation from another psychiatrist who is geographically closer, or cheaper, or whatever. Then I'll get a call asking if I would mind seeing this case. I then receive the previous evaluations as part of the case materials.

One time, I was asked to evaluate two young brothers, aged about 13 and seven. They were in foster care. They had been seen by another psychiatrist in another part of the state. The other doctor's report had a number of problems, including a recommendation that the brothers be split up, and the state was very concerned about that particular recommendation. The other psychiatrist had described the older brother as "very tall and menacing."

I saw both boys. They were cute. At the time, one of my own boys was 13. I asked the 13-year-old brother to stand next to me so I could measure him in comparison to my own son. They were almost exactly the same height (compared to me). I put that in my report. When I spoke to the case-worker, I asked him, "Is Dr. So-and-So very short?" He started laughing and said, "Do you know her?" I said, "I never met her!" (I have since met her. She is, in fact, short enough to qualify as a dwarf!) Tall and menacing is a judgment call and is completely inappropriate in a psychiatric evaluation. That is why when you describe what someone looks like, you say, Joe is a 13-year-old light-skinned African American boy who is five feet four inches tall and weighs about 130 pounds. (I usually do not even bother to do that; I just say, "Looks his stated age," but I supposed if you are four feet eight inches tall at 60 years old, you might need to actually put in people's measurements, and that is totally appropriate). But to describe somebody as menacing is incorrect.

I worked with sex offenders for many years. Some of them were quite menacing. "Menacing" is a judgment. That can go in your conclusions (in the psychiatrist's conclusions). It does not belong in the mental status examination. Physical descriptions DO belong in the mental status. I once got in trouble for writing in my note, "Inmate greeted me with an enormous erection." It was true. Sorry if that is offensive to anyone, but it happened. Another time I wrote, "Mr. C is the only patient I have ever met who was somehow capable of blocking both doors to the room simultaneously. I ended the session and informed the lieutenant." Those sentences are descriptive. They might be more colorful than what most psychiatrists would write. I have never pretended to be conventional. But I do my job the

way I am supposed to do it. Descriptive. Not a judgment. We do not judge. We describe, we evaluate, and then we recommend. And hopefully, we do not waffle. Waffles are for maple syrup. We will discuss the waffling expert later in another chapter. For now, let us catch up with Mo, in the Waffle House off I-80.

Mo has ordered waffles. The waitstaff is whispering about him. He is none too clean. His beard looks rather disgusting. Malodorous is a polite word that only a psychiatrist would use to describe how bad he stinks.

Tammy, the young waitress, brings him the waffles, but in her youth and inexperience, has forgotten to omit the bacon. Perhaps Mo, in his psychosis, had not clearly expressed his wishes. We can't possibly know. Mo sees the bacon and becomes enraged.

"You give me this filth! This *traif! Inshallah! Allah hu Akbar!* Eye of the needle! Excrement of the camel! I cannot eat this filth in this dunghole of the universe of the camel of the needle!" And so forth, until a couple of sheriff's deputies come in, pistols drawn.

Mo, unsurprisingly, shouts louder. Again, this encounter could go two ways. The deputies could shoot first, and ask questions later, but fortunately, they don't. Perhaps seeing their chance to divert a terrorist attack and their own 15 minutes of fame, they manage to subdue Mo (as he is only brandishing a coffee spoon, they are hardly in any danger), cuff him, throw him in the back of their SUV, and bring him to their police station (or whatever the sheriff's office is called. Remember, this story is made up by a city girl.).

What just happened? A lot of people saw craziness. And, as usual, the response was not medical. The response was law enforcement. What will happen next? Will it be legal, or will it be medical? Think about that, while we continue on our journey through the world of psychiatric jargon.

4

Diagnosis v. Jargon: Some Common Psychiatric Diagnoses, and What Exactly Is Schizophrenia, Anyway?

What Is the DSM and How Should It Be Used?

The DSM or *Diagnostic and Statistical Manual of Mental Disorders*, currently in its official fifth edition (i.e., the DSM-V) is a book published every so often by the American Psychiatric Association. Although we discussed it in an earlier chapter, we will recap a bit here. The DSM is created and written by a committee. It is essentially based on what a bunch of middle-aged white guys sitting in Washington think comprises mental illness and the entire field of psychiatry. That said, it is considered the definitive text on psychiatry, the ultimate diagnostic tool, and it is the official document which psychiatrists and other people in the mental health field use to communicate with each other. However, there is a huge caveat. The people who walk into your office will very rarely have any of the disorders listed in this book. They will have something very similar, or a bunch of conditions that are very similar to a few in the book, or they will meet four out of five criteria for something or they will never admit to the required criteria, such as a running commentary of voices, because despite the fact that they are hearing voices, they cannot identify these voices as a sign of illness.

The DSM is both an extremely useful tool and an extremely dangerous weapon. It is also a thing that we as psychiatrists learn. We memorize certain components, and we take tests based on that information. One of those tests is the Certification Examination in Psychiatry administered by the American Board of Psychiatry and Neurology, also known as "the Boards." Sounds good, right? Not only have we taken a bunch of exams proving that we have sufficient reading comprehension to read and understand the DSM (that would have been all the testing throughout our lives), but we then are required to actually memorize huge portions of it. For example, we were supposed to memorize that the criteria for Attention Deficit Hyperactivity Disorder (ADHD) had to be present by the age of seven. Pretty simple, no? Except—in the DSM-V, which was published in May of 2013, that cutoff age was changed to 12. I happen to know these things because I see patients with ADHD every day, and an age is not that hard to memorize. But here is the problem: the last time I took my recertification examination (the "Maintenance of Certification" exam or the MOC exam, which means exactly what it sounds like) that some psychiatrists are required to pass once every 10 years, we were tested on the DSM-IV-TR (the previous version of the

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DSM), only my MOC exam was in February of 2014. When I attended a review course in January of 2014, we were told not to bother with the DSM-V, because the exams had not been updated. What?!?!

I hope this story illustrates the relative worth of the DSM. Is it useful? Absolutely. It provides information about a whole bunch of psychiatric illnesses all in one place. It classifies them in ways that make sense to a treating doctor (e.g., mood disorders, psychotic disorders, intellectual impairment, anxiety disorders, etc.). I'm not going to rewrite the DSM here. Every lawyer, and every doctor, should have a copy (despite its exorbitant price). It's the best of what we have. But it is only a small representation of the field of psychiatry. Most of the people who walk in my door every day have clinical presentations quite different from those in the book. The most important thing about the DSM is that it enables psychiatrists to communicate with insurance companies and thus get paid. A secondary benefit is that we can communicate with each other, with other types of mental health treatment providers, and, at times, with the legal system. We have to use established diagnostic criteria and diagnoses to communicate with the legal system because otherwise we would have a gigantic free-for-all. I cannot in good conscience go to court and give diagnoses of Vivian disorders A–Z and expect to be taken seriously. So I must stick with the DSM, and, within that framework, attempt to explain what that disorder means for that particular individual and his particular circumstances. It can be done. I do it all the time.

Unfortunately, not only is the DSM inadequate in describing what clinicians see in their offices or other practice settings every day, its lack of scientific references can be used by health insurance companies to deny coverage. Did you know that there are insurance companies that will not pay for treatment for posttraumatic stress disorder (PTSD)? They claim it is not a "biological" disorder. At some point, long before any of the brain changes identified in PTSD were visualized with modern technology, some policy makers decided that PTSD was "psychological" (whatever that is). I touched upon this concept in the first chapter, when we introduced the bio-psycho-social model of psychiatry, which has recently been supplanted by what the former president of the American Psychiatric Association sarcastically named the bio-bio-bio model. Just an aside—I was a psychology major as an undergrad. My department was very experimental. Psychology 101 was a lab science, as were many of the higher level courses. Very early in the process, I became frustrated with the concept of the brain as a "black box," inside which things were happening about which we knew nothing. Even though I am deathly afraid of small furry running creatures (rats and mice), I took every course they had in physiological psychology, psychopharmacology, and the like. Back then, the field was still in its infancy (although I "sacrificed" quite a few rats in the name of science). Serotonin had only recently been discovered. By the time I got to medical school, serotonin agonists were being developed, and by the time I was an intern, Prozac® had been introduced to the world. We know that whatever "psychological" might be, the brain has something to do with it. In fact, each of these words and letters that I type involves biological processes so complex that the combined fields of all of medicine have not really been able to figure out exactly how it all works. For an insurance company

to deny coverage because they don't "believe" that PTSD is "biological" should be illegal, but that part is beyond the scope of this book. The important take-home message is that whatever happens in your brain has a bazillion biological components, many of which have not even been discovered yet. Please just keep that concept in mind as you approach anything to do with behavior. One day, one of my insurance claims for a fairly crazy patient was denied because I put "PTSD" as her primary diagnosis. Normally my assistant just reverses the order of the diagnostic codes—she will swap out major depression for PTSD and we will get paid. On that day, I might have been having a diagnostic code of my own, because I just flipped out. I told her, "Call them up and ask them if they want me to send them some articles proving that PTSD is a biological disorder." She did, and I did, including some from the federal government. I was just that angry. Imagine, an insurance company can decide that my patient is not sick enough for them to pay for her treatment. They can decide that I should work for free. I don't see *them* working for free. But the flip side is also true. We cannot be reductionistic and claim that biology exists in some sort of vacuum—that inside the skull is a black box of neurotransmitters that exist independently of one's body, brain, and life events. That way lies (sorry) madness. We know beyond any shadow of a doubt that life experiences are somehow translated into biological processes that exist inside the brain. We cannot have psychiatry without both brain and environment. To think that we can adjust neurotransmitters without paying any attention to the person in which they reside is the height of arrogance, in my opinion. And yet, psychiatrists claim to do it every day, throwing medications at their patients willy nilly, often without even talking to the patients first, or just asking a perfunctory "how's the medication?" I will repeatedly touch on this topic in this book, because this type of so-called psychiatry is not how I was trained, and you as an attorney should not be satisfied with this type of treatment for your clients. Dr. Eric Plakun told me there is a 20-year period of a lost generation of psychiatrists who never learned how to do psychotherapy. I am a member of the last class of psychiatrists who learned how to do therapy and who also learned psychopharmacology. The saddest part of the story is that many of the younger psychiatrists don't really know much psychopharmacology, either. Why? Because the funding is so limited that they were so overworked and so busy keeping patients out of the hospital that they did not have time to learn how these medications really worked. All they had time to do was fill out forms and set up clinic appointments and try to keep the patients from killing themselves. And of course many of the older psychiatrists were trained before many of these neurotransmitters and their putative roles in psychiatry were even discovered. Need I say more?

One of the lawyers I interviewed for this book, Chris Fredericks, practices primarily employment and workers' compensation law. He finds that there is significant bias in judges and juries against psychiatrists and psychologists, and against the whole concept of brain biology. He cites one major frustration as the fact that people who experience PTSD often do not experience symptoms until well after the trauma occurs. He wondered during our interview if I could address this issue in the book: "Why does it take months or years for the symptoms to show up?" My answer, to him and here, is that I don't know, and nobody really knows. There are many proposed biological and

psychological mechanisms. There are clinical manifestations of trauma that are not even found IN the DSM. For example, in children, we often see obsessive–compulsive disorder (OCD) resulting after severe trauma. Literature searches produce some hits, but the evidence is still fairly anecdotal or at best, correlational—there is no biological "evidence" that "proves" that childhood trauma results in OCD. Yet, ask any experienced child psychiatrist or psychologist and he or she will tell you that if you have a kid with severe OCD, look for the trauma. The fact that we cannot always find it or explain it or research it does not mean it is not there. If you read the diagnostic criteria for PTSD, you can see that there is a type that has delayed onset, with its own code number and everything. The proposed mechanisms for delayed onset are not exactly proven. They are proposed. Some are biological, and some are psychological. Someday we will understand how biology and psychology are actually the same thing. We do not understand that yet. But a delay in clinical presentation does not invalidate a diagnosis. It does not mean a disorder is not real, or that it is somehow less than one that occurs on the spot. When you have a client with PTSD, and that client suffered for years before coming to you, use that information. Use it to paint your client as a fighter, as a strong individual, as someone who has managed to cope with abuse and pain. Use those diagnostic criteria to support her diagnosis. And let your expert teach the jury, or the judge, or the mediator, about what PTSD is, and how people suffer and then survive.

Chris would like for me to help override the biases and the ignorance about psychiatry that make it so hard to use psychiatric expert testimony in his types of cases—employment discrimination and workers' compensation cases. I don't know if anyone can achieve that goal, but I hope to start by at least making this sort of testimony a bit more user-friendly, and to help the legal profession understand that psychiatry is a thing, and people should be aware of it.

What Is Psychosis?

Psychosis is a sign of mental illness. It is considered the most severe aspect of mental illness and tends to be associated with the most devastating of the psychiatric conditions, such as schizophrenia and true bipolar disorder ("manic depression"). Many other psychiatric disorders have elements of psychosis at times, and there is a whole slew of disorders that include elements of psychosis in conjunction with other signs and symptoms that meet the DSM criteria (whichever version we are up to). But in order to understand the diagnostic criteria, you have to first understand the lingo. Unfortunately, psychosis may be the most difficult of all the psychiatric concepts to really explain to a jury of non-psychiatrists. Like obscenity, I know it when I see it, but how to explain it remains extremely difficult for many, many psychiatrists, and many high-profile cases have been won and lost, depending on which side you were on, because of this difficulty. Some psychiatrists and psychologists "get" psychosis, immediately, and some never do, relying only on the very concrete definitions and patients', or evaluees', self-reports, which are not reliable.

Psychosis is not a symptom. Signs and symptoms are different. Symptoms have to be reported by a patient (or a person): "I feel tired all the time." "My stomach hurts." "I had bloody diarrhea for a week." Signs of illness are different; they might not be noticed at all by the patient (or, in our case, by the person who may not yet be anyone's patient). The signs of psychosis will be things like, "Someone implanted nanobots in my brain." "I am being controlled by Jesus." "The neighbors talk about me and plot against me all night long." Yes, they are symptoms, but the sufferers do not recognize them as symptoms—they recognize them as upsetting events.

What about "I hear voices"? (Yes, the question mark is in the right place). Hearing voices is often a part of psychosis, but here is a big secret that most people don't know, even though I keep telling you: psychotic people do not usually understand that they are hearing nonexistent voices. They hear their ex-wives. They hear God. They hear the devil, the neighbors, the police, the Central Intelligence Agency, or Czechoslovakians (yes, I had a patient whose psychosis for some reason included Czechoslovakians. The reason he talked to me and not to his psychologist is because he believed she was Czech). But people whose chief complaint is "I hear voices" are either lying or have some other condition that is not psychosis.

In order to be considered psychotic, a person must have a THOUGHT DISORDER. A thought disorder can include many different things, including hallucinations (hearing voices). Thought FORM and thought CONTENT are the two things we assess, and doing this assessment is not hard. The hardest part of psychosis for non-psychiatrists (and even for some psychiatrists) to grasp is the break with reality.

Often we read that psychosis means a loss of contact with reality. While that is a good and accurate description, it is not sufficient, because it does not include the flip side: psychosis is an ALTERNATE reality. The other important component is that this loss of contact with reality, or existence in an alternate reality, occurs in a CLEAR SENSORIUM. Psychotic people are not confused, disoriented, or cognitively impaired. I once heard about a judge who refused to believe a defendant was mentally ill because "He's not drooling." A clear sensorium means that the person is not drunk, not feverish, not DELIRIOUS. We will cover delirium later in this book, as an aside not to be confused with psychosis. The psychotic person can still tell you his name, address, and social security number. He or she might have difficulty telling you these things; might become distracted, derailed, might exhibit thought blocking, or might speak in a circumstantial or tangential way. The person might be too paranoid to cooperate. But there is nothing medically or neurologically wrong that means that he or she is unaware of the reality around him or her.

Psychosis is the presence of a thought disorder resulting in an alternate reality in a clear sensorium

This sentence says it all, but says it using confusing jargon that normal people (the ones who did not subject themselves to years of training in psychiatry) are unlikely to fully understand. This is the problem we face when courts try to deal with insanity defenses (for example) without a full understanding of what the experts are saying. For us psychiatrists,

the language is our language. Just as I don't have to think when I speak or hear English, psychiatrists don't have to think when they hear all of these words. We know exactly what they mean within the context of psychiatric evaluation.

The language of psychiatry is different from English (or from whatever language your mother speaks to you). Every word we use to describe someone's mental status examination has a special psychiatric meaning and implication. I laugh (not in a mean way) when I hear lawyers try to use the jargon of specific statutes in court, and they don't even know the proper pronunciation of some of the words, because AFFECT is the outward presentation of how your mood and emotions AFFECT you. Not the same word. (Accent on the first syllable versus accent on the second). Just because a statute seems to be written in English does not mean that you understand it! So many otherwise brilliant people cannot understand psychosis, because they never learned what it really is. And there is nothing intuitive about insanity. While we all can recognize when people are acting weird or "crazy," to infer from this behavior what they are actually experiencing is the hard part.

I was in court recently on a custody case. The plaintiff was a man I'll call Mr. Shrek, since that is the name autocorrect gave him when I was writing the report. Obviously it is not his real name. And Mr. Shrek's case was not really a custody case. It was a case of an otherwise very intelligent man whose wife left him because of his bizarre thoughts and behaviors. Mr. Shrek became so focused on being correct, not being thought of as mentally ill, and litigating his own case, that he essentially forgot that he was supposed to be fighting for the right to see his children and instead was fighting for some unidentifiable thing which he could not even express.

At one point during my testimony I did a very unprofessional thing. I laughed. I was wearing a dress with a cowl neck and I pulled the extra fabric over my face and looked away as Mr. Shrek and the judge were speaking to each other. I believe Mr. Shrek had just objected to something the judge had said, or possibly he had objected to something I said while he was cross-examining me. Anyway, it was a funny objection and not legally appropriate. Remember, Mr. Shrek was the plaintiff, and my evaluation of him had been court-ordered. He asked me if something was funny. I wanted to say no, but since I was under oath, I had to admit that yes, I thought something was funny. He asked me what. I told him that I thought it was funny that the court needed a psychiatric expert to tell them that Mr. Shrek was mentally ill. The lawyers and the judge and everyone else had trouble keeping their faces blank, but they did all nod. In this case it was obvious that this individual was mentally ill. He had previously been found incompetent to represent himself and had been awarded an attorney and a Guardian ad litem (a guardian for the purpose of the court proceedings only). Those individuals really wanted to help him, but because of his paranoia and thought disorder, Mr. Shrek proceeded to fire all of them and make complaints to the bar association. In fact, the whole case had been moved to a different county with a different judge because Mr. Shrek had made complaints against the original judge. He even made terroristic threats against her and spent several months in jail, in between my evaluation and that day in court. But he did not receive psychiatric treatment in jail. Why? Because, to coin a phrase, he was not drooling. He took showers and looked "normal." He was not

violent. So, no psychiatric treatment. In my original report I had written, among other things: "If Mr. Shrek would agree to comply with psychopharmacological treatment, this whole case would likely become moot."

Psychosis is a difficult concept to understand. Often we have to infer delusions (false fixed beliefs) from the rest of the person's presentation. Thought disorder can only be inferred from speech or behavior. When speech is abnormal, often thought is abnormal, but speech can be abnormal for a variety of other reason too. DYSARTHRIA is the word for physically unclear speech, and if your schizophrenic is also dysarthric, this sign (not symptom, remember?) is most frequently a result of poor dentition or a side effect of medication, not part of his mental illness. However, if he presents with a flight of ideas, loose associations, tangential or circumstantial thinking, word salad (usually a sign of neurological impairment), or a variety of other weird things that come out of his mouth, those are signs of psychiatric disorder.

I'm still involved in a case in which the state wanted to terminate a woman's parental rights to her two children. The whole case hinged on her slurred speech and her inability to comply with psychiatric treatment. Somebody thought that she must be intoxicated because her speech was slurred. It took the psychiatrist (me) to remind them all that this woman had been shot in the neck, and therefore the nerves leading to her tongue and mouth had been injured, which is why her speech was slurred. She was not hiding a secret drug habit that nobody knew about. She was not giving them someone else's urine to be screened for drugs (the powers that were thought that she was doing that, which was why her urine drug screens were always negative). She was not doing any of those terrible things that people thought she must be doing because she was not leaving her home to go to appointments. She was being completely honest. She was terrified to leave her house, because she had walked in the path of gunfire intended for someone else. She had PTSD. She needed someone to actually pick her up at home and take her to the doctor, and her speech was slurred because she had nerve damage. I cried when I wrote her report. She almost lost her children because she had the misfortune to walk in the path of five bullets not meant for her.

In the chapter on Mental Status Examination and the Glossary, some of these terms and concepts are explained more fully. The goal of this chapter is to help you understand the idea of psychosis and what it really means to lose touch with reality and operate in an ALTERNATE REALITY. For psychiatrists, the part about the alternate reality is implicit. We understand that psychotic people have lost contact with reality in such a way that they are able to do things like use public transportation, while at the same time believing themselves persecuted, special, powerful, or one or more of a myriad of other things that are simply untrue.

Another anecdote: Maybe this one is really an urban legend, but the story goes like this. A young black man was found wandering around in the Bronx, one of New York City's five boroughs, and where I did my psychiatric residency. He was disheveled, had no identification or money, and was alternating between speaking gibberish and speaking English with a strange accent that nobody recognized. The police picked him up, at which

point he tried to run away, stating he was the prince of some country nobody had ever heard of. The police assessed this man, who did not know where he was, or where he was supposed to be, and who was dirty and disheveled, as a crazy, homeless individual, and brought him to the psychiatric emergency room.

The young man was admitted to the hospital with a provisional diagnosis of schizophrenia, since all drug tests were negative. He continued to insist that he was a prince of some place and that he wanted to call his embassy. Everyone thought he was delusional, that he was a regular African-American guy who was crazy. But when he could not provide any information—no social security number, no home telephone number, no local next of kin—someone eventually decided to take him seriously. Lo and behold, there really was a country in Africa named whatever it was that nobody in the Bronx had ever heard of, and this young man really was a prince there. He was on a trip to the United States when he somehow ended up in a bad neighborhood where he was mugged and beaten, and found wandering around in a panic.

Now, I blame this story on the fact that it supposedly occurred in July, when the new psychiatric residents are the ones running the emergency room. Somebody did not recognize that despite strange details, the story was cohesive and made sense, and that the man's problem with English was that it was not his first language. But it illustrates an important concept of psychosis—especially in mania and schizophrenia—that we need to understand. This is the concept of GRANDIOSITY. Psychotic people feel that they are super important. They are the center of their own universes and often they believe that they are the CAUSE of significant events, such as storms, wars, earthquakes, etc. Often they may believe that the event, also called a signal event, is what caused their lives to change in this amazing way that made them so important. So a real prince who is disheveled and looks homeless might be mistaken for a homeless schizophrenic because he says he is a prince. Get it? He presents as grandiose when he is really what he says he is, but when everything else about him screams homeless crazy guy.

Somehow the story of the guy who was not really psychotic but was mistaken for psychotic is easier for some people to understand than the guy who IS psychotic and does not present as psychotic, like Mr. Shrek, the father who was litigating his custody case and forgot what he was fighting for. I think that is because in some mental disorders, there is a relative preservation of personality. In general, we assume crazy people should look and act, well—crazy, to be disorganized, disheveled, confused, and to be ranting and raving about being someone super important. In reality, many mentally ill people look perfectly normal until you get them talking. To get to that point can be difficult. The person, be it patient or legal client, or person you are evaluating for a forensic evaluation, has to trust you. Trust takes time. When you have a caseload of 40 cases you are representing as a public defender, chances are you are not going to have the opportunity to develop a lot of trust.

When I worked in a sex-offender prison, one of my duties was to do rounds in the close custody unit twice a week. Other psychiatrists and psychologists did the rounds on the other days. We had to make sure that the inmates were not in danger from themselves, that they were receiving appropriate treatment, and that they were basically comfortable.

They were mostly placed in that unit (one small hallway) because they were too unstable, either from violent tendencies or mental illness, to remain in the general population. I guess this unit is what they call "isolation" in the movies. Each man had his own little cell, and depending on whether he was there for punishment or for safety might have his stuff with him—TV, books, etc.—or might have nothing. The men received their food through a slot in the door and had their own steel sinks and toilets. I'm not sure about the shower arrangements or the exercise arrangements, but they had both. Sometimes they could go to their treatment groups, again, depending on why they were there.

The rounds were just an extra chore as far as I was concerned. These men were constantly monitored and the corrections officers back there were experienced and conscientious, so they would call us if there was a real problem. So time went by and I did my rounds, and the other doctors did theirs, until it was time to evaluate one of these men upon his impending discharge. Where should he go?

Some inmates would just be released into the community. Some inmates were subject to community supervision for life. Some were referred to a forensic psychiatric hospital. And some were referred for involuntary civil commitment under the Sexually Violent Predator Act of our state, New Jersey. At one of our bazillion team meetings we discussed this case. We all agreed that he could not be released, based upon his extensive sexual offense history and the fact that he had made no progress in treatment, as he had spent his entire incarceration locked up in the close custody unit. I opined that this man be sent to the forensic hospital for further evaluation and treatment, because he was too psychotic to go to the facility for sexually violent predators and would not be able to benefit from the treatment there, again, because he was too psychotic.

My colleague, Dr. Bird, another forensic psychiatrist with actually more years of experience than I had, looked at me in astonishment. "What? He's not psychotic. What are you talking about?" (Now, he obviously had not read my notes, but this was prison. It wasn't like we were really worried about continuity of care, like in an outpatient clinic. So we let that slide, although I had always read his notes. Put it this way: my colleague looked more nerdy than I, but I was actually more nerdy in real life).

After this big heated debate, we decided that the only way to decide was to interview the inmate together. The whole mental health treatment team—two psychiatrists, a psychologist, and two social workers—all crammed into the little interview room on the close custody unit. First, the other doctor interviewed the patient, whose nickname was Captain (he had supposedly once been in the military).

"You're feeling okay, right?" Captain nods.

"Nobody's bothering you here, right?" Nods again.

"You don't hear voices or see visions, right?" Another nod.

"Thank you for your time."

Then it was my turn. "Mr. Captain, thank you for meeting with us." Nod.

"I know it must be stressful to be here in this little room with all these people." Nod and affirmative grunt.

"I was hoping you would be able to tell Dr. Bird about the Czechoslovakians."

Pause. Then: "I know that Dr. George (one of the psychologists) is Czechoslovakian, and the Czechoslovakians are plotting against me. That's why I have to be very careful and quiet in my cell. They are spying on me with microwaves…" Captain spoke for 10 minutes, scarcely taking a breath. His associations were loose, although his delusions were fairly fixed and organized. I was sitting slightly to the side and behind Dr. Bird, so I was able to see his jaw literally drop when the psychosis started tumbling out. That was the first time in my life I saw someone's jaw actually drop. It was pretty awesome; until then, I had thought the proverbial jaw drop was only a figure of speech.

The treatment team agreed that Captain would probably not do well in intensive inpatient sex-offender group therapy, and we committed him to the forensic psychiatric hospital when his criminal sentence was over. Later that day, I heard from my treatment team leader. She said, "You know, Dr. Bird came to talk to me afterward. He said, 'Now I know why Vivian is such a good psychiatrist. She LISTENS to the patients'." Credit where credit is due—to my mother, who taught me this expression in infancy: A mute wouldn't have said it in a thousand years. Isn't listening to patients what we are supposed to do?

So back to psychosis. Once you can identify it, it's easy. But it is just not so easy. I have to give you some more examples, because I constantly hear people who think they know what it is, and they do not. If you have a psychotic client, and you can convey to the court what that psychosis really means, you are totally golden. I don't even know if I can explain to you, my dear lawyer reader, how golden you are, because my impression from the media and from all the lawyers and lay people I've been speaking to is that people just don't get it.

A few days ago, just prior to me handing in this manuscript, there was yet another shooting incident. I won't tell you which one, and it doesn't matter, because undoubtedly there will be another one or five before you hold this book in your hands. Of course, the Internet and the cable news shows and the coffee shops were abuzz. Everyone and his mother knew what the shooting was about. It was, naturally, about racism. Because they are always about racism, gun control, or both.

But are they, really? How many racist people never massacre anyone? How many gun owners never massacre anyone? I will give you the answer: most of them. I do not endorse racism, nor do I think buying guns should be easy. But as we will see later in this book, a third factor must come into play. That third factor is almost always some sort of derangement of the mind. Courts have called it derangement of intellect, like in the insurance statute we encountered earlier, or no more reason than a wild beast, like the M'Naughten rule people. The courts have tried to use legalese to explain something that is, by definition, almost undefinable. Intellect and sanity are two different things, but people who have not studied psychosis or even psychology do not have the vocabulary for this type of "batshittery." I need to try to explain this concept further so that you can begin to understand it a little bit. So here are a few more examples.

Here is the first, and the easiest. I was doing a guardianship evaluation on a young woman who was crazy as the day is long. She said something about a Monarch butterfly and then went on and on to talk about how she felt like the butterfly, that she had no stable home, that her wings were clipped, all kinds of loose associations between her

thoughts—her thoughts connected in seemingly random ways that made sense only to her. The attorney her parents hired said to me, very seriously, and with concern: "She thinks she is a Monarch butterfly." Well, no. She did not think she was a butterfly. She thought she was the person she was, but she also had all these ideas in which she related to being this butterfly, like this butterfly, and also in the next sentence like a helicopter and a doormat, because that was how her brain was organized. That ability for her brain to be several things at once is where the word "schizophrenia" comes from. It means "split mind" and was coined by a Swiss psychiatrist, Eugene Bleuler, in 1911. Schizophrenia comes from the Greek schizo (split) and phrene (mind). Please do not confuse this term with multiple personalities, with which it is often confused. The concept of the split mind is what we discussed earlier, that a schizophrenic's mind can remember its name, address, and social security number while at the same time feeling controlled by nanobots and sympathetic to the flight and plight of the Monarch butterfly.

Second example of psychosis: About 20 years ago there was a high-profile shooting of a television worker right outside the studio of one of the big three networks in Rockefeller Center in New York City. I happened to be doing my forensic psychiatry fellowship at the time, so I got to sit in on some of the interviews. He explained that he had seen a news weather report that said that a big storm was going to be moving up the east coast, and he knew it meant he had to drive up to New York and do this horrible act, which involved planning, driving, thinking, and even finding a parking spot in New York City, not exactly an easy feat. I used this example for someone who thought that an insanity defense meant that you had to be completely disorganized. His response was: "Well, he thought he was a storm." No, he did not think he was a storm. He though he was a person, and he thought that this weather report had embedded in it a secret, special message that only HE could understand that meant that he was supposed to do this terrible thing. That's how psychosis works. We ask people, "Do you ever get special messages from the radio or TV that are meant just for you?" They generally respond "no," unless we take a lot of time and get to know them, and then they might tell us the truth. Or sometimes they inadvertently let something slip. Elsewhere in this book, I tell you the story of a patient whose wife kept bothering him. Psychosis is not always obvious even to professionals. To nonprofessionals, it can remain totally obscure.

The third story is a case I worked on a few years ago. I'm including it here in a form close to the way it was in its report, because I wish to make a point: the court did not wish to permit any psychiatric evidence into the trial, despite the fact that the defendant had been taken to psychiatric treatment almost directly from the crime scene and had been psychiatrically treated throughout his incarceration. I wrote the report anyway, handed it in, and the entire case was changed—post-conviction. Did you hear me? POST-CONVICTION. I got someone to listen to me. Don't knock the power of a good psychiatric expert report. No, I'm not trolling for business. I have plenty, and anyway I'd rather write books, even if they don't pay as well. But here is the story of a young man I'll call Johnny Rocket, because it suits him. I don't think there is a copyright on that name. If this report seems a bit vague at points, it's because I took out all the identifying details, and there is no point in making

up dates or locations. Trust me, they were all there in the real thing. I'm not giving you the whole report, I'm just giving you the beginning that explains why I was interviewing him, and then the amazing part in which he tells me what it felt like to be him the night he was arrested. Another important thing for your expert, besides the ability to ask the right questions and the ability to listen, is the ability to type fast. You want her to be able to get all the crazy words down.

I met Johnny Rocket when he was a 23-year-old white male incarcerated at the Special County Jail. He had recently accepted a plea-bargain agreement, and his sentencing was pending before I was able to secure an appointment to interview him. Apparently his mental state was not considered by the prosecution at all.

The Psychiatric-Legal Questions I was asked to consider were the following:

1. What is Mr. Rocket's psychiatric diagnosis?
2. What mental defect was he suffering at the time of the instant offense?
3. Does Mr. Rocket have the capacity to consult with his attorney in a rational and factual manner to assist in his own defense?
4. Is Mr. Rocket a danger to himself or others?

I reviewed a whole host of sources of information, but many documents were withheld or missing from the discovery provided to Johnny's attorney and therefore to me. I was able to glean the following relevant data:

The authorized reader is undoubtedly familiar with the facts of this case. According to the documents listed above, on a specific date at 10:10 pm, Johnny Rocket approached the scene of a motor vehicle accident at the intersection of Broad and Market Streets in Everytown, NJ. Johnny was on foot. Officers at the scene were watching the accident scene when they heard "wheels squealing" and saw one of the patrol cars, #29, heading east on Broad "at a high rate of speed." A chase ensued, and "a short time later" the vehicle had been recovered in Another Town by the Everytown and Another Township police.

Johnny allegedly drove the police car through five townships and was finally stopped and apprehended in Another Township, where he was combative and uncooperative. A police dog was utilized to bring him down. He was eventually subdued and taken to the emergency room at a nearby hospital. Officers at the scenes initially suspected Johnny of Driving Under the Influence and sent blood for toxicology (according to a form filed with the police report), but the results of any toxicology were never made available for review by the prosecution. Critically, no medical records from Johnny's arrest and transport to Beachtown Hospital were ever provided either, and the hospital did not respond to multiple requests for medical records accompanied by appropriate releases. After being treated (although we do not know for what or whether his psychosis was documented), Johnny was transferred to the local jail and later to the county jail. He was indicted for seven out of a total of 11 charges, including Theft, Eluding, Theft by Receiving, Unlawful Possession of a Weapon, Attempted Escape, Aggravated Assault, and Resisting Arrest.

Since the date of his original offenses, Mr. Rocket has been incarcerated, primarily at the Special County Jail, where he currently remains. Upon admission to the jail, he was

immediately identified as psychotic and referred for psychiatric treatment. His treatment has been inconsistent, as his treating psychiatrist took a short leave of absence, and Johnny was changed to a new medication regimen. However, in discussion with his treating psychiatrist and psychologist, as well as via a review of his records (copies were not provided), it is quite clear that this young man was quite psychotic (i.e., out of touch with reality) upon admission to the county jail, believing himself the victim of a conspiracy, in fear for his life, and responding to voices and internal stimuli. Once treated with appropriate medications, Johnny started to do much better, but he then began to refuse to take the medication, typical of individuals with chronic mental illness, and currently remains paranoid, although cooperative.

Johnny provided me with his own version of events: "Well, I wrote a timeline—there was this thing that like, the world was going to come to an end…everybody knew about it, everybody was talking about it, and I didn't really believe it but I tried to trick myself into believing it." Johnny says that after he "tricked" himself into believing that the world was going to end, "things started happening." He describes an entire sequence of events that he witnessed while sitting on his front porch, involving a girl, a truck, two guys, and intimidating and suspicious behavior. He returned to his house and they followed him back to his house "so they saw where I lived." From that moment, he decided he did not want anyone dealing drugs on his corner or hanging around his house. Whenever anyone looked suspicious to him he "made it known that I didn't want them to do drugs in front of my house." He says he would stand real close to them or stand behind them and cough or stare at them meanly. He was living with "this girl from high school and her father." He reports he had been moving around to various relatives and then decided to live with this friend. He was not living with his parents because he was not in school and he and his mother had a disagreement about his Adderall. He moved out of the home about two years prior to the instant offense.

During all this time spent on the porch, he was not working. He stayed there for about two months and rode his bike to various towns looking for work. He went through a string of jobs previously, but when he moved to Everytown, he had to find something in walking or biking distance. He says he had a job lined up for after Memorial Day, but because he was arrested, he never got the job. He and this girl across the street "developed this indirect relationship—we never talked, but she used to wave at me." He says that people used to drive by and beep and wave to him because he was out there so frequently. Then the guy across the street started spending huge chunks of time staring at him. He invited a girl to spend some time on the porch with him and she noticed the guy across the street staring at him and they went inside.

The next night the guy across the street walked past him and "said 'bitch' real loud." He says that this episode of staying on the porch and playing neighborhood watch took about four weeks. One night he was standing outside on the porch and twice the police rode by, looked at him, and flashed their lights real quick. "I took it as 'keep up the good work.'" A couple of nights later, again on the porch, a black SUV with tinted windows pulled up right next to the porch and started playing loud music, "and he pointed at me and then he peeled

off real fast. This scared me but inspired me at the same time." He felt that his actions were making people react in a certain way. He says that he was effecting this influence on others just by standing on the porch. He says he witnessed money and drugs being traded in front of the store across the street, and this was the behavior he wanted to eliminate.

The next day he went out job hunting on his bike. When he returned home, "there was this man standing across the street with his hand on his waist." So Johnny got off his bike and stood with his hand on his waist. He says that he thought that the guy might have a gun, so he wanted the other guy to think that he had a gun. Then the neighbor drove up, and the guy across the street ran away. That night Johnny did not sleep and put a knife under his pillow in case someone came after him.

Johnny thought he was getting involved in something that these people thought he had no business being involved in. The next day he went on his job search, and when he came home, he was outside the house when a car across the street started up and pulled into his driveway. He says the car pulled into his driveway and shone its brights into his face. He believes that this behavior was deliberate: "I took this as a sign of, 'stop doing what you're doing.'" At this point, he was scared so he took glass bottles and filled them with vodka and put rags into them, so he made Molotov cocktail bombs. He heard a girl scream outside and ran outside to see what happened, but he did not see anything. He went back inside and did not sleep that night. By this point, Johnny was very scared. He thought that these individuals were going to try to shoot up his house.

The people he was living with were working constantly; the dad worked at a casino and slept all day and was out working all night; the girl was mostly in Beachtown, where she worked and where her friends were. He says that he thinks they knew something was wrong, but he "felt sort of ashamed, so I just kept it totally a secret."

Johnny had been taking Adderall for his ADHD. It was prescribed by a doctor. He took his last 10 mg Adderall that morning at 10:30 am. At this point, his mind started to experience racing thoughts. He was riding his bike and listening to music through his ear buds.

"I thought the music was so like—it was rap music and it related so much to what I was doing and how they were trying to intimidate me…Eventually I came to the conclusion that they were singing the music *to* me…" He says that he thought he was a victim of a big conspiracy, and the people that were trying to intimidate him and the rappers were the same people. He returned to the house and sat on the porch. He started thinking that the trucks with the logos on them were passing his house trying to send him indirect messages that the companies wanted him to work for them. He walked to where one truck was parked and asked the driver if he needed any help with the job. The driver said no.

He then returned to his house and went inside. He was living with the female roommate, so he thought he heard her screaming, and then he thought there were people inside the house who were raping her. He ran out of the street and ran into the pizza store down the street and "acted like I was trying to apply for a job." He kept looking at people's faces and thought they were trying to gesture with their faces (he shows me) that he had to get out of there. He ran out of the pizza shop and "busted into a restaurant" through the back door. "I was confronted by the owner," and he told the owner that someone was chasing him,

but the owner told him that nobody was there. He thought he saw the police in front of the house—"I thought I saw a police and a fire truck," but he is unsure. He thought that maybe something really did happen. He does not know why he did not call the police himself when he thought someone was being attacked: "I wasn't sure if it was happening or not—I didn't want to call the police if it might not be true." By this point, he was scared of every car that passed him. He walked about five miles into Another Town, went into a restaurant and asked for some water. He sat down and then told the girl behind the counter that he was going to the beach. He walked on the beach and started approaching girls, because he thought the reason people were chasing him was because he would never walk up to girls and start speaking to them. He kept hearing a loud noise that he thought meant he was supposed to do this. He also thought that he was safe on the beach. Eventually, he approached three girls and spoke to them for 15 or 20 minutes. He believes the conversation was going well until he said "something kind of like, insensitive—I think it was something like, I want to hang out with one specific girl; I didn't want to hang out with the other two." He approached another girl, spoke to her, and then walked away. He walked toward the back of a restaurant and saw a worker unloading a truck, and "he lifted up the back of his shirt and I saw all these scars, like thick 20-year-old scars. I don't know why he showed me that." He then had this idea that the town was being taken over by black men who were enslaving the white women and making them prostitutes. He then started to walk home and started thinking that all the stores were fronts for brothels, and "if you went in there you would be turned into a slave and taken to Africa."

Currently he thinks, "Something in my mind was off, but I do think there's some significance to what I thought. I think that this is what every person fears the most subconsciously…there'll be nights that…I think that this really is true." The part that he fears the most is the slavery part, because he read *The Tommyknockers* by Stephen King, and it somehow (and I could not even get this part at all) supports this theory that Johnny was walking home and "kept hearing people out in the distance shouting out. 'Watch out, they'll rape you out here.'" He thought that all these homes were being taken over by the rappers, who were climbing into people's windows, raping women, and had control over the richest part of town. "I drew Barack Obama into it somehow." He then saw a truck on the side of a house and saw two white guys working in construction. He was about 50 feet away when he saw one man make a gesture, which he thought, meant, "go ahead, get out of here." He thought it meant that the guy was giving him his truck to escape. He got into the truck and could not start the truck. He asked the guy how to start the truck. The guy told him, "What are you doing?" and pulled him out of the truck. The guy told him to empty out his pockets but Johnny convinced him not to call the police.

He got home and under the girl's window he saw a blue Crips sign "with the arrow pointing up." He thought that somehow this gang symbol meant that this girl was under the protection of the Crips gang. He left and kept walking; he asked the neighbor if he could stay there, and the neighbor said no, so he continued walking and kept finding different signs in different places. He approached all sorts of people asking for rides but they all said no. He passed another pizza shop and the back door was open about six inches: "This woman

had her foot sticking out… And I saw a chain around her foot, and I thought that she was being slaved. It just confirmed my paranoia, I guess." He then passed a bar and a quick glance revealed a man chained to the bar. At this point, about 10 pm, he believed that he was the last free man in the state and had to get away. He started to sprint; "the only way off the island is like five miles down this one road; then you have to cross over a bridge." A police car passed him, so he followed it. He reached an accident scene, and there was a police car with its door unlocked, the window rolled down, and nobody in it. He thought that the car had been left for him in order to make his escape, because the previous police car had flashed its lights at him, which was some sort of code or signal. He ran up to the empty police car and got in. He believed that the police were being controlled by the slave masters: "I thought they were slaves too, and they were trying to help me get away, but they had to make it look like an accident, because if they were caught trying to help me, they would be killed." He thinks the car was already running when he got in. He "took off." He noticed there was a gun in the car and he thought that "they were giving me this gun, too." He drove around the block. He says he was not sure what direction he was headed, and he thought that the police were chasing him because he thought that they had to make it look like they were chasing him because of the slave masters: "I thought that was why they were so far behind me because they were trying to let me get away." He drove around and was in such a panic that he got lost and was eventually cornered in Another Town, about 10 miles off the island. The first thing he did was he put his hands out the window. He says they started yelling at him to do certain things and he initially cooperated. Then he started to back up, and they told him to slow down.

"They tried to put the one handcuff on me…" He says that he thought he was going to be handed over to the slavemasters and killed on the spot. They released the police dog on him; he started screaming (he does not remember being told that if he did not cooperate they would release the police dog on him). He says the dog started whimpering: "I guess it sensed my fear," and then the police officer told him to "stop acting." He was put in an ambulance and taken to the hospital. He thought he was going to be raped and sent over to the slavemaster. He says that he knows that he said he was on Adderall and meth ("and a bunch of other drugs too") but he says that he knew he was going to jail and he wanted to make himself sound tougher than he really was.

He says he was not seen by psychiatry in the hospital, although he thought that the police were still trying to help him escape by making subtle gesture with their faces (he shows me). He tried to escape a few times; one time he did run down the hall, then stopped, and the police officer punched him in the face. "Oh yeah…They took me to the Another Town Jail, and in the jail I was thinking that they had stitched me up in the hospital, and in the jail, one of the stitches popped…" He was bleeding, and he started smearing the blood around, and in the smears, he saw the Virgin Mary. He says that when they tried to take his blood in the hospital, "I thought they were vampires…And I came to the conclusion that I was Jesus Christ, and they were trying to prepare me for a crucifixion." He says that he now does not believe that part is true, which also suggests to him that the rest might be "not right."

Johnny admitted to a past psychiatric history—he says he saw a psychologist for therapy about five years ago after he was robbed at gunpoint. He does not feel that the therapy helped. He denies any history of psychiatric hospitalization, suicide attempt, treatment with any medications besides Adderall, or self-mutilation.

Johnny's mother provides a different history. She reports that Johnny suffered a childhood trauma, which he does not even remember, but began psychological treatment when he was very young. He saw a counselor of some sort until he was about five years old. He then began experiencing some fatigue and anxiety around the age of 12 or 13, and the family sought various medical opinions until one doctor identified a condition called POTS (postural tachycardia syndrome) and started Johnny on Adderall, a stimulant, for these symptoms. Johnny was able to finish school, although he did spend part of his last two years of high school on home instruction, and was accepted to State University, where he again began experiencing various emotional problems. Two years ago, in May, Johnny told his mother he was under a lot of pressure from school, and "started talking about things that didn't make sense. How he could control people with his eyes. How people were watching him and he had to be careful about what he says…" His mother took him to the crisis center at a local hospital. The clinicians there thought that these symptoms might be due to the Adderall, and Johnny agreed that he would cut back on the dose. However, he continued to use the Adderall, which he obtained from a doctor by prescription. Johnny was then identified as eligible for involuntary admission to a psychiatric hospital, but as the night wore on, Johnny was deemed to be ineligible for admission and was referred to an intensive outpatient program (IOP) instead. He went to the IOP but apparently did not see a psychiatrist there, and the various "therapists" identified a variety of problems, none of which had anything to do with psychosis. Only toward the end of his treatment did Johnny start to feel comfortable enough to share his delusions. However, he was discharged and wanted to go back on Adderall to help with his studies, although all the doctors he saw by that point did not think a stimulant was a good treatment plan, that his psychotic episodes would only get worse if he took a stimulant. However, Johnny eventually found a psychiatrist in New York City who agreed to prescribe Adderall, "no questions asked." He became psychotic, and the events described above and in the official records ensued.

Johnny says he stopped taking the psychotropic medications about two months prior to our interview. He says that the psychiatrist here in jail does not know that he is not taking the medications. Dr. Jones, the jail psychiatrist agreed that she was unaware that Johnny was not taking his medications. She and I were both horrified to see that while Dr. Jones was out on medical leave, the covering psychiatrist started Johnny on Wellbutrin, an antidepressant that can also increase psychotic symptoms. Fortunately, Johnny has not been taking that medication either.

I do want to tell you all what I found at the end of the report, but the point of sharing this story was really to show the questions that were asked and how I approached the case. I don't want to give it all away. The really important part is the part where Johnny tells me his version of events. Does anyone have any doubt that he is psychotic? Is there any way to

spin his interpretation of what happened that day that he stole the police car? Can anyone really believe that he just made up the story? Apparently the judge did not believe Johnny made up the story either, because after a conviction, Johnny's sentence was changed to time served, and he was transferred to a psychiatric hospital. Everyone understood that he was psychotic. The idea is that there is no other possible motive. Could someone fabricate a story like the one that Johnny shared? Absolutely. Hollywood does it all the time. Would there be any motive to such a fabrication? Let's think about that. I can't see one. The details, the fear, the irrational behavior, the pointlessness of the actions, everything in this story screams crazy. I don't understand why some people insist that there has to always be some secret, rational, evil motive for crazy behavior. We know there is such a thing as psychosis. The motive, therefore, makes sense only within the psychotic person's delusional world. It does not have to make sense to us. The perpetrator does not have to *be* a storm or a Monarch butterfly. The idea of having no more reason than a wild beast means that the wild beast does not understand that the zebra has a wife and kids—the wild beast lives on the savannah where it gets hungry for zebra. It does not have to live by society's rules, because it has its own rules.

Hopefully now we understand psychosis a little better. But that's only part of it. The bigger question is what does it mean if you have a psychotic client?

The legal definition of insanity is different than the colloquial definition. It is different than what I told you it is:

Psychosis is the presence of a thought disorder resulting in an alternate reality in a clear sensorium

The federal insanity statute is an affirmative defense (i.e., the defendant is sane until he or she proves otherwise), and he or she has to show that:

> *…at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.*
>
> *(18 U.S. Code § 17)*

Most US jurisdictions use some version of this statute. But what does it really mean? Let's break this paragraph down, starting with the last part, which is the easiest:

Mental disease or defect does not otherwise constitute a defense.

That's fairly simple. Just because a person is mentally ill does not mean he or she is automatically not guilty. However, because it is so easy to understand, many people seem to think that "mental disease or defect does not constitute a defense," leaving out the "otherwise."

Many otherwise (sorry) very intelligent people cannot understand the first part of this statute, because they do not understand what it really means. Lawyers, in particular, do not seem to understand, which is terribly sad because they are the ones trying these cases.

The first part also seems simple, at least in words:

…at the time of the commission of the acts constituting the offense…

Unfortunately, this part is often the hardest part to prove, especially when people try to prove temporary insanity. However, someone with a chronic mental illness who suffers from systematized delusions, paranoia, and who lives in an alternate reality, is likely to have been in that state when he committed the crime if he or she still is shortly thereafter and can be proven to have been shortly before. The time thing is critical. A good forensic evaluation can often determine whether or not this part of the statue was met. Often, the timing part also depends on the criminal act itself. Many times criminals who plead insanity are either untreated or noncompliant. Some of the famous insanity cases of the past 50 or so years involve individuals who were never recognized as mentally ill prior to their crimes, but who presented as severely mentally ill when apprehended and who were determined to be paranoid schizophrenics later, even after not being adjudicated legally insane. I would argue that one of the reasons that obviously insane and irrational criminals are convicted and sentenced to prison is not because they do not meet the criteria for an insanity defense, but because the experts rely on reputation and the distance between their pinstripes instead of on their knowledge of psychiatry to testify in these cases.

Chronicity and Cyclicity: Movies, Snapshots, and Why Full Disclosure Matters

The concept of time is critical in psychiatry. Mental illnesses can be time-limited, chronic, or remitting and relapsing, or some combination of all of those. Individuals can suffer from more than one psychiatric disorder. Comorbidity, or the simultaneous occurrence of more than one psychiatric disorder, is always considered in the evaluation of psychiatric disorders. So clinical presentation can be extremely complex, inconsistent, and sometimes baffling.

The best way to determine a real psychiatric diagnosis is to observe someone every single day of his or her life, 24-7, and interview him or her constantly. In real life, of course, we cannot even monitor people weekly. Even reality shows give people some privacy, and so do psychiatric hospitals. However, most psychiatric patients never see the inside of a psychiatric hospital, and they seek treatment only if they feel bad or if they get in some sort of legal trouble.

Only one of the lawyers I interviewed, Amy Cohen, made a point of stressing the importance of the impartial expert. Amy has been practicing civil litigation for over 25 years. She practices mainly medical malpractice defense and premise liability defense, which she jokingly explained to me is also called “slip and fall” defense. Her medical malpractice keeps

her very busy, and she says she usually is able to obtain a favorable outcome for her clients. She has never defended a psychiatrist in a malpractice case, although she has represented some in complaints at the state board level. Amy says that it is always important to retain an expert who reviews all of the information in every case. It is always crucial to her to have the perspective of "years and years" of records. She finds that treating psychiatrists or psychologists—or even other treating physicians in other types of cases—are very loyal to their patients and are advocates for their patients in ways that "sometimes go too far."

Distinguishing between the types of patients who seek help because they feel bad and those who are sent to treatment by a third party is crucial. The doctor–patient relationship is crucial. Some people think that your expert will have more authority if he is actually the treating psychiatrist. The American Academy of Psychiatry and the Law holds the position that an expert should be impartial. I personally agree with that opinion. When we treat patients, our allegiance is to our patient, and anything we say is subject to that allegiance. If our patient commits a crime, we will look for something to explain away his criminal behavior.

As Amy Cohen points out, we forensic psychiatrists have no such allegiance to a stranger. When we are brought in to evaluate an unknown individual for a legal matter, we are supposed to evaluate with fresh eyes. We use our psychiatric expertise to examine the individual and the situation from an impartial perspective. If we find that mental illness contributed in some way to his actions, our opinion means much more than if we argue for leniency toward someone we have known and cared for and about for many years. Any attorney who utilizes psychiatric experts should understand this concept and apply it rigorously in his work. And if you hire an impartial expert, and the other guy brings in the treating psychiatrist only, or a defense expert only, you need to speak up and say that THIS EXPERT IS NOT IMPARTIAL AND HIS OR HER OPINION CANNOT BE IMPARTIAL OR TRUSTWORTHY. Because that is how the system works. When we treat patients, we have a sort of parental role toward them. No parent is going to go to court and essentially tell the judge that her child misbehaved and needs severe punishment.

So back to the concept of time. The one advantage that a treating psychiatrist has over an expert hired for a specific case is that a long-term relationship with a patient should give that doctor a good sense of how that person's mental illness presents over time. At least a decent psychiatrist with a patient who is more or less compliant will have an idea of that person's longitudinal clinical presentation, which is very important, because time is a factor in every single DSM diagnosis. Unfortunately, given the constraints of modern psychiatric practice, some doctors do not seem to have that type of relationship, or, if they do, do not have the documentation skills required for any potential legal matters. Here is an example of something that happened just a few days ago.

I had recently begun treating a very nice woman when I received a phone call from a doctor representing her disability insurance company. She had been on disability for two years for her psychiatric issues. She had told me she did not like her previous psychiatrist and felt he had been overmedicating her. When she told me the story of what had led to her psychiatric decompensation, treatment, and leaving work on disability, I really did not

know what was going on with her. I actually feared there was an undiagnosed neurological issue, but she insisted she had undergone a neurological workup. I documented her mental status, including her disorganized thinking and speech, my difficulty in following her story, and her clear inability to return to her job where she worked with the public and large amounts of money.

I actually left the disability forms for my assistant to fill out—she has plenty of experience and knows how to do this work. When I received the phone call from the disability insurance company, I thought perhaps the fax had gone astray or there had been some clerical error. No. This man was calling to ask me why I had documented that this woman was psychotic when the previous psychiatrist, let's call him Dr. Normal, had been writing—for the past TWO YEARS—that this woman's mental status examination was WITHIN NORMAL LIMITS.

I must say I was speechless (and for anyone who knows me, speechless is not a word usually used to describe me. One friend recently asked if I had an off button.). I thought I had misunderstood. I asked Dr. Disability Insurance, "You want me to tell you what Dr. Normal was thinking?" But no, he said, "Why would he write 'Within Normal Limits?'" I replied that I had no idea why Dr. Normal would have written that. I could tell him what I thought of Dr. Normal. No thanks. Well, would Dr. Disability Insurance like to read my chart notes on this patient? Certainly, that would be useful.

The thing I really did not understand is why a disability insurance company would pay psychiatric disability for TWO YEARS for a subscriber whose psychiatrist wrote every month that her mental status examination was Within Normal Limits. How is that even possible? I would not be able to sleep at night without writing specific comments about mood, sleep, appetite, concentration, suicide, homicide…and I would not be able to write those comments without asking. I was taught to do my job a certain way, and I am constantly astounded by people who take shortcuts with other people's lives.

This particular patient is quite psychiatrically compromised. Dr. Disability Insurance asked me what her prognosis is. I told him, truthfully: "If she has something growing in her brain (for you lawyers reading these words—if this patient has a brain tumor, or some sort of degenerative brain disorder), then her prognosis is going to be up to her neurosurgeon. If this is simply psychiatric—I will get her better." Perhaps that sounds arrogant, but I believe in my patient and in my ability to get her better. I am also fairly confident that the disability insurance company will not suddenly cut her off for actually being disabled, when they permitted her mental status to be normal while she remained on disability for two years and never once questioned the treatment she was getting. Fortunately, this patient retained sufficient insight to understand that she should have been improving after all this time, and left treatment with Dr. Normal, who should be ashamed of himself.

Now imagine that this patient ends up actually having a brain tumor. I hope she does not—she is a real patient, after all, and I like her, and she has youngish children. Let's say that the neurologist I just sent her to discovers it. She decides to sue Dr. Normal for not identifying that something could be wrong. Dr. Normal has repeatedly documented that her mental status was "within normal limits," so in his mind there was no need to refer

her for neuroimaging studies. But then, why did he dose her with industrial quantities of medications? Why would he fill out disability forms for her? And finally, did he not care about her at all? And did he ever actually speak to her when she had her appointments with him?

The evaluation of people over time only works when we actually evaluate them over time. I hear so many patients and people who I evaluate forensically tell me, "Oh, my other psychiatrist just asks me, 'How's the medication?'" Another popular one is, "Do you think you need medication?" Gee, I don't know. Let me check with my blood sugar on that, or my heart or my thyroid. Need any medication today, buddies? Psychiatrists who practice this way may as well stop practicing today, and you do not want them as your experts because while the actual level of delivery of psychiatric care might have sunk very low in recent years, the standard of care has not quite fallen that low—yet. I read an article just yesterday on the tragic dearth of psychiatrists in this country. What a surprise. Psychiatry is considered the armpit of medicine. People do not believe we are a specialty; everyone thinks they can do what we do, and as of this writing, the number one selling medication in the United States is a prescription antipsychotic, inappropriately prescribed as an antidepressant by thousands of family doctors and nurse practitioners, who learn their psychiatry from television commercials. And prescribed too by thousands of psychiatrists who trained before psychopharmacology was actually a thing—who learned how to do psychoanalysis really well, and who are now practicing a specialty for which they have no training, no experience, no knowledge, no affinity, and no hope.

The metaphor that psychiatrists have always used for the description of psychiatric illness is the snapshot versus the movie. Today we have camera phones and maybe not everyone even knows what a snapshot is, so maybe we need to use Snapchat versus a YouTube video, but the concept is the same. A quick evaluation in an office or clinic or even in an emergency room gives you a photograph, a limited amount of information about a person's clinical presentation. If you could observe that person over his lifetime, you would have a movie—the reality show of his life. You could see the cyclical nature of his illness; you could identify the triggers, the things that make the signs and symptoms better or worse; you could see what treatments work or don't work. But we don't have that magic 24-hour surveillance camera, so whether we are doing a forensic evaluation or an interview in the emergency room, collateral information is key. The more information we can amass, the more accurate our clinical impressions can be.

We cannot infer past or future behavior or mental illness from the current snapshot; we can only learn it from actual information. Making inferences like that can be very, very wrong. I learned this lesson myself very early in my career. A young woman presented to the psychiatric emergency room with all the signs and symptoms of major depressive disorder. She was tearful, suicidal; she had lost weight; she was apathetic and anhedonic. She was a walking snapshot of the description of major depression. But she also most likely had a severe crack cocaine habit—and in those days, we could not simply get a urine toxicology in five minutes—we had to wait for blood to come back from an outside lab, which could take days or weeks. My supervisor told me not to bother to admit her, that she most likely was a crack addict who was lying to me about her drug use, and

that she would feel better in a day or two and want to leave and score her next hit. But I felt so sorry for this young woman, and so convinced by the clinical picture, which was so textbook. In those ancient days before cell phones, we could not reach any family members (usually we could reach someone, who would tell us how their family member had stolen from them—money, jewelry, anything. We had some observation beds, so we compromised and kept her there overnight. Of course, the next day, the acute withdrawal phase was over, and my depressed patient just wanted to get out of the hospital, steal something else of her parents' to pawn, and get another hit of crack. Live and learn. I learned fast.

Meanwhile, what were the police learning from our friend Mo back in the sheriff's department holding cell? Presumably, nothing. He was ranting and raving about Allah and bacon-contaminated waffles and his rights, but in between all the verbiage, he shouted the magic word: "Lawyer!"

And that's when his fun really began.

5

Bad v. Mad: Doing It on Purpose versus Doing It Because You're Crazy

In Chapter 2, we discussed the concept of all men being created equal under the law and in the US Constitution. In general, any legal matter assumes that all parties do what they do deliberately and with a certain motive or for a specific reason. Attorneys create a "Theory of the Case." For example, last night, as I was drifting off to sleep, I heard a newscaster say something like, "Prosecutors state that he killed his mother-in-law because he resented her interference with the way he was raising his daughter and his jealousy of his ex-girlfriend's new boyfriend." Think about that. The theory of the case was that a man *killed* the grandmother of his child because she did not like the way he was parenting his daughter on his custody weekends, and he did not like the daughter's mother's new boyfriend. One word, readers, don't be shy, call it out…CRAZY!!!

These ideas might actually be the so-called motive, but these are the motives of a delusional individual. Normal people do not murder other people because the other people don't like them. Think about this statement that I just made. We are a society of laws, based upon a whole bunch of preconceptions—the rule of law, morality, common sense, the ten commandments—a lot of things that people take for granted. Most people stop for red lights in the middle of the night when nobody is there (I'm not going to waste time looking up the reference, but I know I read it somewhere). Most people (ibid.) use the correct gender restroom even in an otherwise unoccupied service area in a deserted service station. People obey rules and the rule of law because they are used to it. It is not hard to obey the rule of law. Most rules make some sort of sense and maintain some inner and outer logic. I take off my shoes and wash my hands when I get home even though I have not lived with my mother for 35 years. So when someone has a "motive" to kill another person, and that motive is that the other person criticized them, someone in this mixture is not just a bit strange but exhibiting a new diagnosis I just learned about recently, from a psychologist friend: "plain ol' batshittery."

Does that make it perfectly okay for this man to murder his mother-in-law? Of course not! (Based on the story, she probably was not even technically his mother-in-law, since we are claiming to be writing a book about the interface between law and psychiatry, but that is just semantics and not that important right now). Should he have known better? He probably did know better. Should he go to jail, or to a psychiatric hospital, or to a psychiatric unit inside a jail? I don't know, since I don't know the facts of the case, and I did not examine the individual. But the point I would like to make is that reporting on cases

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like this one and saying that the theory of the case is that the man murdered someone because she annoyed him is inaccurate, trivializing of his mental illness (if he has one), and also trivializing of psychiatrists and our input. Perhaps the man murdered this woman because she left him a million dollars in her will (greed). Perhaps he did not murder her—perhaps it was an accident. Or suicide. Or a dozen other things. But when newscasters make these types of comments, the general public starts to think that normal people might do abnormal things in the course of a normal day. And that is just not normal. So when a psychiatrist comes along and says (as an example—remember—I don't even know what case this was; I just heard it as I was falling asleep): "Mr. So-and-So is schizophrenic and had a delusion that his mother-in-law was going to kill his daughter and fry her up for dinner, so he killed Mrs. Mother-in-Law to prevent this tragedy," the jury of the general public and the press says, "Oh, that's ridiculous, there is no such thing as schizophrenia, he just did not like Mrs. Mother-in-Law because she said he was a bad father."

How do we know if someone is Mad or if someone is Bad? We often do not, but we do know that there is a lot of overlap. I personally have a theory that the truly Bad often go unrecognized. I have no way of proving my theory, and we will talk about psychopathy later, but, serial killers notwithstanding, people who simply like to take advantage of others for their own personal gain are often very intelligent and are able to do what they need to do without getting caught. I'm sure nobody wants to hear this theory, but I think that there are many undiscovered murders every year, in the United States and all over the world—murders motivated by greed or by well-controlled passion or anger. We will never know, but in my other career as a fiction writer, I know that the murders of mystery novels rarely occur in real life. Real-life murders are clumsy, messy events, premeditated in the way we premeditate slapping a mosquito to death when it lands on our thigh. Only fictional murders involve detailed planning, accessories, subterfuge, and elaborate alibis.

So in the world of Mad versus Bad, there is a lot of Mad in the Bad. As we mentioned earlier, the prisons are the largest repositories of the mentally ill in the United States. Although I could not find a specific number, I would venture to guess that they are probably the largest holding cells of the mentally ill in the entire world. People generally obey the rule of law, and it is something in the psychological makeup of potential or actual lawbreakers that interferes with that ability. In general, people who are unable to conform their behavior to somewhere within the rules have some reason that they cannot do so. Usually there is some Mad in there. The Mad might be the result of a substance—alcohol, illicit drugs, prescription drugs, over-the-counter medications, or something else. It might be part of a mental illness. It might be the result of temporary stress—bad news, a bad day, even a rude comment, a bad test grade, a death in the family, a rejection by a potential romantic partner, an unwanted sexual advance, or anything else you can dream up. Potential stressors are basically limitless. The point is not that anyone who behaves in a lawless way is crazy and should not go to jail—please do not confuse this message with that message. The point is that most bad behavior is influenced by something other than a *rational* decision to behave badly. In other words, rational behavior is generally normal. Irrational behavior, by definition, is influenced by irrational stimuli. An irrational stimulus

does not mean that the resulting behavior is not within our control. The resulting behavior is somewhere on a continuum. All behavior is somewhere on a continuum, influenced by our own personal biology, which in turn is influenced by our own personal internal and external environment. When a legal matter includes some crazy behavior, be it criminal, civil, or other, all of those factors should be taken into account, and then the matter needs to be processed accordingly.

Earlier I mentioned my one-day seminar on Psychiatry for Lawyers. I would like to present that case here, as an example of Mad versus Bad. I know we can't actually discuss the case, but it illustrates some of my points.

I'm changing the name of my guy to Menace Polansky, just for fun. It's not his real name, but it will do. The facts of the case are disguised but unchanged. I'm not worried that he will ever read his words here, and his lawyers won't mind. I find this case fascinating because it includes one person who managed to put a foot in every place a mentally ill person can possibly kick a lawyer or a judge. This case will be the longest one you will read in this book. Don't worry. It's not boring. It just juxtaposes the issues of mad and bad so intricately and brings up so many problems that you will stew about them for the rest of the chapters, and I can keep coming back to it, over and over.

I first came across the plight of Menace Polansky when he was a 36-year-old defendant facing removal from the United States in proceedings that threatened to send him packing off to Poland. He had been ordered removed from the United States by an immigration judge after having been found to be an aggravated felon pursuant to the Immigration and Naturalization Act, and therefore ineligible for any of the available forms of relief from removal from this country. I was asked to evaluate Menace Polansky by his immigration attorneys in a last-ditch effort to determine if he:

> *pled guilty to various criminal charges without the knowledge that to do so would result in classification as an aggravated felon under the Immigration and Naturalization Act, rendering him ineligible for all forms of relief from removal from the United States.*

Menace had been brought to the United States at the age of three, was officially adopted by the age of four, and since then, had never, ever set foot outside the United States. His American family did not maintain any connection with his ethnic Polish roots or his native language. Ironically, or perhaps not, his adoptive family's ethnicity was of another Slavic country, but they all spoke English at home.

When Menace was about 17 years old, his parents petitioned the then-Immigration and Naturalization Service for citizenship. Menace himself reapplied several years later when he was 21. Both petitions were denied, but no specific reasons were provided for either denial.

How did Menace find himself facing removal proceedings as an aggravated felon pursuant to the Immigration and Naturalization Act? Apparently, he had quite a history of mad/bad behavior for many years. His parents allowed him to hit the proverbial rock bottom, but when his father learned he might actually be removed from this country

forever and sent to the country that had essentially rejected him in the first place, Daddy stepped up and found some money to pay the lawyers and me. I included an extensive list of sources of information in my report, including things like medical and criminal records, the proceedings of his immigration hearings, psychiatric records, and of course, the documentation of our interview. Here is what I learned:

According to the records, Menace Polansky was removed from his biological parents in infancy and placed in an orphanage. His birth parents were documented to be alcoholics and unfit to care for their child. Just prior to his third birthday, the Juvenile Division of the Regional Court of Lembork, Poland, awarded full parental and custodial rights to Menace Senior and Mary Polansky, both United States citizens.

Menace was admitted to the United States as a legal resident, where his adoption was finalized. He lived in the United States for essentially his entire life and identified himself as American. His two daughters were born in the United States and were natural-born American citizens who reportedly were unaware that their father had even been born in Poland. Menace never married the mother of his daughters, but had voluntarily provided his children financial support throughout their lives.

His American mother reported, and Menace's affidavit reiterated, that Menace had been treated by several psychiatrists and psychologists throughout his life, and eventually was prescribed the medication Ritalin, a stimulant used for Attention Deficit Hyperactivity Disorder (ADHD). However, he recalled the same doctors informing his parents that his ADHD treatment might not be successful, as the disorder was not diagnosed until he was approximately 11 years old. I personally do not understand why the treatment would not be successful, but that is one thing that Menace himself remembered and used as a sort of excuse for his subsequent bad behavior. One psychiatrist wrote a letter describing "long-standing behavioral problems at school and home." These issues included "difficulties with inattention, impulsivity, and hyperactivity…impairments in judgment and decision making." The doctor also stated that "progress was minimal, as the child would improve his behaviors, and then backslide." This doctor further wrote, "His impulsivity, lack of insight and poor judgment often resulted in poor decisions, which exacerbated his problems at school and home." That doctor noted that his patient was never "tested" (his word) for Fetal Alcohol Syndrome (FAS); but then remarked that there is no such definitive test available. And that doctor was right—there is no test for FAS, but we knew from the beginning that Menace's parents were both alcoholics. Let the buyer beware.

Through our interview, and also reported in various documents, I learned that Menace's behavioral problems went back to early childhood. He had been hospitalized in a variety of psychiatric hospitals for poorly defined and poorly described psychiatric problems, primarily wild behavior and impulsivity. He had been expelled from a number of schools, including a private boarding school. Menace had never been the child his parents had dreamed of when they adopted a cute little towheaded toddler from the Polish orphanage.

Menace's adoptive parents split up when he was 18 years old. Around that time, he went to jail after pleading guilty for Grand Larceny Auto, and he said he was in state prison for three months.

"My father refused to pay for an attorney—he wanted me to learn a lesson." At approximately 20 years old, Menace was convicted of robbery in the second degree. Several years later, Menace pled guilty to one count of Theft by Deception ("public defender again"). He says that the actual crime was cashing Citibank checks against a bank account that belonged to his father: "I used his name. I asked him for help—he was going to help me halfway as long as my kids' mother helped me the other half."

Menace told me a convoluted story about how the kids' mother did not hold up her end of the deal, so his father decided also not to put up any money, and so Menace went and stole money from his father's bank account. "Poor decision." He then told me he was "mentally abused" by his parents. He said he was a "joke" to his father: "I was his plaything, his little Pollock… His way of dealing with raising me and me costing him money all the time. I cost him a fortune. But he gets off on downgrading and—mental degrad—downgrading—he gets off on that, that's how he gets by." This horrible father was the person paying Menace's attorneys and me, trying to keep Menace from being deported. Later, we will talk about insight, but these statements can serve to foreshadow that topic and illustrate the fact that this particular man had little insight into his behavior or his relationships, or the destruction his behavior caused to his family and the people who loved him.

Menace explained (using many incorrect words) that his father feels better about himself when he puts down all the people around him. "The safest thing for me to do is avoid him at all costs. I'm still trying to figure out why he's paying for this (Cancellation of Removal defense)."

During his incarcerations, the Menace obtained a GED (General Education Diploma) and then attended Community College, but did not obtain a degree. He was in regular school growing up. He says he was smart, but disruptive, "didn't care," and "I got thrown out of every school I went to." He was suspended "countless times" for fighting, problems with the teachers, and other issues.

"I fought everybody in my life every step of the way." He said he went to the BOCES (Boards of Cooperative Educational Services, a vocational program in New York State) for auto mechanics and welding, and that he loved working on cars and doing home projects and landscaping. It was this last part that led to his current plight. The instant offense that demonstrated moral turpitude to the immigration court, and that also led to his most recent felony conviction, occurred when he went to a big home improvement store, loaded up his cart with a variety of tools and plants, and headed for the exit without paying. This event occurred in the days before self-checkout, or he might have gotten away with it. When he saw the security guard running after him, he abandoned the cart and ran away. But here is the kicker—the incredibly stupid thing that he did that resulted in his getting caught, arrested, charged, and convicted: he drove a few miles down the road to the next big orange sign, entered the next big home improvement store, and did the exact same thing again. Only this time he got caught, arrested, charged, pled guilty, and incarcerated.

When I met Menace, he had two jobs, working at a seafood store and a fast-food restaurant. He had never married: "I didn't want to marry her even though it would have

helped (with the immigration case, which actually it wouldn't have)—I don't believe in that—marrying somebody so I can win my case." However, he has two children with the same woman, with whom he broke up at the birth of his second daughter. "I didn't want to be with her, I just wanted to have sex with her. If there were feelings, they were just very mild slight feelings. I was selfish—I was wrapped up in myself and my own priorities." He told me he tried to support his children, and there was no court order for child support. He even told me he tried to file child support against himself while incarcerated so that his former paramour could get payments from the state while he was incarcerated, "but they refused it." He claimed he gave his ex-girlfriend the rest of his accounts and his "brokerage services accounts" while he was incarcerated.

Menace was unsure when he was supposed to be deported. He then told me he could not be deported: "It's illegal…I don't have travel documents—the consulate will tell you that." He was not particularly worried that he would be returned to Poland, although he reported that he had lost his appeal in the Third Circuit just prior to meeting with me.

He told me that if he were returned to Poland, he would "start a new life." He would learn Polish: "My mother is more than happy to send me a translation book." He did not really expect to be returned to Poland and did not really know how he would survive there, but joked, "At least I'd have good credit. Wouldn't have to pay off my credit cards." He did not know any of his biological family in Poland and did not even know how to begin to find them.

When I met with Menace, he was no longer on probation or parole; he finished his parole while in the custody of immigration. When he was released from his shoplifting sentence, he was taken directly to County Jail for his immigration proceedings, where he spent two-and-a-half years waiting for "something to happen." He believed his father did not want him to be released: "He didn't want me getting out and getting into more trouble…when I caught wind of that, I did some legal research in jail and found out that there are laws about how long they can hold me…" So he asked to be released and was. At the time of our interview, he was living in his own apartment, as mentioned above, and working two jobs.

So what did I write for his immigration lawyers? Here is part of my formulation, edited for anonymity. I took out the references since I haven't used references elsewhere in this book, but they are in the references at the end.

The psychiatric-legal question I was considering was the one I showed you, above:

> *To determine if Mr. Menace Polansky pled guilty to various criminal charges without the knowledge that to do so would result in classification as an aggravated felon under the Immigration and Naturalization Act, rendering him ineligible for all forms of relief from removal from the United States.*

Here is what I found:

On both plea agreements, Menace checked off "Not applicable" on question 17: "Do you understand that if you are not a United States citizen or national, you may be deported by virtue of your plea of guilty?" At the time, the defendant believed he was a citizen of the

United States. It would have been up to his attorney to point out the possible consequences of this guilty plea. In fact, Menace was a permanent resident of the United States and did not have the opportunity to consult an immigration attorney, nor did he have the knowledge to do so and was not advised so by his criminal public defender. Therefore, he was not made aware of the fact that by pleading guilty to the criminal charges, he would be considered an aggravated felon subject to deportation under the immigration laws.

Unfortunately, Menace's clinical presentation, including his personal and psychiatric history, strongly suggest that he was exposed to alcohol as a fetus and subsequently developed what is known as Fetal Alcohol Effect (FAE). The more well-known Fetal Alcohol Syndrome (FAS) includes a specific facies (facial abnormalities) but is otherwise virtually the identical disorder. Prenatal exposure to alcohol can produce all of the behavioral and cognitive problems that the defendant has exhibited throughout his lifetime. His criminal behavior, in particular, was so peculiar and poorly thought out that it easily falls into the category of "Pseudopsychopathy," a term coined to describe the apparent psychopathy of people with right frontal lobe damage.

Pseudopsychopathy is described as "a condition of personality following frontal lobe lesion in which immature behavior, lack of tact and restraint, and other behaviors symptomatic of psychopathology are apparent but are not accompanied by the equivalent mental or emotional components of psychopathology." Researchers investigating neuropsychological functioning have identified deficits in learning, memory, executive functioning, hyperactivity, impulsivity, and poor communication and social skills in individuals with FAS and FAE. Investigators using autopsy and brain imaging methods have identified microcephaly and structural abnormalities in various regions of the brain (including the basal ganglia, corpus callosum, cerebellum, and hippocampus) that may account for the neuropsychological deficits. Results of studies using newer brain imaging and analytic techniques have indicated specific alterations (i.e., displacements in the corpus callosum, increased gray matter density in the perisylvian regions, altered gray matter asymmetry, and disproportionate reductions in the frontal lobes) in the brains of individuals prenatally exposed to alcohol, and their relations with brain function. Clearly, the effects of alcohol on the developing brain are extensive and can demonstrate themselves in a wide variety of clinical symptoms.

It is my opinion that because of his cognitive impairment, that he was unaware of the inappropriateness of his actions, or if he was aware of behaving inappropriately, that he did not possess the cognitive ability to meaningfully distinguish right from wrong. When the defendant says he "didn't care," he is being completely truthful. He did not care, because he has a brain abnormality that affects his ability to care about the consequences of his actions.

The situation with his plea-bargain agreements is slightly different. When the defendant says he "didn't care" about the consequences of his actions in the past, he literally did not care. Had he understood factually that he would be subject to removal from this country—had his then-attorney advised him of this fact—then undoubtedly this same attorney would have also advised him differently in terms of the plea-bargain. The defendant himself

lacks the cognitive capacity to think that far into the future. To clarify, he is not mentally retarded, but his brain lacks the ability for some of the cognitive functions that we take for granted—to moderate and inhibit impulses and to think abstractly in terms of time and space, for example. This concept is a bit difficult to understand, but it is not by any means controversial. Psychiatrists and psychologists have known about frontal lobe syndromes, even in monkeys and primates other than humans, for at least a century in documented reports and probably for far longer in anecdotal form.

Therefore, Menace Polansky did not understand that by pleading guilty to felony charges, he would later be found to be an aggravated felon by the immigration court, denied all forms of relief from removal from the United States, which would otherwise have been available to him, and he would therefore become subject to deportation. In addition, he lacked the normal reasoning capacity of someone without his type of brain injury to inhibit his impulses to engage in the illegal behaviors to which he pled guilty, and he also was misinformed about the possibility of removal. Overall, the defendant was being subjected to an outcome that he could not have anticipated, and despite the possible imminence of removal, he still did not have the cognitive ability to understand the permanence of such a removal or to anticipate the associated consequences.

I know that I have hit you, my dear reader, with a bunch of gigantic words that seem to have come out of nowhere. These words have meaning, but their primary meaning in this chapter is to show that mad might look like bad. Here was a guy who was exposed to alcohol in utero, who then lived in an orphanage during his early life, most likely developed a form of reactive attachment disorder, then moved to a different country where he had learning and behavior issues, and lived in a family that clearly had its own issues because his parents split up when he was 18. This man was subjected to, most likely, genetic, environmental, and chemical stressors throughout his lifetime. He engaged in high-risk behaviors. He became involved with the criminal justice system. He continued to engage in illegal behaviors. He had minimal impulse control. He made irrational decisions. His brain was clearly involved. But what else was involved? His mother? His father? At what point could someone have intervened in a more appropriate way? We really do not know. All we know is that this man presented to me at the proverbial eleventh hour, about to be sent to a country about which he knew nothing, where the words are spelled with all consonants. I cannot imagine learning Polish as an adult, and I already speak a few other languages. For a man like Menace, the challenge is immense. I expect he would eventually find out how Polish prisons compare to American ones, and sooner rather than later.

The last I heard, his lawyers had managed to stay his execution, deportation, removal, or whatever it was called. I do not know if I had anything to do with it. I also do not wish to suggest that I take sides in these cases legally, but in this particular case, we see that this individual's brain was so messed up that his ability to make rational decisions was just not within his control. Everything in this case will come up again later in this book, and I will try to point out the connections. For now, just be impressed by my big words, and the possibility that some people's stupid criminal acts might be the result of something besides simple greed and stupidity. They might actually have totally messed up brains.

Many years ago, as a college freshman, when I first envisioned a career as a psychiatrist who "goes to court and tells everyone what is really going on with that crazy person," I was obligated to write what was fondly termed the "Six Weeks Paper." As of this writing, I believe it remains buried in a box somewhere in my parents' house, or else I would probably be quoting it here. I still remember the premise, because even as an impressionable 18-year-old, I realized that something was not right with the world of psychiatry and law. I took Abnormal Psychology on a whim, mainly so I could take a class at Swarthmore and meet some new people (which I didn't because I took it as a fifth class, and the bus schedule back and forth to Bryn Mawr was really tight). But it was a fantastic class, and to this day I have to thank my professor, Dr. Jeanne Maracek, and the influence she had then on the psychiatrist I have become today. One of the books we read was *Models of Madness, Models of Medicine*, by Miriam Siegler. Unfortunately out of print, this book was extremely influential in my development as a psychiatrist. In my Six Weeks Paper, I used Siegler's models of mental illness to interpret various portrayals of mentally ill fictional characters. The main premise of the book, and my paper, was that society sees mentally ill people either as sick or bad. The law tends to see everyone as bad. Today, the medical model sees psychiatric patients as sick and helpless. Other models of mental illness are presented in the book, quite interesting but perhaps more subtle, and not as useful as these two to our purpose. The legal system in the United States seems to have great difficulty reconciling the mad versus bad dichotomy, and as we shall see in a later chapter, this struggle is reflected not only in the structure of the law and punishment, but also in actual delivery of non-psychiatric medical services, the publication of medical information, and how students are taught medicine.

I believe it is very important to understand that like most things in life, and unlike most things in the law, mental illness and goodness and badness are on a continuum. Yes, people make bad choices and poor decisions, but as I keep saying, those bad choices and poor decisions are influenced by an infinite number of factors, including our personal biology, our environment, our upbringing, even what we ate for breakfast and how we feel at that moment. Who hasn't made an impulse purchase of junk food because he was super hungry? (I refrain from using the word starving because it is highly unlikely that anyone reading this book has ever actually experienced starvation). Who has not bought an article of clothing that was not quite right because the event was tonight, and she was running out of time? Those are poor choices governed by a variety of factors that have absolutely no legal consequences, but they illustrate my point—that choices are never pure. They do not occur in a vacuum. Just as our example, Mr. Menace Polansky, made terrible choice after terrible choice, we cannot say he was really bad. However, he was not really mad, either. He sort of knew he was doing wrong, but he also sort of did not. He sort of thought it would be nice to make a garden for the mother of his daughters (who herself had clearly made some questionable decisions by mothering two children with this loser). He sort of knew it would be bad to get arrested. But at the same time, his brain did not have the biological ability to control his impulses the way a normal person's would. That biological impulse control function is not something we can see or measure or photograph; we do not have

a blood test or scan or biopsy for it—yet. The lack of a definitive test makes its existence questionable to the general public, including courts of law. The concept of a part of your brain in charge of impulse control, while at the same time obvious, is simultaneously ridiculous to anyone who has ever seen "brain salad" on a menu (go to your local Romanian restaurant—it's there!)

Every psychology student (hopefully) learns the story of Phineas Gage. Gage was a worker on the American railroad when a freak accident drove a large iron spike through his left frontal lobe (and presumably through other parts of his skull and brain) and out of the back of his head. Despite the dangers of infection of the times—the mid-19th century—Gage survived this accident, but with a bizarre twist. The formerly pleasant, mild-mannered construction foreman, known for his shrewdness and business acumen, turned into a disinhibited, distempered individual with a foul mouth, who actually ended up leaving the United States for some time, able only to find work as a stagecoach driver in Santiago, Chile, where presumably nobody could understand what he was actually saying.

The Phineas Gage story is taught to students as a landmark case identifying the left frontal lobe of the brain as the seat of self-control. Later, scientists tried ablating the frontal lobes of monkeys to induce similar clinical syndromes and succeeded, learning along the way that the frontal lobes—that the brain in general—is so much more incredibly complex than anyone before had ever realized. Every day, new research identifies brain areas and functions and neurotransmitters that are more specialized and amazing than what we knew the day before. I can't possibly begin to list them all here, and by the time you read them they will be wrong. The point, though, is that the brain really is the place where thinking and decisions happen, and it is far more complex than we can even imagine. If I sound a bit obsessive on this point, it is because I need to keep making this point and for you, the lawyer who wants to win her case, to understand and believe it. But remember, environment and experience influence biology. Talking and thinking influence biology. Neurotransmitters are the way the brain communicates with itself, the outside world, and the rest of the body; the brain is not just a bunch of neurotransmitters. Your smartphone does not exist by itself—it is a tool that you use to look at pictures of cats and text your friends. If you wanted to, you could use it to access all the information that mankind has amassed since the beginning of time. Do not be fooled into thinking that your brain is limited to neurotransmitters any more than you should be fooled into thinking that your phone is limited to Facebook and Tinder. You can actually use that thing to call your mother. I do it all the time. Well, occasionally.

Let's look at our friend Dr. Mo. The last time we saw him, he was in a cell in some midwestern sheriff's department, and had just asked for a lawyer. I'm not keeping the location obscure out of the New Yorker's proverbial disdain for the flyover states, only because it really doesn't matter. Pretend Mo is going to be your client. He was ranting and raving about bacon, his rights, and who knows what else, because at this point in his illness, he was becoming mentally disorganized. So the sheriff's secretary calls the public defender on duty, who happens to be you. Let's give you the typical midwestern pseudonym of Jessica Zhang.

"Hi Mr.—um, Goldstein?"

"It's *Dr*. Dr. Abu-Amy. I used to be Dr. Goldstein, but I had to give up the name of my people because it was an invented name, the name of oppression, I chose the name of my enemy oppressor to take the name of the enemy oppressor means to become one with the enemy is to be the master of the enemy the master of disaster, the winner of the loser, the master of the universe. I'd shake your hand, but I don't want to get any demons on you."

You can imagine how poor Ms. Zhang is feeling at this point. Taken aback would be the polite phrase. Now she has several choices, but they boil down to two main ones: she can play it straight, or she can ask for psychiatric intervention.

Let's pick the option in which Jessica's youth and inexperience causes her to play it straight, and focus only on the word "enemy."

"What's he charged with, Officer?"

Jessica learns that Mo/Ben is charged with a variety of local ordinances and one indictable offense: Terroristic Threats. The truth is, I don't know if Terroristic Threats is an indictable offense in this made-up state we're in, but it is in my home state, and in fact requires nothing actually terror-related about it—it can be as simple as "I'm going to kill you, you moron," when someone accidentally hits your car with a shopping cart in the parking lot. However, Jessica, in her youth and zeal, zooms in on the word *terror*.

How should this story end? Jessica's duty is to her client, of course, but somebody can call the FBI, jurisdiction can be transferred, and somehow Mo/Ben can end up in Federal Prison for the rest of his life. Presumably, he would eventually be seen by a psychiatrist, or at least a forensic psychiatry fellow (a young psychiatrist doing post-training specialization in forensic psychiatry), where he might get some medication and might at least get a little stable. So let's go back, and pretend that Jessica had access to a good course in mental health law and to a book like this one, when she was in law school.

Jessica thinks to herself, "No sane person can possibly speak like that. He doesn't want to get any demons on me? What on earth is he talking about?" Then to Mo: "Mr. Abu-Amy, do you have everything you need here? Are they treating you okay?"

As tempting as it might be to make up anther disjointed 10-minute rant to boost my word count, I will refrain. You get the picture. Jessica encourages Mo to get some rest, asks the staff to please not feed him any pork products, and calls the local psychiatric hospital. She then goes to her cubicle to begin preparing her brief to get Mo transferred to the hospital for an evaluation, and in it she includes every psychiatric-legal question she can think of:

Is he competent to stand trial (fit to proceed)?

Did he understand the consequences of his actions when he committed the instant offenses?

Does he need psychiatric treatment, and is he competent to refuse treatment?

Is he capable of actually making child support payments? (she somehow picked up that he was in default)

Is he capable of managing his own financial, legal, and medical affairs?

Does he qualify for disability payments?

Where should he live—can he live independently?

Did he change his name legally, and if not, which name should be used in the legal documents?

As you can see, Jessica Zhang, like me, is a first-generation American and a bit of a nerd. Go Jessica!

Meanwhile, back at the Prosecutor's office, Harry Boyle, 10th-generation American lawyer and first cousin twice removed of the county judge is rubbing his hands together in anticipation of convicting his first real-life Arab terrorist! And right here in good ole Hee-Haw County, who'd have thunk?

In all fairness, Harry is not a dummy. He's just tired of prosecuting a bunch of dummies, idiots who beat each other up in the same stupid bar fights, who drive drunk, who cook meth, who do nothing criminally creative at all. He could have stayed in Chicago after he finished his clerkship and passed the bar, but he felt so anonymous there. He preferred being a big fish in a little sea. So home he went.

Harry really did not say or do those things I said. He just never took a course in mental health law because at his school it had been an elective, and he had taken an extra course in tax evasion law instead. So he was very hazy on how insanity fits into crazy illegal behavior, or into any illegal behavior. Harry, therefore, played it straight. A guy makes a nuisance in a public venue. He is dirty and unkempt, with a big beard, using words that nobody understands. That one of them was actually a Yiddish (Jewish) word (*traif*) was not only irrelevant to him, but also unknown to him. Harry had no reason to suspect that this dirty man threatening harm to everyone's future generations and spouting words about demons and terror was anything other than what he seemed to be—a dangerous terrorist. His mission as a prosecutor was to prosecute and convict dangerous terrorists, and nowhere in his training had he been taught that someone who presented as a dangerous terrorist might actually be a harmless Jewish podiatrist from New Jersey.

At this point, we can leave our lawyers and our hybrid podiatrist/terrorist, knowing that at each step of the process we have the opportunity to both stop a legal process that is relatively pointless, as well as intervene in a way that would not only help this mentally ill individual and his entire extended family, but also allocate funding and resources to places where they might be utilized appropriately and effectively—perhaps on those methamphetamine producers or even on actual potential terrorists. Right now, Mo/Ben is on his way to court, and then hopefully to the county psychiatric hospital, where Drs. Patel and Rodriguez will do their utmost to figure out what is really going on with him.

What have we learned in this chapter? Perhaps I have not done my job well, and we have learned nothing. But I hope I have made a few points. First of all, that madness and badness are each on a continuum. Neither bad behavior nor crazy-seeming behavior is either/or. Biology influences behavior, and biology influences choices. At any moment in time, the irrational impulse can overtake the rational. For most people, the truly irrational never fully overtakes the truly rational, so the only irrational outcomes we have are dresses that do not really flatter us, people we may have once dated that we wish we hadn't, or extra calories we should not have ingested. Yes, I'm keeping those irrational choices clean for our polite academic readership, but you all know exactly what I mean. For people

whose brains are not properly wired, either as a result of mental illness or of neurological disorder, irrational choices come much easier. In the novel *The Corrections*, by Jonathan Franzen, a character is working on the outside of his home when he needs to move the ladder. Now, who among us has not had this fleeting thought—just jump with the ladder to move it over a foot or so? It works in cartoons. In real life, we know what the consequences would be. In fiction—if you did not read the book, you should, just for this one passage. Fiction works because when crazy thoughts become actions, they create drama and plot. Real life is sort of boring because people can anticipate what the consequences might be. Sigmund Freud himself, the father of psychoanalysis, wrote in his 1908 paper, *Creative Writers and Day-Dreaming*, that writers take their fantasy lives and turn the unconscious into plot using language, and that things that might be boring in one's own life become interesting when put into words by someone with that undefinable thing called talent. But Freud's point is really the same as mine (or I should say, mine is the same as Freud's), and the same as Mr. Franzen's—that isolating unconscious, or partly conscious, thoughts and desires, and putting them into words, can be entertaining and interesting. The problem with disinhibition is that people take these unconscious thoughts and put them into action without the buffer of a work of fiction, screenplay, or comedy routine, and now these actions are weird and uncomfortable for the onlooker—no longer entertaining or goofy, but rather something that requires medical attention.

The practice of law assumes a dichotomy between mad and bad, with maybe some lip service played to the concept of diminished capacity. In reality, I would argue that every illegal act is the result of someone's engagement in a behavior that occurs somewhere on the intersection of the mad and bad continuums. Sometimes the behavior is deliberately bad, but not super bad. I live in a neighborhood that was a new development 20 years ago, when we moved in. It was built on something called "zero-lot-line," which means that most of the houses have one wall right on the property line (not my house, fortunately, but many of the later ones). We learned about a dispute that one of the neighbors had when he tried to sell his home. He was originally from Scandinavia, and when he bought his house, he signed all the papers, thinking he knew what he was doing. It turned out that he had given permission for the neighboring home to be built partially onto his property. Several years later, when his company transferred him, and he needed to move (now with a wife and child), suddenly he learned that no potential buyer wanted a house that permanently included a neighboring house forever on its lot. The eventual sale and move was stressful, expensive, and depressing. Clearly, the builder knew exactly what was going to happen ("Acme Builders, since 1776!") and had deliberately taken advantage of a European customer. Mentally ill? Not really. Evil? Not completely. Just a bit greedy, taking advantage of someone when a situation presented itself by putting a bigger house on a lot that was not supposed to hold it when they saw they could.

Sometimes a behavior is mad, but not super mad: Natasha Delaney told me about a divorce client who was very depressed and went to our local WaWa (a convenience store in Pennsylvania, New Jersey, and Delaware) to buy milk. Let's call her Michele. Michele was preoccupied with her problems and somehow walked right out the door without

paying. The local police also frequent that WaWa for their coffee and donuts, and so some policemen happened to be right outside. Michele was not a United States citizen, although she was a professor and here legally. I live in a very international area, a sort of brain drain capital. The police apprehended Michele, and in her depression and confusion, she immediately began to cry and held out her wrists for the handcuffs. She did not attempt to run away or even to apologize or to pay for her gallon of milk. The police officer, naturally, was happy to oblige, since not much happens around here. (Marginally related note—I was once on a course with a lot of law enforcement personnel from all over the world. They had this idea that the police in the United States spend most of their time rescuing cats from trees. Every time a siren would pass outside, one of them would mutter, "Oh, Frisky is up a tree again." I have to admit it was kind of funny, especially since the course faculty were all former FBI and extremely serious.)

Poor Michele made an error in judgment—she forgot to pay for her milk. In my favorite movie of all time, *My Cousin Vinnie*, one of the characters accidentally shoplifts a can of tuna because his hands are full, so he sticks it in his pocket, setting off a cascade of events that ends with Academy Awards all around. What Michele should have done was say, "I'm so sorry, Officer, I have a lot on my mind, I was daydreaming," gone back inside, paid, and the incident would have been forgotten. But severe depression includes feelings of guilt and hopelessness. There is a horrible Russian saying that goes, "When you get home, beat your wife. She knows why." I include this horribly misogynistic saying only to illustrate how depressed people can feel—that they actually deserve the bad things that might happen to them. This poor woman—a woman with a PhD who taught at an Ivy League university, so clearly no dummy—at that moment, felt, because of her depression, that she deserved to be *arrested* for accidentally walking out of WaWa without paying for her gallon of milk. She then felt that she deserved to lose her job, lose her visa, and be deported for an act of moral turpitude. I'm not the one that makes up these words. She did not think to get any psychiatric treatment. Natasha tried to get Michele to see me, but Michele refused. The divorce was a mess. The removal proceedings were a mess. The whole thing was a mess—and why? Because this previously high-functioning intelligent woman developed severe depression, and her insight and judgment became so impaired and clouded that her ability to make rational decisions became completely defective. And the legal system requires that any defendant in any of these matters, from shoplifting all the way up to cancellation of removal, make an affirmative argument as to why she should not be subject to the law as it is written. The lawyer works for the client. Natasha worked very hard to convince her client that she needed to try some other things besides sitting in the courtroom crying and telling the judge that fine, she will leave the country forever, that she would also leave her young child in the custody of her American husband forever and never see her child again, that she would leave her job, her livelihood, her home, her friends, her career, and everything else—all because of a gallon of milk. And unlike Jean Valjean, who, after all, did deliberately steal the baguette, Michele was just so lost in her thoughts that she headed for the door instead of the checkout line. Who has not done something like that? We say, oops, sorry, get back on line, pay, and everything is fine.

In Michele's case, her depression basically ruined her life. I have to remember to ask Natasha what the outcome was, although I'm not sure I want to know.

Most bad/mad behavior would fall between the two possibilities of deliberate malfeasance and total ignorance of one's mental state. Naturally, not every case will require a psychiatric expert. Hopefully this book, and the knowledge it is giving you, will serve as a stand-in, so you can be your own expert, and determine where the cutoff is, and where you should think about getting that expert, or not pursuing an actual legal resolution to something that is, in the words of the people I went to high school with, completely mental.

6

Insight v. Lack Thereof

The concept of insight is critical in psychiatry. I know, I keep telling you that things are critical, but that is because they are. This whole book is a distillation of the most important and the most critical key concepts in an entire profession. So let's try to understand what insight is supposed to be and how to determine if someone has it or doesn't have it, particularly with respect to the legal matter at hand, whatever that may be.

Insight is defined by *Merriam-Webster's Online Dictionary* (I did not even bother with the print version, although I do own a copy) as:

- the ability to understand people and situations in a very clear way
- an understanding of the true nature of something

However, the entry then states that the full definition of insight is:

1. the power or act of seeing into a situation: penetration
2. the act or result of apprehending the inner nature of things or of seeing intuitively

To further complicate my understanding, we come to the actual "medical" definition:

1. understanding or awareness of one's mental or emotional condition; especially: recognition that one is mentally ill
2. immediate and clear understanding (as seeing the solution to a problem or the means to reaching a goal) that takes place without recourse to overt trial-and-error behavior

Why would I include all of this dictionary stuff here? Because I want to demonstrate how even in an official document whose purpose it is to define words, the definition of insight is not exact (and neither is their punctuation, which changes from section to section!). I would like to extract from all of these definitions the one that I find to be most relevant, and then expand upon it in the ways that we need to understand for our particular purpose of understanding psychiatry for lawyers and the courts—the medical definition, above:

Understanding or awareness of one's mental or emotional condition;
Especially: Recognition that one is mentally ill

Recognition that one is mentally ill is important in psychiatric treatment. In order to encourage a patient to comply with treatment, to take his medications, to come to appointments, and to refrain from drugs or alcohol or even foods that might make his condition worse, he first needs to understand that he has a mental disorder that requires treatment. But this definition of insight is important primarily for treatment and compliance with treatment. It is not the same insight that we address when we perform a mental status examination. It is not the same insight that psychoanalysts assess during

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the years of introspection, in which patients engage on the proverbial psychoanalyst's couch. And even the level of insight that patients have into their own mental illness differs depending on the illness and the disorder. The understanding that one is mentally ill is the bare minimum amount of insight required to get someone to show up for his prescriptions or injections. This insight is not the insight we are talking about when we discuss insight in a legal setting. If it is, then we deserve to be laughed at for not knowing our business as experts.

Let us, then, discuss what insight really is, how to assess it, the levels of insight we can look for in clients and patients, and how this information might be useful in legal matters.

If we return to the first part of the special medical definition, we can tease out quite a bit of information. Recall that Messrs. Merriam and Webster defined special medical insight as the following:

Understanding or awareness of one's mental or emotional condition

I am not about to start giving the dictionary definition of every single word in that phrase, but the word understanding itself can be defined on many levels. We can understand, or be aware, of the fact that we have a disorder. Medical students have all sorts of apocryphal stories of the patients who claimed to have "screaming mighty Jesus" (spinal meningitis) or "a mild case of cancer." Clearly, the patients with those levels of awareness lacked meaningful insight into their disorders. I frequently see patients, or the families of patients, who want to "bump up the serotonin as fast and as high as possible," or "find the right medication cocktail for me." Those people sound as if they know a lot more than the screaming mighty Jesus patients, but the key is that they *sound* as if they do. A little knowledge can be quite a dangerous thing—to wit, a friend's mother who died of serotonin syndrome because all of her doctors apparently believed that a quadriplegic *should* be depressed, so if she was still unhappy after being given every serotonin-increasing medication known to the medical profession, better give her a little more. In my own defense, I did try to intervene, but she was not my patient and I was a thousand miles away, and by the time I could arrange something, she was gone. I'm still so sorry. I asked my friend if it was okay for me to include her mother's story here, and she said it was. She told me that the 10 years prior to her mother's death, while she was living as a quadriplegic, had been incredibly difficult for her mother. Her mother was depressed. She was sad. She did feel as if her life had no meaning anymore. She had gone from being a successful pediatrician in the former Soviet Union to being a bedridden, motionless, scary grandmother in the United States. She was not happy. But she was not suicidal, either. She wanted to see her children settled and happy. She lived to hear and see the faces and voices of her grandchildren and to feel their kisses on her withered cheeks. She was sad, but as we keep saying about the mentally ill, she was far from stupid.

Here is the irony in case you missed it—the patient in that case was a doctor. A doctor who had suffered a tragic accident, to be sure, but still a doctor, and had anyone bothered to show her the list of medications they were giving her, she may very well have spotted

the problem herself. But often physicians assume that to be paralyzed in one's body is the same as to be paralyzed in one's mind. Even doctors don't always have insight.

I include this story because it demonstrates what insight is—a very complex thing covered by one simple word. A patient with schizophrenia might be considered to have excellent insight into his illness if he understands that he needs to come to his monthly appointments, take all of his medications, and stay away from drugs and alcohol and not shoplift. A CEO of the same age and gender—maybe the first cousin of this schizophrenic—might be considered to have excellent insight if he works hard, loves and respects his parents, wife and kids, gets to his kids' sporting events, dance recitals, and school plays, and sets aside some of his huge bonuses each year as charity donations toward the schizophrenia foundation, understanding that there but for the grace of God (or mother nature, or genetics, or whomever) goes he. Insight is relative. People used to enter psychoanalytic treatment to understand themselves better. Since the invention of modern psychopharmaceuticals and managed care, people do not seem to want to understand themselves better. Insight has taken a hit. People go to therapy to learn how to manage symptoms and life problems, not to understand themselves. And the role of insight in treatment has thereby changed.

We can live with patients whose understanding of insight is that they have a "chemical imbalance" (as always, in quotation marks since we don't know what this purported chemical imbalance really is). The current focus of psychiatry is this chemical imbalance thing, and if it keeps people on their medications and out of the hospital and able to go to work, I can live with it. Since we have a national shortage of psychiatrists, and from what I can tell, based upon the job solicitations I receive in my email inbox every day, pretty much an international shortage, at least in the English-speaking world, as well, we either have an epidemic of mental illness, a great need for psychiatrists, a problem with the delivery system, some other problem, or a combination of all of these. In other words, keeping the sickest people on their medications and out of hospitals and prisons might be the best we can do, and giving them the level of insight required to help them keep their clinic appointments might be the only insight we can give them.

But this chapter is about insight required in various legal settings. The bar is set quite differently, no pun intended. Assessing insight is different for different individuals in different settings, for different matters. Assessment of insight is crucial for considering competence and capacity for all legal issues, even when competence and capacity are not actually being considered. Let me say that again, because you might have missed it:

Assessment of insight is crucial for considering competence and capacity for all legal issues, even when competence and capacity are not actually being considered.

Don't believe me? Let's go over some of the cases we've discussed here already—the real ones, not the one I've been making up for your learning and reading pleasure. The case of Menace Polansky, the guy with the Fetal Alcohol Effect, that we discussed in the previous chapter, who wanted to build a garden for the mother of his children and ended up subject to removal (i.e., deportation) from the United States—remember him? One of

the issues in his cancellation of removal proceedings was that he had not been told that he might be subject to removal from the United States and *that he did not have the capacity to understand this particular consequence of his criminal behaviors*.

The very first case I mentioned in the Introduction of this book was that of a convicted sex offender who had pled guilty to his offense, on a written form, after first indicating that he was unable to read and write the English language. Some public defender thought he was doing his client a service by pushing him to accept such a plea agreement. Some prosecutor did not notice this little glitch. Some judge thought that such a plea agreement was acceptable. The appellate court, however, finally did get to this case, and agreed with me that such a plea was, in fact, not acceptable. The sex offender in question did not have the capacity to enter into a plea bargain agreement, and his conviction was vacated.

Now, you might be thinking, who cares about a sex offender? Maybe nobody. Maybe this particular case had some extenuating circumstances (it did, and not the abuse excuse you might be thinking about, but more like the fact that no crime was actually committed). The point of the story is that the issues of insight and capacity come up over and over, and if you miss them the first time, ignore them, or think you can get the other side to ignore them, they might come back to bite you, the attorney or the judge, where it hurts. No sitting judge wants her acceptance of a routine plea agreement overturned because the defendant who agreed to it did not understand what he was signing. I can give you plenty of examples of judicial incompetence, but such a case should never be one of them.

Maybe you don't practice criminal law. Maybe your area is solely civil, and you hardly ever step foot into a courtroom. Perhaps your work is all paper, all the time. Here is a case that is on my desk right now, details changed for the purpose of that all-important confidentiality.

Several years ago, Mrs. Arrogant Heiress divorced her first husband. They entered into a divorce agreement. She left him a nice settlement, to which he agreed. Their understanding was that despite any future marriages, the bulk of her estate would pass to their children upon her death. Later, she married again, and, surprise—as unpleasant people sometimes do, she divorced again—or rather, her new husband divorced her. They too entered into a divorce agreement. Then what does Mrs. Arrogant Heiress have the chutzpah to do? That's right, she dies!

Well, the rightful heirs—her adult children—have just landed a windfall. But her first ex-husband is not so happy. He suddenly decides that he did not get enough in his divorce settlement if there was still something left over for the second divorce. Here is his plan—he will go to court and say that his ex-wife had been incompetent to enter into a divorce agreement at the time she (and he) made their agreement, and therefore the second husband inherited too much. In other words, ex-husband B would now have to pay ex-husband A some of the money ex-husband B got in his divorce.

The court is taking this claim seriously, and I get to wade through literally thousands of pages of documents to try to figure out whether or not Mrs. Arrogant Heiress was in her right mind on the day she signed her divorce agreement with ex-husband A. Here is

the part that I, as a non-lawyer, find especially ridiculous: ex-husband A also signed the divorce agreement. If he thought he was not getting his fair share back then, or that she was not in her right mind then, what in the world prevented him from speaking up at the time? I will leave that part up to you legal eagles (although I might mention it somewhere in my report), but again, the crux of this matter is insight—insight into the ramifications of this divorce agreement, and really, on the part of both parties, the ex-husband and the ex-wife.

If you think somebody does not have insight into what they are doing, into their situation, their profession, their responsibilities, whatever it is they are contracting to do, whether formal or informal, you might not want to get involved with that person or those people. But if you do, remember that insight is a clue to outcome. I often have patients who show up in my office after being treated by other doctors, as I've frequently mentioned in these pages. These patients have enough insight into their conditions to know that they are not doing well. They might not have sufficient information or education to know what the problems are, but they know that their normal mental health is better than the way they are feeling after the treatment they are currently getting. So whose insight is impaired in this scenario? Often, unfortunately, it is the treating physician's. Some psychiatric illnesses really cannot be managed without hospitalizations and side effects, but many can. The depressions and anxiety disorders that are most commonly seen in outpatient practice are fairly easy to treat. When I see those patients walk into my office with 30-pound weight gains, shuffling gaits, and blank stares, I know someone was a little too enthusiastic with the off-label use of medication. Where did those doctors put their insight and judgment? Likewise, when a patient comes in and tells me she has no psychiatric history, and I see those same physical signs, I can usually get them to confess to a long history of antipsychotic medication use.

Insight is not the same as "street smarts," but in some cases it could be. In psychiatry, the disruption to insight is often the first sign of psychiatric decompensation. Contrary to popular belief, people frequently do not know they are going crazy, but rather they believe they live in a world where their strange beliefs are facts. We discussed this concept in the chapter on psychosis. Sometimes when a patient is doing well, the first thing we might see is a slight suspicion that something is not right in his life. For example, a previously well-managed and functional young woman with a known history of true bipolar disorder, who lives at home with her parents, might suddenly feel that her parents are being controlling and manipulative. This young woman generally knows that she has a psychiatric disorder. She is normally compliant with medication, does not use alcohol because the last time she was manic she got drunk, totaled her car, required a whole bunch of surgeries, and lost her license. She normally has a great relationship with her parents, who always drive her to her appointments and whom she—and you—trust implicitly. She has recently started a job to which they drive her, since she still does not have a car, although she did regain her driver's license. You notice that she has become more irritable lately, and you point it out to her. She agrees to increase her mood stabilizer and return in two weeks. You tell her father that you are concerned. He agrees to watch her closely. In two weeks she returns, and now

she is furious with her parents. They do not "let" her drink. They do not "understand" that she "needs" to see her friends. They do not "understand" the stress she is under.

Now, you, the reader, are a lawyer and either a young person or a parent, reading these words, and you are thinking, "What the heck is she (meaning me) on about? That's just normal, this patient is a young person rebelling against living at home." Nope. This patient is a young manic-depressive (aka true bipolar) entering into a mixed episode. Her insight—her understanding that she has a mental illness and that she needs to do certain things like not drink alcohol, sleep well, reduce stress, etc., is evaporating. She is attributing inappropriate, malicious intent to things her parents do out of love—things I have documented her saying that she appreciates in the past.

I prescribe antipsychotic medications, and tell her to come back next week, and also not to go to work because I'm afraid something bad might happen there. Unfortunately, before she can return to my office, her parents have to call the police and she ends up admitted to a psychiatric hospital because she has trashed the house.

We all saw it—the deterioration of insight as the very first step toward psychiatric decompensation. Even my secretary (who by now is practically an honorary psychiatrist) noticed it. You can't always do something about it—you can't always make the patient take more medication, and the medication does not always work right away. This patient went to the hospital and nobody called me besides her parents. When I called the hospital to speak to the doctor there, the doctor told me, "Oh, it's because she's an alcoholic, right, she drinks, and then decompensates?" I said, "No, it's because she's a true bipolar, she decompensates, and last time she drank," and the other doctor said, "Really, how interesting," and then hung up on me. The last time, incidentally, had been over three years, which should have been relevant to this doctor but is not necessarily relevant to the anecdote.

My patient was in and out of the hospital three times before she stabilized enough to be seen as an outpatient in my office, and even then it took a long while for her to get back to her usual self. The way I could tell was by monitoring her insight—mainly her understanding about whether her drinking and other behaviors were appropriate or not. Each time one of her parents brought her. Those parents are amazing. They don't get angry. They understand that their daughter is mentally ill. They love her anyway. They do what they have to do. They pray that she will remain stable. They understand that she is on strong medication and might not be able to have grandchildren for them (because you can't risk being pregnant on those meds out of potential dangers to the fetus). But the parents are always there for her. They could teach a course on how to be parents for a bipolar person. They could be fictional parents in a romantic suspense novel by Nora Roberts. They are perfect. They have insight. And they have it even when their daughter's insight starts to fail, and she starts to believe they are being mean to her. Most families do not display this type of fortitude. Most parents I see meet their children's failing insight with anger, hostility, and a failure of insight of their own. They take words at face value, without any attempt to understand that perhaps some kind of thought disorder motivates them. Remember the news announcer who claimed that a murderer's motive was anger at his mother-in-law's criticism of his poor parenting skills? That is an example of someone

taking words at face value without attributing any lack of insight to them. We need to be fully, deeply, and consciously aware of people's insight into their own and others' behaviors when we evaluate behaviors. Motive is only motive if it makes sense. A motive based on craziness is not really a motive. The law might like you to believe that it is, but remember King David pretending to be crazy so that he would not be put to death? Human beings inherently know that insanity includes a lack of insight, which includes an inability to make rational decisions. The problem is that people might look as if they are thinking rationally when they are not. Remember, people do not have to be drooling in order to be mentally ill. And they certainly do not have to be drooling to be lacking insight.

What else is insight? I have another funny example. I use it because it is true, even though it is kind of crazy. Many years ago, during my fellowship training in forensic psychiatry, I evaluated a man for Fitness to Proceed (competency to stand trial, although remember, competency is a legal decision, not a psychiatric one) in a murder case. I never really knew much about the case—I do know that I found him fit. I remember we used to do those evaluations every Tuesday when the inmates were bussed in from Riker's Island to Bellevue Hospital. Occasionally, we would get a high-profile criminal, and the whole department would sit in, but this particular defendant was nobody special, just some guy from the Bronx.

I finished my fellowship and moved to New Jersey, and then one day a year or so later, I received a call from a public defender in the Bronx who wanted to hire me to explain to a jury what AIDS encephalopathy and AIDS dementia were. These issues were marginally related to this man's case and did not even include a psychiatric evaluation of him.

The most interesting part was how the lawyer had found me. His client was the man I had evaluated for 30 minutes a year earlier. He remembered me and had told his lawyer that he could "see in her eyes that she understood me." Now, all I had done was determine that the man was fit to proceed. Whether or not he had an underlying mental illness I do not even remember, and those reports, alas, are on ancient floppy discs that no modern computer can read. However, I think this case illustrates how an individual can be a bit delusional and have limited insight into his mental illness, yet retain the ability to be fit to proceed with his criminal trial and the required insight to work with his attorney ("Let's get someone to tell them it's my brain damage that was responsible"). This man displayed some ideas of reference and grandiosity (he believed he was very important, and the psychiatrist showed by the look in her eyes that she "got" him). He had no insight into the fact that his specific brain was not functioning properly (I am positive that my eyes did not communicate any special knowledge to him), yet he did have insight into the fact that there could be something theoretically wrong that he could use in his own defense. I suppose he just remembered me and liked me, and his unconscious mind had somehow turned that into some mystical sort of understanding. For a young forensic psychiatrist just starting out in private practice, the case was a coup, and really fun to not have to feel as if I was picking a side, to just explain some basic psychiatric stuff to a jury and to the lawyers and judge who had never heard anything like it before. Insight can be a very difficult concept to grasp, even for psychiatrists. When we learn, and then teach the mental

status examination, we tend to gloss over this part because it is actually so complicated. We say, "Do you think you have a mental illness?" and when the patient answers yes or no, we write down that her insight is good or bad. We kind of know that our quick conclusion is insufficient and that if insight were a one-word answer, we would not have had to spend hours in supervision, in the old days, writing process notes, understanding our own responses to our patients, our counter transference, and why we chose to follow certain lines of information in treatment and not others.

For those of you who don't know what any of these things are, which undoubtedly includes some young psychiatrists, I'll give a quick summary. We used to have individual psychotherapy patients while we were in training. For some of these patients, we would have individual supervisors. After spending at least an hour in individual therapy each week with these patients, we would write down, with a pen, in our own handwriting, every single word that we could remember from the psychotherapy session. Then we would take those notes to supervision, at some ungodly hour not included in our paid working hours, and share them with our supervisors. Then we would discuss what it all meant. What it all meant to our patient—and—the hard part—what it all meant to us. Did we forget part of what they said? Was that an emotionally painful topic for us? Was it boring? Why was it painful? Why was it boring? Were we tired? What were we doing that was making us tired instead of focusing on our patients? And then the insight part. . . was there some reason that we did not follow up on that topic—or did follow up on the other topic?

Apparently, nobody does this process anymore. It's hard and time-consuming. Today, they video record sessions in the training programs that teach psychotherapy, which are few and far between. Video recording is also interesting, and I'm sure very educational, but in a totally different way. I think, if it were me in those videos, I'd be super focused on how I looked and sounded, and much less focused on what I was actually saying. I've been in videos and on television, and even in a little movie, and I cannot bear to actually watch myself, so I know that watching myself in a video for the purpose of supervision every week would be torture. For me, personally. But perhaps focusing on how we look and sound may be symbolic of the world we live in today—appearances count much more than substance—and that is what is also called an *insight*.

7

Treatable Disorders v. Permanent Brain Damage

Thus far, we have been discussing psychiatric and neurological disorders with a certain disregard for overlap. Psychiatrists and neurologists pay our examination fees to the same organization, The American Board of Psychiatry and Neurology. Our examinations themselves have quite a bit of overlap. Our patients have quite a bit of overlap. We use similar medications and often see similar clinical presentations. We all utilize the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) to the degree that we can tolerate and that we have to utilize it. Why then do we have two different professions, and what exactly is the difference?

The answer is, I don't really know, and I'm not sure that anyone else does, either. But the practical and historical answer is that neurologists treat brain disorders that have some sort of physical correlation. Strokes, tumors, and movement disorders caused by depletion of dopamine in the nigrostriatal bundle (Parkinson's disease, or the similar version caused by long-term use of antipsychotics, called tardive dyskinesia), various dementias, both of the Alzheimer's and other types—all of these disorders have some sort of teeny tiny lesions that can be identified and localized with technology if you look hard enough. If they cannot be found on living people, the lesions can be found on dead brains and the clinical correlations can be drawn later.

Psychiatric disorders, so far, have no obvious physiological correlates. Except that every day new papers are published showing amazing radiographic (X-ray), histological (cell), or genetic (DNA) markers for different clinical psychiatric conditions. The future is almost here. To further complicate matters, the father of psychoanalysis, the famous Sigmund Freud, whose action figure self sits on a shelf in my office monitoring my every move, was actually a neurologist, not a psychiatrist. The overlap between the two specialties has always been bigger than the nonoverlap (Figure 7.1).

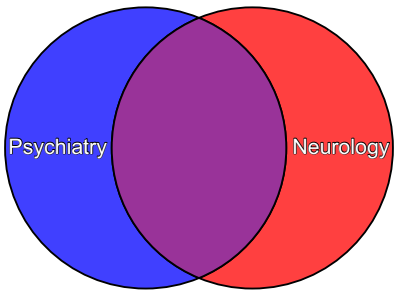

FIGURE 7.1 Venn diagram of overlap of Psychiatry and Neurology.

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Dividing disorders into neurological and psychiatric does not make a lot of sense from a medicolegal perspective, in my opinion. Plenty of neurologists do forensic-type evaluations, even if forensic neurology is not a fellowship specialty the way forensic psychiatry is. Pure neurologic disorders can sometimes seem to be more medical in their presentation, resulting in changes in movement, physical behaviors, or pain, without changes in emotions or personality.

Early-stage dementias frequently present to a psychiatrist first. The diagnosis is not that hard to make once you've seen a few cases, but family members have an idea that dementia should look a certain way. People believe that dementia should present as forgetfulness. They know that there is a thing called Alzheimer's, and that is the only dementia they've ever heard of. Actually, most dementias are not Alzheimer's. In fact, I should not even be using the term "dementia," because the DSM-V changed it to cognitive impairment just to confuse everybody, even those who are not cognitively impaired. Many cognitive impairments present initially with psychiatric signs and symptoms, and experienced psychiatrists have a feel for those symptoms, just like my internist knew that what I thought was a bug bite was really shingles. Don't knock clinical experience.

Another way of looking at mental disorders is organic versus psychiatric. I mentioned in a previous chapter that one of the major no-nos of my early training was missing something organic. In that context, missing something organic meant missing an acute medical event or something treatable: a stroke, intoxication, an overdose, or a brain tumor. Missing dementia was certainly not going to get the doctor in trouble, because there was no treatment for dementia. Even today, the few treatments we have are only marginally useful, and while they have been shown to slow the progression of disease, they are not cures. So you are okay missing the initial signs of dementia. But you definitely do not want to be the doctor—or the lawyer—who misses a brain tumor.

I know I have a tendency to say "the other day," when something might have happened a week, or a month, or even 10 years ago, but this incident actually did happen the other day. In fact, I met someone just last Friday who told me a story about his personal life. I met him again, the way you do, in life's nonrandom-seeming randomness, the following Wednesday, when he proceeded to tell me exactly the same story in almost exactly the same words. Here I am, this big grown-up psychiatrist, and I was just *annoyed*. When I got home, I told my husband about the incident, and he, not a physician, said, "Obviously, there's something wrong with him. Probably dementia." Well, duh. If I'm not on duty, so to speak, I'm not necessarily paying attention. As I looked back on the couple of hours I spent in that individual's presence, I realized that of course he was in the early stages of some cognitive impairment—he was demonstrating perseveration, cognitive rigidity, concrete thinking, and probably more signs of failing cognition that I had not even noticed, because we were first at a meeting and later at a dinner, not sitting across a desk from each other with me as the doctor and him as the patient. If you are a lawyer, and you have the infuriated feeling that your client just wants to keep tooting his own horn over and over, without giving you a chance to actually do your job, stop counting the dollars for a second, and think: is his brain functioning normally, or is some underlying cognitive impairment

causing him to tell you the same five things every time you meet? You might be happy about the billable hours, but in the end, he might be incapable of actually "winning" anything, and he might be incapable of paying his bill, if his ability to work is permanently compromised. The concept of permanent brain damage, either via injury or neurological illness, is very important, which is why I picked it to get its own chapter.

In this chapter, therefore, I would like to look at a third way of considering mental disorders. This way considers disorders that are permanent versus disorders that can respond to treatment. Although I do not necessarily know of any other reference guide that uses this system, I find it particularly useful for conceptualizing mental disorders for legal purposes. We have seen that the gap between psychiatry and neurology is closing daily. In another 100 years, or perhaps another five (unlikely, given the logistics, although not the science), they will combine into one medical specialty, or will be clearly divided along the lines of movement and behavior/emotion (another way we can consider their classifications, although again, it is not exactly correct).

When a lawyer has a legal matter in front of her, she needs to know if the mental issue can be resolved prior to the legal issue, or if it is a permanent part of the legal case. So in that regard, understanding whether brain issues can get better or not can help in dealing with their related legal issues and make the legal matters much easier to conceptualize.

We have previously considered the chronicity and cyclicity of many psychiatric disorders, and the concept of viewing a psychiatric illness like a movie that takes place over a person's entire lifespan. When we look at diagnostic criteria for mental disorders in the DSM or ICD (International Classification of Diseases), each disorder has a specific time frame associated with it, from days to weeks to years. Knowing that somebody is schizophrenic, for example, does not mean he will be psychotic every single day for the rest of his life, but it does mean he will be schizophrenic for the rest of his life—that diagnosis does not go away. A diagnosis of major depressive disorder, however, does allow for full recovery. On any given day, though, a person with depression might be in the midst of an episode so severe that she might not be capable of cooperating with whatever she needs to do that day, but you, as the attorney in the case, can expect that one day she will be able to recover fully, and for sufficient time for the legal matter to be resolved. Other types of diagnoses have different prognoses and different potential outcomes. In general, most purely psychiatric diagnoses, in this day and age, can generally be medically managed to get their sufferers a day in court, if that day in court is what is required. However, if you are a lawyer for the disability insurance company, I cannot promise you that every single claimant will be able to go back to work. If you are an attorney for the Office of Parental Representation (or whatever it is called in your state or province or country), I cannot promise that your client will one day be fit to parent his children. We are just not there yet.

Brain disorders—what we used to consider neurological disorders, but which we have seen can look like psychiatric disorders—are different. Someone who has suffered a traumatic brain injury (usually abbreviated as TBI) may be capable of some recovery. Outcomes differ on a continuum from no permanent damage to a permanent vegetative state. The field of concussion science is rapidly growing (as is every other discipline I've

mentioned in this book, with the exceptions of psychoanalytic theory and medical disorders masquerading as mental illness, which we will get to in a later chapter). Children's head injuries on the ball field used to be shrugged off by the kids, their parents, and their coaches alike. Today, they are taken quite seriously, sometimes requiring months of rehabilitation, home tutoring, and even permanent withdrawal from the team. Professional athletes—or their heirs—are receiving seven- or eight-figure settlements from teams who once thought that being knocked about was all part of the fun of the game. (The settlement does not appear to prevent new athletes from continuing to incur brain damage, now that the potential damage from recurrently hitting your head while playing hard contact sports is known, begging some new questions which are way beyond the scope of this book.)

The politics of football aside, we know that TBI can result in a whole host of brain issues that run the gamut from minor and temporary to severe and permanent. Psychiatric disorders, too, can run the same gamut. One might think, therefore, that this distinction might be unnecessary, and in many ways, one might be correct. However, precision and completeness are never frivolous, nor are they superfluous. The closer an expert can get to an actual diagnosis and prognosis, the better any court can come to understanding the implications of the psychiatric or neurological issue. The permanence or temporariness of the brain lesion is a critical factor in understanding prognosis, but the underlying causality, whether it is a psychiatric disorder or a neurological brain lesion, is a critical factor in understanding whether it is permanent or temporary. While this reasoning might sound circular, it is not. Remember our case from Chapter 1 in which the state's expert, Dr. Sneaky, refused to pin himself down to a diagnosis and instead considered an ever-revolving list of rule-out diagnoses? Many of the lawyers I spoke to while writing this book had the same question: what does is mean to have a rule-out diagnosis? Shouldn't you be able to rule it in or out? Attorney Natasha Delaney wanted to know how she could rely on an expert's treatment recommendations at all when he gave her a list of rule-outs but no actual rule-in.

"This one psychologist billed for over 40 hours," Natasha told me. "He made more money off that divorce than I did. He made more than the *wife* did. In the end, he said the wife needed to go to counseling. He had no idea what was wrong with her, but said she should have 50 percent custody." I hope that by now, anyone reading this is horrified with what is basically extortion and manipulation of a family already in a terrible situation. Nobody needs an expert to tell them that a divorcing wife can benefit from someone to talk to, or that the law requires shared custody unless another arrangement can be shown to be of greater benefit to the children. The role of the psychiatric or psychological consultant is to make that assessment in a meaningful way. In reality, most of these so-called experts administer a battery of psychological tests, score the tests by computer, opine that "people with these scores may have clinical pictures consistent with blah blah blah," provide a list of possible rule-out diagnoses, and recommend joint custody. Nice work if you can get it, I suppose, as long as you are not particularly attached to your own image in the mirror every day.

Let's return to our topic, which is mental disorders that persist versus those that go away. One would think that in a divorce situation, the distinction would be critical. (Yes, I know, I am fond of this word. But let's say, super critical.) We would hope that a vulnerable

young child would not be left in the full-time care of a parent who might be significantly psychiatrically impaired and unlikely to recover. At the same time, we are cognizant of the fact that divorce is stressful and that people going through one are frequently not on their best behavior. People cry. They yell. They say mean things to and about each other. They make threats. They hide assets. These are people who once loved each other, after all. We don't usually bother to hate people we never felt anything for. It's the people we care about who we care enough to hate. That's not especially deep or psychiatric—it's common sense. Now, to give credit where it is due, many family court judges have seen it all and have little patience for the histrionics of divorce court (I know that divorces are not adjudicated in family court in every jurisdiction, so I'll use it here as a figure of speech rather than as a hard-and-fast legal rule). Unfortunately, these jaded judges sometimes miss a real threat or a real wacko. In one very memorable case, a truly disturbed parent was so effective at drowning the court in paper that the judge actually missed a written threat, which very clearly stated that the judge would be sorry and the judge would die—yes, DIE—if the judge did not provide the noncustodial parent with immediate visitation. And that is all I will say on that subject, since, as I keep reminding the reader, sometimes the mentally ill can be very, very smart. In fact, there is evidence that some of the genes for intelligence are located close to genes for insanity on the human chromosome. During mitosis and meiosis (remember high school biology?), the chromosomes tend to break in certain ways that allow the genes for insanity and for intelligence to travel together during sexual reproduction, when genes are inherited. Nobody should ever be surprised when they hear of a famous genius doing a really insane thing. We should probably be surprised that public insanity does not occur more frequently. And is it really a coincidence that the word genius contains the word gene? Okay, maybe that last one is a stretch, but I don't want to pass up a teaching moment. I learned this concept from my psychotic patients early in my career. One super crazy patient (I wish I could share every super crazy patient with all of you, since I learned so much from each one) told me that I must be a very ethical and good doctor. How did she know? Because I was giving her a medication called Tegretol. "Tegretol—integrity—it means you have integrity, so you are ethical, it means you are taking care of me properly." Yet again, crazy does not mean stupid. A psychoanalyst would explain that the psychotic patient was using her psychosis to express her emotional understanding of feeling cared for. A geneticist would tell you that this young woman's genes for her schizophrenia were very close to her genes for intelligence and had been passed down together for generations until the right combination just flared up in her, so she was able to hear the similarity in the words the marketing department had identified for the sale of their drug.

The then-department chairperson, Dr. T. Byram Karasu, a very big name in psychiatry (yes, I am admitting this in print for all the world to see), was charmed by my "cute" case formulation that this patient was bipolar with an underlying personality disorder of borderline. Then he explained to me and the other 50 people in the room that this young woman was a typical hebephrenic schizophrenic—a young schizophrenic whose delusions had not yet congealed, or become "systematized." These young schizophrenics present with every psychotic sign and symptom out of the box: every type of thought

disorder, including loose, clang, and other associations, flight of ideas, ideas of reference, delusions of being controlled, grandiosity, and more, all jumbled together and likely to pop out at any moment with any or no provocation. To see them in their unadulterated and virtually unmedicated state does not occur very often anymore, but in those days, untreated schizophrenia was commonplace and, it must be said, kind of cool (although certainly not for the patient). Also, any observer had absolutely no doubt that she was witnessing a psychotic person being psychotic.

As far as that particular case presentation went, in my own defense I will say that (1) I was the only psychiatric resident brave enough to be willing to present to Dr. Karasu; and (2) in honor of that presentation, I bought my first computer, which you can see (not the actual one, but the same model) if you go to the MOMA, the Museum of Modern Art in New York City. And I learned something about the initial clinical presentation of schizophrenia that stayed with me for my entire life. And you, the reader, learned something about loose associations, clang associations, and hebephrenic schizophrenia that you did not know before.

A few months after that memorably embarrassing day, the first atypical antipsychotic, clozapine, first marketed under the brand name Clozaril, was introduced to the US market. By then, I was rotating through a hospital where we were actually participating in some post-market clinical trials. The patients were selected very carefully and had to meet all sorts of criteria. Now I'm going to bring the topic back full circle to the concept of permanent brain disorders versus treatable conditions, so pay close attention. The patients had to have diagnoses of schizophrenia, which you will recall from many previous chapters is a chronic, cyclical, remitting and relapsing, but never totally resolving lifelong condition. Since the invention of the first atypical antipsychotic, the actual diagnostic criteria of the disorder have changed, and the interested reader can check her back copies of the DSM to see how those changes have evolved over time. My point here is that the changes in the diagnostic criteria have occurred because of the efficacy of medication, not because the disorder itself has somehow changed. The disorder is a chronic lifelong diagnosis that gets better and worse with treatment and other stressors—hormonal, environmental, infectious, other (i.e., the full moon), and unknown. A person with the diagnosis of schizophrenia will always have that diagnosis. His clinical condition may improve. Some first-break schizophrenics today can be successfully treated to the point of returning to school, graduating college, and having full lives with careers and families. The only thing they need to do is comply with medication indefinitely. Others are not so lucky—even the best medications do not work that well for them. And most do not comply with medications indefinitely, which is a different issue, and one that we keep touching upon, and again includes that hazy concept of insight.

One of my patients, when I was a resident, was included in the Clozaril study. He was a fascinating patient and I had actually chosen him as my psychotherapy supervision patient because his delusions were so systematized and interesting to me. He believed that the inside of his body was made of money. He used his brain to control the flow of money all over the world. My amazing supervisor, the late Tomas Agosin, MD, taught me that

these delusions represented one of the fears of all schizophrenics—that they felt as if they were not human and that they were being controlled by a force outside of themselves. My patient's need to control the flow of money around the whole world was his way of taking back some control. He did it with his mind via "mind talk," which was really his way of understanding his auditory hallucinations, of which he was unaware—he had no insight into the fact that he was hallucinating. As an aside, this man, who did not feel human, had his best and most human interval during a time period when I had sprained my ankle and was on crutches. Because my office was on another floor and to get there and back during the allotted time for our therapy sessions could have taken the whole day, somebody had organized me a wheelchair to use for that short commute. My schizophrenic patient would light up during our twice-weekly psychotherapy sessions when he would get to push my wheelchair, call the elevator (push the button for the elevator—possibly saying "call the elevator" is a New York expression), and then wheel me to my office. So we established that he was, in fact, a human being capable of empathy, despite the guidelines that tell us that the psychiatrist has the power and should not exploit the patient, blah blah blah. Sometimes, to paraphrase Dr. Freud, a cigar is just something you smoke. (For the purists or the baffled, Sigmund Freud, father of psychoanalysis and modern psychiatry, at one point became frustrated with his followers who thought that he meant that every single human behavior was sexually motivated, and stated, "Sometimes a cigar is just a cigar.")

Back to our topic of permanent versus treatable brain disorders, and how to tell the difference: My patient was now on Clozaril, and he was pushing me in the wheelchair, and feeling more human, so what was making him depressed? I asked him what was going on with his mind-talk (since he did not know he was hearing voices). The response? Of course he was sad.

"Business is slow," he told me, seriously.

This man had lived with schizophrenia for years. He did not know he was paranoid or hearing voices. He ended up in a state hospital where he believed he was manipulating all the money of the world (grandiosity) via mind-talk (auditory hallucinations). He was there on a forensic status (unfit to stand trial) after assaulting his wife because he had been suspicious of her infidelity and that she had been poisoning him (paranoia). Prior to his complete deterioration, this man had been an engineer with a good job. Remember about the intelligence and insanity traveling together? I can also refer you to the wonderful book *A Beautiful Mind*, by Sylvia Nasar, and the movie, filmed right here, between Princeton and New Jersey, where Nobel Laureate the late John Nash until recently was still seen around town (he died in a car crash just a few days before I finished this manuscript). Both John Nash and my patient suffered from chronic mental disorders that could respond to treatment. These individuals were still smart. They could handle a day in court (for my patient, eventually, after the introduction of Clozaril) or in the Nobel Prize auditorium. But their illnesses were still there, lurking in the very cellular structure of their brains.

What is a temporary brain disorder, then? There are many. A concussion is temporary, although its sequelae can be permanent. You can get hit on the head and be knocked out for a second and be fine. You can get knocked out and wake up in 20 minutes, or an hour,

or a month. There are those rare stories in which someone comes out of a coma after a year or 10 years and sits up as if nothing has happened. I've never witnessed such a dramatic recovery, and I personally am skeptical, but I have no doubt that there are recoveries after long periods of time. Brain injury is a weird thing. Someone who lived around the block from me when I was little got hit on the head and had to learn to walk and talk all over again. Rehabilitation medicine used to focus on these types of brain injuries, and some of these specialists still do. There is a vast body of literature that shows how some people recover brain function thought to be essential to life. This evidence generally suggests that the younger the victim is, the more likely it is that the necessary functions can be taken over by some other part of the brain. However, we also know that perinatal anoxia (the lack of oxygen to the brain around the time of birth) causes cerebral palsy and that the outcome can often be devastating and permanent. The brain is a tricky and fickle life partner, but we are stuck with it. And even though this book is about the brain, it is not that kind of book about the brain. I'm not qualified to write that book, and you are not qualified to understand it, so neither of us is going to pretend that I should go research a bunch of articles about the outcome of anoxia to the posteromedio-lateral bundle of the nucleus incumbens versus the mediofrontal striae of the global meniscus of the pons (these are made up, by the way—my memorize neuroanatomy class was over 30 years ago), and then I will write all that stuff here, and then somehow it will change your practice of law or my practice of forensic psychiatry. We know that there are a lot of detail-oriented scientists doing that sort of research. My dream is that they are going to invent one of those wands like they have on Star Trek, and I will be able to get one and wave it over all my patients, as well as family and friends, and everyone can get a diagnosis and a treatment virtually instantaneously. Until that happens, I will stick with what I can do, and the scientists in the labs will continue to publish, and as soon as anything has actual psychiatric-legal relevance, I'll try to let you know about it.

The point is that if someone has one of the biggies, like schizophrenia or bipolar disorder, these disorders are likely a result of real cellular problems inside their brains. Science is finding those problems, which are most likely at least partially inherited, but we still do not know what they are. Medications can help, but not completely or permanently. Those disorders are permanent, but each individual affected by such a disorder suffers in his own unique way. And he or she will suffer forever. Some days he will suffer more, some days less. At some point she may understand that medication is a lifelong commitment, but by that point, the chance for "normal" may have passed her by. The socioeconomic downward drift will probably have already occurred, she will have lost the support of friends and family, she will have given up on an education and a career. Cognitive decline is part of schizophrenia even in patients who comply with medication, and cognitive impairment is sadly one of the side effects of treatment with medication. Psychiatric disorders might be treatable, but they reside inside the cells of your brain.

So what types of disorders are temporary? We hear about women chopping off their husbands' you-know-whats and then getting acquitted as Not Guilty by Reason of Insanity. They are adjudicated temporarily insane. As a psychiatrist the concept of temporary insanity

is ridiculous, although as a wife…Just kidding. Well, not really. I think that most people have their moments of anger and craziness. Those types of cases are few and far between, and I have never been involved with one of them, so I really cannot speak about them or even speculate from any position of authority. Temporary insanity is probably a legal diagnosis, not a psychiatric one. However, many things can change someone's mental status temporarily. The battered woman defense is an established and meaningful defense in many jurisdictions, as well it should be. Post-concussion syndrome is a form of TBI, which I personally experienced following a car accident in medical school (I was not the driver). The experience was both bizarre and educational. I had something called Raccoon eyes and Battle's sign (basically two black eyes), which was fascinating to all my classmates, since we were rotating through general surgery at the time. But it was the emotional signs and symptoms that were the most bizarre. I was at a happy time of my life. I had survived the car accident, which had occurred a block away from my house. I was in my last rotation of that all-important third year of medical school, the clinical year. I was doing well academically. My personal life was good. But I would burst into tears for no apparent reason. I did not have flashbacks or anything like that—it was not posttraumatic stress or psychological trauma. To this day, I know it was not, because although I can remember everything about the accident, I do not remember the moment of impact or of actually breaking those two windows with my head. I do remember the part where I climbed over the gear box and out the driver's side door, because in the popular shows of the era, like MacGyver, cars were always exploding after impact, so I knew I had to get out of that car immediately, and I was proud that I had thought quickly enough to do so. (Note: Of course the car did not blow up. That only happens on television.) My brain was just scrambled, and it took it some time to quiet down—several weeks, or maybe months. I'm sure my kids would tell you it still hasn't fully recovered after 28 years. At the time I had not heard of post-concussion syndrome. All I knew is that I was very moody, had difficulty concentrating, that what should have been a perfect score on my surgery written exam was not so perfect, and that even though I was hungry all the time, I kept losing weight, which was the only positive part of the car accident (and never happened again after that). I also found a little piece of car window glass that migrated out of my head a week later, right through the glue-in-lieu-of-stitches, which was a sort of new concept at the time, which was interesting but hardly emotionally scarring.

Today we know that head injury can cause permanent brain changes that can lead to very bad things, including, but not limited to, cognitive disorders, movement disorders, and emotional disorders like Pseudobulbar Affect, now with its own FDA-approved medication. Many neurotransmitters with heretofore-unknown roles have been postulated to have critical (that word again) roles in the etiologies of some of these brain disorders. Glutamate and *N*-methyl-D-aspartate are two of the most important neurotransmitters, which once were thought to be incidental—that is, to have no real function. When I started thinking about writing this book, nobody really knew what these substances did in the brain. Today, the pharmacology industry is collectively staying up late at night trying to beat the competition to market with new drugs because these pathways have suddenly

been discovered to be so important. I remember learning as a student that the brain has gastrin receptors. Gastrin is an important hormone found in the gut. I can't wait to learn what it does in my brain. You'd think it would make you hungry, but who knows? It might be in charge of having a sweet tooth, or not liking licorice. You never really know, until one day some genius figures it out.

Some brains recover from being scrambled; some don't. Some brains respond to medications and seem normal; some don't. A diagnosis does not equal a prognosis, but it helps to predict a prognosis. A rule-out diagnosis, on the other hand, gives you absolutely no information about prognosis, so if you are a lawyer and you need to know the prognosis before you can proceed with your case, you clearly need more information. How do you, personally and professionally, proceed in such a case?

First of all, you need more information. If your expert cannot give you at least a choice between two diagnoses (i.e., this is either schizophrenia or schizoaffective disorder), then you are either paying him too much (because he is not really an expert), or you have not provided him with sufficient information. Some lawyers will withhold records when they find them to be unfavorable to their cases. You know who you are. And we know who you are, too. I won't mention places, people, or things, but entire case files have been found stashed in abandoned filing cabinets, where they could not change people's already made-up minds. Experts, too, will withhold information if it does not fit in with their preconceived notions. Even though alteration of medical records is technically a felony, someone needs to identify it and prosecute it before it can be one, so…as the kids say, yeah. Sadly, all of these things happen. I cannot tell anyone reading this book how to practice law, but I can tell you that if you want to build a case including psychiatric testimony, your best bet is to start with real psychiatric information. Figure out what is wrong or not wrong with your client, whether the case is a sex offense, a divorce, or an immigration case. From there, you can move on to a theory of the case, its structure, formulation, arguments, and so on.

That said, it is very important not to withhold information from your expert. The opposing expert is going to obtain the information. If your expert is on the stand and you never provided her with something really important, like an entire 10-year sentence for rape that your client served in another state, and the opposing attorney asks her about it, you better believe she is going to throw you under the bus. Do not ever expect a board-certified psychiatrist to say something like, "Oh, I must have overlooked that trivial detail." I told you about the expert who mixed up the two John Smiths and then wouldn't even take that mix-up back! In a similar case, another expert, or maybe the same one, swore under oath that when he misread someone's handwriting as "foot fetish" (the original text said "denies fetishes" or something like that) that the inmate had a foot fetish which would make him dangerous, presumably to untold numbers of innocent feet. If these psychiatrists are not going to back down over actual, innocent mistakes that they really made, and prefer to perjure themselves rather than admit that they forgot their reading glasses at home, they are not going to take the hit for you not providing them with a full record. Nor should they.

Conversely, if you provide your expert with a full record and a detailed psychiatric-legal question, sit back and prepare to be amazed. Attorney Samantha Hill had what I thought

was a pretty routine testamentary capacity case for me. We spoke on the phone about it. The deceased had been a teacher. When Samantha described the situation, I was a bit puzzled.

"I don't understand," I said, thinking about the expense of such a lawsuit. "How much did she leave?"

"About two," Samantha said drily.

"Two what?" I'm a psychiatrist, remember. The armpit of medicine.

"Two million." A teacher. A spinster teacher, from a Catholic school. *What?*

So I did the case as I always do them, organizing all the records by date, and I found the date on which the deceased had written her will, and I found several people who had interviewed her and even obtained informed consent from her before and after she had made the new will on Legal Zoom (don't let anyone tell you the Internet is destroying the private practice of law! Dr. Google has not hurt my practice much, either!). I wrote it all up, fixed the typos, sent it in, and then Samantha called me, amazed.

"Is this true? Did those records really say that?"

"No, I made it up. Of course—everything was in the records you sent me."

Friends, Samantha Hill had never seen a report like mine, that was actually based on the facts of the case and the woman's medical records and life, and was not a generic letter from some family doctor saying, "Since these medications can cause confusion, Ms. Rich Dead Lady was not competent to write a will on the day in question." You, as an attorney, can try your luck with the generic letter. But be forewarned. You might have me on the defense team, like the two million-dollar Catholic schoolteacher did.

I want to go back now for a minute to the concept of treatable disorders and the revolving door of public psychiatry. We spoke about the effectiveness of some of the newer antipsychotics, as well as the amazing treatments in the pipeline for disorders that have barely been identified. Chances are high that even before these words see print, new medications will be available, or existing medications will be available with new indications. Every day brings us closer to a world where brain disorders can be treated, and permanent brain damage can become less permanent.

The one problem that nobody really knows how to treat, however, is that proverbial revolving door. Patients become mentally ill. They get some treatment. They get a little better. They leave treatment. They get worse. They often get in trouble with the law. They get incarcerated or hospitalized. They get some treatment or at least get locked up. Then they are out on the streets where again they cannot function properly. Again they have social, financial, and legal problems. Again they have to be taken off the streets or out of society. Again they may or may not get appropriate treatment. The best treatments, unsurprisingly, are also the most expensive treatments. Once teaching hospitals provided the best treatments, and some of them still do.

Do any of you have the same bad habit that I do of checking your email on your phone before even getting out of bed? Every day before I even get up, I get an average of three emails asking if I am available for a psychiatry job. Before 7 a.m., eastern time. By the end of the day I generally lose track of how many psychiatric job requests I've

received. The need for psychiatric treatment in this country is ginormous. Psychiatry traditionally has been an enormously labor-intensive specialty. Training was, and as far as I know, still is, four years. We had to learn psychotherapy, psychopharmacology, all the different subspecialties, neurology, internal medicine and/or pediatrics, have individual psychotherapy supervision, do some research, and also take formal coursework, including, in my program, read Freud and his psychoanalytic brethren in very bad old-fashioned translation. I am still thankful they did not expect us to learn German and read him in the original, which frankly would not have surprised me. We had exams, presentations, calls, and then some extracurricular activities which most of us participated in. Also, you know, we were 20-something, so…whatever.

I feel like I gave up a lot to be a doctor. I gave up my twenties. While many of my friends were partying and procreating, I was working and studying. I'm not complaining, I'm just describing. Now there is a countrywide shortage of doctors, but somehow we are supposed to work for less money than we would make working retail, if you factor in the employees' discount. The places where we are needed are often disgusting. I worked in corrections for 10 years. I had a baby while I worked there. I *pumped* in a sex offender prison. Do I recommend this career path for other young women? I don't know. It was kind of fun working there. Would I have preferred having a nice, well-appointed, private lactation room with paid time off and a personal refrigerator and water cooler? What do you think? So when you hear that nobody is going into psychiatry anymore and that thousands of psychiatry jobs around the country are unfilled, you tell me why that is happening. I could work two full-time jobs at Hooters (well, maybe not anymore, at my advanced age), but a young psychiatrist could do that, and make more money than working one full-time psychiatry job, which is about 80 hours a week, making the same money and being treated kind of the same, or maybe even better. And risking her mammary glands to the same fate as I did in the sex offender prison by just trying to do the right thing by my baby.

Treat your experts nicely. Pay them fairly. Give them the whole medical and legal record. Be specific about what you want them to tell you. And in return, you will get a full, thorough report that will help you to get the best possible outcome for your client, and by extension, for you.

I know that again we have veered off the topic, but again every topic has many layers, like an onion, or an ogre. Permanent and temporary brain disorders are on a continuum. Patients do not engage in treatment or counseling and then improve, stop treatment, and get better forever. Your clients cannot take medication for a week and then be cured. Schizophrenia is not strep throat. I did write a book in which a medication caused a gene mutation that was permanent, but that was fiction. In real life, medications must be managed by a doctor, and nobody can predict how a patient will respond to treatment. If you want to calculate a settlement based upon the average response to an average treatment, you'd better have a crystal ball embedded in that calculator. While drugs do come in standardized dosages, you can never really predict how your patient will respond. You never know if a particular individual will respond to treatment easily and well, or if she will need years of therapy. You cannot predict the details of someone's clinical trajectory.

I think it is prudent when you are trying to predict therapeutic outcome for a legal case, to go with the worst-case scenario. Expect the worst and hope for the best. I was hit on the head in a car accident and suffered post-concussion syndrome. I finished medical school, became a psychiatrist, passed all my exams, remained gainfully employed, got married, had some kids, wrote some books, and even knit some sweaters, so I think my outcome was okay. But it is not unheard of that I could have found myself unable to concentrate, dropped out of school, ended up depressed and incapable of doing anything, and would now be working in a convenience store and dropping all the stitches on my knitting. It could happen. And who knows, perhaps, as I keep telling people, I could have been the chairwoman of psychiatry at Harvard by now, had medication for ADHD existed in my childhood and had I never had that bump on the head. Maybe I could have been surgeon general. Nah, Washington is too muggy in the summer!

My point is, besides trying to make you laugh, that we never really can predict future outcomes. The best predictor of future behavior is past behavior, but if the past behavior is a result of mental illness, and we can treat that mental illness, we can modify the future behavior. So in that regard, every brain condition is somewhat treatable. The difference between a treatable brain disorder and a permanent one is not, as we might have thought at the beginning of this chapter, clear-cut after all. The difference is very subtle and a flexible, fluid concept. Yet the general shape of the brain problem, the gestalt, must be identified before the legal case can proceed. TBI must be differentiated from chronic psychosis. The general category of disorder must be identified, and the type of disorder must be identified as closely as possible. The rule-outs must be ruled out. The prognosis must be made and qualified as much as possible. I frequently write:

PROGNOSIS: Excellent with appropriate treatment, poor without treatment.

Is that a sentence fragment that requires someone to pay attention? Yes, it is. Am I being paid to write a report that nobody is supposed to read? That was a rhetorical question. Read the report!! Don't just skip to the end!

Finally, if you are an attorney involved in a case involving a lot of money for someone who has a permanent brain injury, I have just given you a goldmine of legal strategy. You're welcome.

8

Mad v. Sick: Medical Problems Masquerading as Mental Illness and Iatrogenic Psychiatric Symptoms

In previous chapters, we have repeatedly stressed the importance of not missing anything organic when confronted by what looks like a psychiatric disorder. Thus far, these disorders have all included pathology that occurs somewhere inside the head, whether psychiatric, neurological, or some sort of overlap or combination. This chapter will focus on an entirely different topic. These disorders have effects inside the brain, but the original problem is usually elsewhere. Back in the golden olden days, the psychiatric manifestations of medical illness were hugely stressed in both medical and psychiatric training. I did my very first hospital rotation on an inpatient unit led by a liver specialist. He taught our group of students that pancreatic cancer often presents as untreatable depression years before any cancer is ever found. I have made the diagnosis of pancreatic cancer in too many people based on this presentation to even remember. But is there a book about it? Not anymore. The last book I could find specifically devoted to the topic of the psychiatric manifestations of medical illness was published in 1980—the year I graduated from high school.

What does this lack of information mean? Several things. First of all, many people are seeking treatment for psychiatric disorders that are not psychiatric, and they are not getting help because their psychiatrist did not happen to be there on the day that somebody mentioned a bit of trivia. But second, and more importantly, the appropriate mindset is missing from both the psychiatric and primary medicine community. Partly because of ultra specialization and partly because of the pressure from insurance companies to see patients quickly and treat only the presenting problem, doctors do not have the time or the tools to do the types of evaluations and workups we really should be doing in order to fully determine what is going on with our patients.

Subsequently, if you as an attorney are faced with someone who does not feel right to you, and your case hinges on having a client, plaintiff, or defendant who has or does not have the mental capacity for something, you might need to investigate further with the help of an expert. You have done your own mental status examination, as described in Chapter 3, and you have identified the areas that feel off to you. Now you've called your favorite expert, whom you know is ethical, reliable, fair, well-groomed, and well-dressed when she appears in court. The next part is up to you. You have to present her with an appropriate psychiatric-legal question, which encompasses what you want to know about the person. You have to supply all the documents pertaining to the case, no matter how trivial they might seem to you. And you have to present the client for an evaluation.

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You would be amazed how frequently these simple things do not get done. I had an immigration case in which I was retained by the federal government. The federal government! It wasn't like I was being paid by José the landscaper! The guy was being held in a county jail that had a contract with the feds to house overflow inmates. He was a sex offender, and the government wanted to know if he was a sexually violent predator, and if he should be civilly committed under the New Jersey Sexually Violent Predator Act or possibly if removal proceedings should be initiated. I actually do not even recall on what statute they were relying. What I do remember is that even though the feds had ordered the evaluation, and the feds were paying me and paying for the guy to be housed in the jail, the jail people refused to let me see the inmate's jail file, called his classification folder. They only permitted me to see his medical record, which was about 500 pages long—the guy definitely had a psychiatric history. If any of you has ever done any sex offender civil commitment evaluations, you will recall that the statistical instruments utilized to assess risk require a knowledge of institutional infractions and past criminal history. Somehow, the jail administrators got it into their heads that since I was a psychiatrist, I only had a right to see medical records, and that I was there to get the guy out of jail under some abuse excuse mandate or other. They naturally assumed that I was some sort of softie left-wing idiot. For extra fun, they put us in a room next to a dumpster. I did not realize until my interview was done that it was the garbage that stank, not the inmate.

I had to call the person who had hired me at the Department of Homeland Security and make a second trip out to the jail to go through the classification folder and score the risk assessment. I was pretty furious. I know, New Jersey is supposed to be so tiny, but 25 miles to the next county seat can take well over an hour with our traffic. And even the federal government does not pay for travel time.

When I go into the jails and prisons I check and recheck that I will be given access to everything I need. My laptop is another huge issue. Several years ago, when I still worked for the state, I had an injury in the courtroom. (No, I did not sue for worker's comp, and the statute of limitations is over, but thanks for thinking of me). I injured my neck and now writing by hand is torture. I used to have beautiful handwriting—so beautiful that my attending (my supervisor), when I was an intern in pediatrics, would mistake my lengthy, detailed chart notes for the social work notes and skip right over them. Now I have to type, or I would be there all day, and not be able to read my own writing at the end. For me, bringing my laptop into the jail is literally an ADA (Americans with Disabilities Act) issue, although I am not going to invoke it every time—too much of a hassle. We literally have to call about 20 times prior to every jail visit to make sure that I can bring in my laptop. You'd think these days it would not be a problem, but please, lawyers, do this little thing for your experts—make it happen. Get the laptops in. They will be grateful!

So now your expert is in the jail, assuming this is a jail type of case, and she is going to do an evaluation. What type of medical problems might be confused with psychiatric issues? The short answer is, many. Even if we do not consider any neurological or brain

disorders, regular medical disorders frequently disguise themselves as psychiatric illness. The most common one is delirium, which is a brain disorder, but generally occurs in the context of medical illness.

Delirium is an acute brain event that makes a person looks crazy. The primary distinguishing factor between delirium and actual mental illness is that the person who suffers from delirium lacks a clear sensorium. He is generally disoriented to time, place, and/or person. He may not know his own name or how he got to where he is. He may be suffering from hallucinations and may be acutely aware of his hallucinations. Often, but not always, there is a proximal, easily identifiable cause, such as the ingestion of a substance. My sister once had surgery and was given Demerol, a strong narcotic. She then saw our mother turn into a coat. Whatever might be chronically wrong with my sister, it's not that. That was an example of a drug-induced delirium that resolved when the drug was removed from her system.

Many substances can cause delirium. One of the most famous is delirium tremens, frequently shortened to its initials, DTs. You have probably heard of DTs, which is a sign of acute alcohol withdrawal and can be fatal. It includes hallucinations, delusions, shivers, fevers, seizures, and ultimately, death, if not treated properly and in a timely fashion. Other medical complications can and do arise, but in its early stages, DTs can look much like a psychotic episode. I have frequently seen patients brought to psychiatric units or emergency departments in DTs misdiagnosed as psychotic. How does this mistake happen? Easy. Their blood alcohol count is zero, they lie about having used alcohol, no reliable information is available, and they look crazy. Only after a day or two do their vital signs become unstable, and the hallucinations and delusions start to look really organic. The patients begin to shake, their delusions are clearly tactile and visual, not auditory, and only then does it become clear that they require intensive medical support.

Delirium also frequently occurs following surgery, from anesthesia, particularly in older people. When I worked in a hospital, I had postsurgical consultations almost daily. I found it remarkable that the surgeons remained unaware that psychiatric disorders did not spontaneously develop in previously non-psychiatrically impaired individuals following surgery. The surgeons always called for a consultation when the patients were confused after surgery, when they were on pain medications, in a different room, and coming off the anesthesia.

Drugs and alcohol are fairly obvious, and delirium in general is fairly easy, because it either resolves, or the underlying medical condition necessitates some sort of medical intervention. But what about other types of medical problems that cause psychiatric symptoms?

Most autoimmune disorders can mimic some type of psychiatric disorder. When residents train at teaching hospitals, they not only get really proper training but also risk the occupational hazard of working with certain doctors who have the proverbial bee in their bonnet. As I mentioned earlier, my very first supervising attending for internal medicine was a liver specialist, and I learned all sorts of trivia about livers, pancreases, and

the gastrointestinal (GI) tract. I also saw my very first insertion of a balloon into someone's esophagus to stop the bleeding at what I thought was way too young and inexperienced a stage in my career. Like my father, whose parents thought age 13 might be a good time to visit the anatomy lab so that he might one day become a doctor (and who then fainted and later became an engineer), I knew immediately that GI was not for me.

The next hospital rotation was the actual internal medicine course, and that professor was a specialist in autoimmune disorders, especially systemic lupus erythromatosus, known commonly as lupus, or SLE. Lupus is called the great mimicker, because it can present as anything—dermatological illness, kidney disease, even heart disease. The residents in that department told us, the medical students, that for the purposes of that rotation only, we would include lupus in every differential diagnosis (like the rule-outs we were discussing in previous chapters, but these were medical patients with acute medical problems requiring hospitalization). They reminded us of a famous medical student adage: "When you hear hoofbeats, you don't think of a zebra (i.e., you think of a horse)." But for this particular professor, zebra was always on the menu. He would be hopeful for a few days, then all the blood tests would come back for something normal, like a heart attack (remember I went to medical school in the 1980s when things were not as quick as they are today), and by then the patient would be stable, and the professor would have moved on to the next rarity. However, people do get lupus, and they do get all of the weird autoimmune disorders that are in the books. I have at least one of every single unpronounceable and unspeakable disorder patients in my private psychiatric practice. I have quite a few autoimmune disorder patients who have yet to receive an appropriate diagnosis. Thanks to that one rotation and the way we used to include all those disorders as "rule-outs," I have picked up more than a few zebras from among the horses to gallop into my office with vague complaints of pain and depression. They are definitely out there. Your expert should definitely not be saddling up her zebra before doing her due diligence, but knowing that it could be an autoimmune disorder and knowing how to at least screen for one, and then having a little information about the time frame leading up to seroconversion (up to seven years after symptoms start) can be very helpful both in understanding how to proceed with your case and also in how to manage what can be a difficult relationship with a client.

Here is the kicker though: Guess what we give these patients to treat their disorders? Steroids! And guess what happens when you take steroids? You go crazy! Treatment of autoimmune disorders with steroids seems to be a far greater cause of bizarre behavior resulting in legal intervention than the autoimmune disorder itself. People with autoimmune disorders end up having legal problems because they look normal, and their disability insurance companies do not want to pay them benefits. That problem, while legitimate and widespread, is a separate issue. If you are a disability lawyer, you will encounter it. If you are a lawyer for a disability insurance company, you will try to get your company to avoid paying by making some sort of claim that the problem is psychiatric, psychological, invented, or something. Let me save you the trouble: autoimmune disorders are devastating. While many people have "light" autoimmune disorders that they work

through on a regular basis, just having one is difficult. Having one that requires a mental map of every toilet within a 30-mile radius, one that means you cannot walk up a flight of stairs without fatigue, or one that means that you cannot eat normal foods without breaking out in hives—think about it. Maybe the workplace is threatening and scary for those people. Maybe they really cannot work. Maybe normal people would prefer not to have those problems and go to work, rather than sit at home watching the world pass them by but knowing where the bathroom is at all times.

Anyway, back to treatment with steroids. Just in case anyone reading this does not know—steroids are a real thing. Our bodies create them and utilize them for many things. We have many steroid-based hormones in our bodies. We cannot survive without appropriate amounts of steroid hormones. Our sex hormones are steroids, and cortisol is a steroid. Without these we have grave problems and serious diseases.

Synthetic steroids have also been used for many years for a variety of applications. They are commonly used for the treatment of autoimmune disorder flare-ups, including disorders such as asthma, ulcerative colitis, Crohn's disease, rheumatoid arthritis, lupus, myasthenia gravis, and all of the other disorders that present with those dreaded nonspecific physical symptoms. Steroids work. Many asthmatics—people you know, who may sit next to you at work, or at church, or who you play cards with sometimes—are alive because they get steroids when they need them. Many people hear the word "steroids" and totally freak out, believing that steroids are an evil worse than heroin, and they somehow do not understand that steroids are critical, lifesaving medications that must be used when needed.

Steroids are also available over the counter. That cortisone cream you put on your poison ivy? Steroids. The now over-the-counter Flonase you use for your seasonal allergies? Steroids. The stuff in your birth control pills? Steroids. If this information is scaring you and you don't believe me, and you need to go ask Dr. Google, feel free. I'll wait right here.

Okay, you checked, found out I'm right, and now we can move forward. Here is the problem. When someone takes systemic steroids, the effects can be markedly different than when we put steroids in cream form on our bug bites. Steroids do have all sorts of unintentional side effects. For our purposes, we will assume that the steroids in question are not the illegal kind—those exist, and they are more suited to building up muscle mass and decreasing testicular volume than they are to treating autoimmune disorders. They too have effects on emotion and cognition, but presumably their involvement in your legal cases will come about in a different way than what I am discussing right now, which is the iatrogenic causes of psychiatric problems.

When a doctor gives a patient a medication to make a medical problem better, sometimes that problem gets better but a different problem gets worse. A typical and common example is weight gain. Many antipsychotic medications cause weight gain and the concomitant metabolic problems. In fact, there is some controversy in the literature about whether the weight gain causes the metabolic issues, or whether the medication causes all the problems. This weight gain–metabolic syndrome issue is an example of an iatrogenic problem. Another one that you might have heard of is something called

nosocomial infection—infections that are created in the hospital, and are often with very bad pathogens like the famous MRSA—meticillin-resistant *Staphylococcus aureus*—becoming very hard to treat and resulting in devastating losses of life and limb. Because of the way healthcare is delivered, sometimes the treatment is worse than the disease.

Most of these problems are not psychiatric. But in the case of corticosteroids, the treatment very frequently can result in what looks like mental illness. Very early in my career, I was taught that if a patient with a known autoimmune disorder presents with psychosis, it can be either the disorder itself or the treatment causing the clinical presentation, and it is very unlikely to be an actual, independent psychotic disorder. You can't really know, and you also cannot withdraw the treatment because the underlying medical problem will worsen, possibly to the grave danger of the patient. So you provide supportive treatment for the patient and hope for the best.

I was involved in such a case a few years ago. Naturally, it started with a divorce, which had occurred years prior to my involvement. I say naturally because if there is no conflict, and families are involved and supportive, they can handle quite a lot of strangeness and inappropriateness. We don't generally hear about the amicable divorces (if they really do exist, which I sort of doubt, but that is a completely different topic). These parents had been divorced for years when the mother's physical condition became inexplicably bad, and she eventually incurred a diagnosis of lupus. She continued to work. This entire incident was prior to the explosion of biologics (a class of medications now used instead of throwing steroids at everything), so whenever the woman had a flare-up, her doctors would give her pulse steroids—very high doses of steroids, then taper down in the hope that her symptoms would resolve. She also had several children that her ex-husband was constantly trying to remove from her custody. As in many such nasty divorces, he merely wanted to hurt her. The kids were fine and had no particular problems bouncing between the parents' homes, or not any more problems than other kids in similar custody arrangements had.

We know that athletes who take anabolic steroids do crazy things. We've heard of "'Roid rage," and the concept has even been used, possibly even successfully, as a criminal defense. Yet until this particular case crossed my overloaded desk, I do not think that the New Jersey Department of Children and Families had ever heard of such a concept outside of the world of competitive sports.

On one particular occasion, leading to my involvement in the matter, mom had the kids and also was having a flare-up. She was a dental assistant. She was holding it together with her patients but anything to do with her divorce and her ex-husband just pushed her buttons, and those steroids gave her a short fuse. She was able to get to work, but on this one particular day when she arrived home, one of her teenage daughters had done something that teenage daughters unfortunately do—she had sent a sexually explicit text to a boy. Not a totally innocent thing, but also not something completely out of the norm for a fairly normal teenage girl.

Mom went ballistic. She ended up in the hospital psychiatric emergency room. She grabbed a pair of scissors and cut off her daughter's beautiful long hair. Her immediate

goal was to make her daughter sexually unattractive so that boys would not be interested in having her "sext" them. (By the way—did you know that "sext" is now recognized as a word by spellcheck?) The daughter, unsurprisingly, called her father to pick her up because mom was acting crazy. The staff in the psychiatric emergency room, unsurprisingly, called Child Protective Services and the police. The only mildly surprising part is that no actual psychiatrist ever spoke to the mother. Only a social worker made an assessment of the mother, and that social worker decided that she was not a real danger to herself, and only a potential danger to her children, primarily to her children's hair. Although at some point somebody asked about medical problems and medications, nobody made the connection between treatment with steroids and crazy, inappropriate behavior. The children were removed from their mother, which at that moment in time was not inappropriate. What was inappropriate was the subsequent move on the part of the state to move toward the termination of the mother's parental rights to her children based on a mental illness that did not exist.

The father, of course, was happy as a pig in poop. He wanted to deprive his ex of her children, without any concern for what might be best for them in the long run. The children repeatedly told every interviewer that their mother was not normally like that, that she had never done anything so crazy, that they knew she was sick with "that lupus thing," that she took some medications but that they did not know what the medications were, and that she had been extra angry recently, but they did not know why. The state did not interview the mother's doctors. They did request a psychological evaluation, which resulted in the usual computer-generated nonsense about how people with this type of profile might have a clinical diagnosis consistent with some personality disorder or other. They did not have any expert review the mother's medication list. Nobody asked Dr. Google what lupus was or what its signs and symptoms could be. Nobody looked up prednisone to see what class of medication it was or what its side effects might be. They did send the mother for a substance abuse evaluation, concerned that perhaps she was using illicit drugs, but since she denied them, the geniuses at the drug abuse center also did not bother to inform anyone that prednisone could cause changes in mood and behavior.

By the time the case got to me, the father almost had his revenge against the wife who had left him: he almost got his kids back full time. There was a lot more to this story (and it included this man raising his hands against this woman, but not against his children), which should have come into the ultimate custody arrangement, but did not. Fortunately for this mother and her children, they got assigned me as their psychiatric expert. The funny part is that even though I spent half my education looking out the window and the other half reading a book (when I wasn't talking in class), I was paying attention and I picked up on the steroid/lupus situation immediately. I wrote up the case and I explained to the court that this family needed to have a backup plan for care of the children if and when the mother needed to go on steroids in the future. Not that hard, right? They actually understood. The custody arrangement remained unchanged, the kids continued to have a relationship with both parents, the father did not get to raise his children unilaterally and poison them against their mother, and the mother got to have lifesaving treatment with

steroids when necessary and not lose her parental rights to her children. Imagine that! All by enlisting the help of the two grandmothers and a couple of aunts and neighbors. I don't know if the teenage daughter ever got her phone taken away for sexting, though. Personally, if it had been my daughter, she would have gone to convent school—and I'm Jewish. Which is probably why God only gave me boys. But again, I digress. We must now turn to the biggest mimicker of insanity, a topic which needs its own chapter, and which really should have its own book: Substance Abuse.

9

Drugs v. Your Brain

Substance abuse is the biggest mimic of insanity. Substance abuse is its own area of expertise. It has its own fellowship within psychiatry, and has its own fellowship within other medical specialties as well. Countless books have been written; movies have been made; therapists train as substance abuse counselors; billions of dollars are dedicated to different types of rehabilitation programs; candidates run and win or lose based upon whether or not faith-based programs should accept federal dollars for substance abuse treatment. The list could go on and on and on. I cannot begin to even list all of the different ways in which substance abuse influences the very fabric of our society. Children are taught as early as preschool to beware of using drugs. I personally was shown a movie called *The Littlest Junkie* back in fourth grade at P.S. 187, in which we watched a heroin-addicted woman give birth to an addicted baby. The problems caused by illicit drugs and alcohol in the United States are estimated to cost this country approximately $366 billion yearly.

I also cannot begin to list all the ways in which drugs and alcohol impact the criminal justice system. We know that the majority of inmates locked up in all penitentiaries in the United States are there because of drug-related offenses. Forty-nine percent of all US inmates are incarcerated on drug charges. If we add inmates convicted of other offenses not directly linked to drugs but somehow related, such as robberies motivated by needing money for drugs, we can ratchet up that number considerably. In trying to find information to present in this chapter, I was overwhelmed with the sheer volume of contradictory and unsupported claims all over the Internet. In my daily work, I receive hundreds of pages of so-called substance abuse evaluations that seem to be based upon little else than someone's opinion of what substance abuse is or is not. Any medical evaluation seems to be limited to the self-report of the person being evaluated and a supposedly random urine toxicology screen that is always administered on the day that the person appears in court. There are no standardized rules for substance abuse evaluation, treatment, prevention, or interpretation in legal settings. The bulk of my forensic work still revolves around the family courts, and parents who, for one reason or another, lose custody of their children. In these cases, the use of any substance is considered taboo if it is illegal, but perfectly okay if it is a substance prescribed by a physician. Except if the person using the substance is a former heroin addict now stable on methadone or another prescription medication used to prevent the use of street drugs—then suddenly the social workers and the courts are not happy and think that these parents cannot parent.

Let me describe this situation in more detail, so I can start to explain what some of these issues really are. Clearly, we cannot cover every single psychiatric-legal issue which might touch upon a substance abuse situation. The possibilities are virtually infinite. We have barely mentioned alcohol, which is not a new crisis, but remains a chronic one. Kids, and adults, still drink. The local famous university has, at last count, 23 observation beds

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for drunk students who cannot be sent to their rooms overnight. Rumor has it that those beds are full every night, and on weekends, the overflow goes to the local hospital.

We touched upon Delirium Tremens, or DTs, in the previous chapter, but, to reiterate, DTs are the syndrome of medical withdrawal from chronic alcohol dependence. This syndrome can result in dangerously high blood pressure, seizures, and death, in addition to the shaking, hallucinations, delusions, and bizarre behaviors that are scary and dramatic but not life threatening. However, acute alcohol intoxication is not without its risks, and can result in many ill effects, from stupid decisions, to car accidents, driving under the influence of alcohol, violence, impulsive decisions with long-acting consequences, psychotic-like syndromes, mood symptoms, hallucinations, unconsciousness, physical illness, vomiting, and everybody's favorites, sexually transmitted diseases and unplanned pregnancies.

Alcohol use over time can cause medical problems. It can cause cirrhosis of the liver, and possibly liver cancer. It causes brain damage, which presents as a psychiatric, neurological, or perhaps neuropsychiatric manifestation. Wernicke–Korsakoff syndrome can result in one of the few real amnesias psychiatrists meet in their careers. This syndrome is technically two unrelated disorders that occur in alcoholics. Wernicke's encephalopathy is caused by thiamine deficiency and presents as an acute state of mental confusion, ataxia, and ophthalmoplegia. In English, these last two words mean unstable gait and eyes that do not move properly, respectively. While occasionally thiamine deficiency can be caused by other factors and the resulting syndrome can present identically, the original syndrome described by Polish neurologist Carl Wernicke in 1881 was seen in alcoholics whose thiamine intake was deficient because of poor nutrition in combination with other gastrointestinal factors related to alcoholism. All alcoholic and intoxicated patients get thiamine in the emergency room, just in case.

Korsakoff's amnesia is a late neuropsychiatric manifestation of this thiamine deficiency in which the damage to the brain becomes permanent. Korsakoff's therefore presents with memory loss, including both anterograde and retrograde amnesia, and confabulation. The initial phases of the disorders, the Wernicke's phase, can be treated with emergent administration of thiamine. Once the disorder has progressed to the Korsakoff's phase, the disorder is thought to be mostly permanent.

Although alcohol has been around prior to recorded history, and presumably alcoholism has been around just as long, alcohol is legal. And although we have numerous legal opiates—too many, if certain outspoken vocal activists are to be believed—it is the illegal drugs that garner most of the attention. I met former New Jersey Governor Jim McGreevey at a conference this past spring. He was incensed at how easy it was for people to obtain prescription narcotics in emergency rooms. I spoke up and said that some people needed those narcotics to manage their pain—don't forget I had experienced a broken knee two years earlier, so I knew pain. But I had never known addiction.

The former governor and I had a little exchange of values before we both simmered down and realized that we were on the same side. Neither one of us wants to see any increase in addiction rates. Mr. McGreevey currently works in New Jersey helping addicts reenter the community after being incarcerated. He turned out to be a terrific guy in

person, very charismatic. I could see how he was elected governor. He not only works directly with recovering addicts reentering the community and the workforce after prison, he sometimes actually represents them in court, since he is an attorney. We need more people like Jim McGreevey out there in the trenches, working to keep the addicted off drugs and in homes and jobs, living productive lives. Unfortunately, the United States ranks far behind most Western nations when it comes to the management of opiate addictions.

Exact information is hard to find, especially because nobody really seems to have studied it. One leader in the field of addiction medicine in the United States is Russell Portenoy, M.D. Dr. Portenoy apparently sparked controversy, though, when he encouraged more widespread use of opiate analgesics to treat pain back in the 1990s. He claimed that "only" 15 percent of patients had the potential to become addicted to opiates, and therefore the benefits of treating pain with opiates outweighed the risks. Unfortunately, in 2012, Dr. Portenoy, the Chairperson of Pain Management at Beth Israel Medical Center in New York, the first such department of its kind, recanted, saying that perhaps more than 15 percent of patients might become addicted, and perhaps opiates were not so great after all. There were other problems involved, including the financing of his research by the makers of a well-known opiate, and the push to make pain the fifth vital sign, which it now is, although it cannot be objectively measured (the other vital signs are temperature, respiration rate, heart rate, and blood pressure, all of which can be objectively measured). But this 15 percent figure is fascinating to me. Most people who take opiates for one reason or another do not get addicted. Yet 15 percent of all the people who were ever prescribed an opiate for any reason, in a society where opiates are so widely prescribed, is a lot of people. Some authors estimate, though, that as many as 50 percent of human beings exposed to opiates have the genetic predisposition necessary for addiction. And other studies claim little to no genetic predisposition—that is, some authors believe that anyone can become addicted to opiates, given the right external environment.

Personally, I disagree with the idea that anyone can become addicted, because some people just do not like opiates. I took Percocet when I broke my knee, and then when I had my knee surgery, and I hated the opiates. They made me cranky and nauseated. I couldn't wait to stop taking them. But I have had patients tell me: "They make me feel like I own the world." I have never felt like I owned the world. But if a pill made me feel that way, I'd probably want to take another one. That difference has to be genetic. There is no other explanation. My brain is different than the brain of the patient who felt that way. In her brain, dopamine pathways are activated by Percocet. In my brain, something else is activated—maybe those gastrin pathways that don't seem to belong in our brains. In her brain, she feels rewarded and powerful. In my brain, I feel lethargic and nauseated. Little money is spent on researching these differences. Little money is spent on treating addiction. Other countries do much better. But I do not think there is a psychiatrist, an attorney, a medical doctor, or a human being anywhere on this planet who has not encountered the devastation of opiate addiction in some form or another. We need to be aware of addiction and we need to know about treatment options other than throwing people into jail.

An American Epidemic is a new documentary, which was just completed in 2015. I spoke to the producer, Lawrence R. Greenberg, about his experience making the film with director Michael DeLeon, and what he learned throughout the process.

"I learned that there's some sort of a stigma or shame associated with mental health in general and addiction in particular that prevents people from being honest and talking about it."

"A million little things that indicated that—when I would read the obituaries they would never mention the cause of death—(the obituaries would say things like) 'died suddenly, cardiac arrest in a young person'—these are young people. Another thing making the movie taught me was that people weren't talking about addiction—every place we went, we would ask them where is the addiction problem worst, and they would say 'it's worst here.' Everyone thinks it's worst here—wherever 'here' is. People are not sharing. They are not talking honestly."

"I heard these parents saying how their children were suffering from addiction, but these families were shunned, and hiding the addiction problem, and nobody was supporting them either before or after their child's death. If the child had been contagious, people would not have been keeping their children away the same way. People with *HIV* did not have the same type of shunning. If their child had cancer, they would have had casseroles and candlelight vigils. Addiction is now the number one cause of accidental death, more than car accidents, but it's a secret cause of death, and nobody is talking about it."

Lawrence told me that we have money for full treatment until you're cured for medical diseases, but for substance abuse "we sort of have a little bit of money for acute illness." I've observed this problem with my own treatment patients. One young man was addicted to heroin but was too anxious to even try to get off it or to enter a treatment program. Very recently, after treatment with medication and psychotherapy for anxiety and depression, he finally mustered the courage to enter an inpatient rehabilitation program. Five days later he was deemed "treated" and discharged. He came to see me last week and explained that he knew he was not ready to leave. The day he was discharged, he smoked marijuana. The next day, he bought and snorted heroin. About a week later, he realized he could not cope and finally attended a Narcotics Anonymous meeting and has been struggling to stay clean and sober. The inpatient program provided no instructions, no aftercare, no method for maintaining sobriety, and even told him that he should not be taking psychotropic medications for his depression and anxiety because they were a "crutch." How these so-called substance abuse professionals expected this young man to stay off drugs under these circumstances is beyond me. It is a credit to his own inner strength that he is willing to try.

Lawrence told me about a new concept that the movie discovers and discusses called Harm Reduction. This protocol has been successful in Europe, although it has barely been introduced in the United States, and just as I was working on this chapter, we had a glimpse into why. Harm Reduction is based on the concept that opiate addiction cannot be eliminated in some individuals—it can only be managed. So medical programs substitute methadone, Vivitrol, or even heroin in a supervised, safe way. "You treat the

crime problem rather than the addiction problem," Lawrence says. In his movie, different people offer suggestions about what the real solution to the drug problem might be, and in the end (spoiler alert!) the answer is that different addicts might require different solutions, different treatment plans, and different lifetime interventions. The goal of treatment is to give these people back their lives and to prevent their ongoing involvement with the mental health and criminal justice systems, as much as possible.

I told you that we had a little preview into why the Harm Reduction model might not work here in the United States. Lawrence had sent a copy of his movie to someone who had expressed an interest in reviewing and promoting it. I happened to be speaking to him when the potential reviewer sent a message stating: "We do not agree with the idea of using medication to treat addiction, and we do not believe that the science supports this plan, so we cannot endorse your movie."

What a blow! A blow to the moviemakers, but also a blow to science, to psychiatry, and to the legal system. We know that the by-products of addiction—criminality, the destruction of families, early death, living outside the rule of law, poverty—all those things are what destroy lives. Heroin itself, ironically, is not really dangerous in measured quantities. Yet in this country, the concept of reducing harm is not widely accepted at all. The concept of addiction as a brain disorder is not really accepted, despite the fact that we know that there are different types of opiate receptors in different people that make some of us more susceptible to addiction than others. As in so many things in the United States, we can choose to believe or not believe in science.

People interviewed for the *American Epidemic* movie did not talk about the reward properties of opiates, but they did talk about how they kept returning to using. And to support their habits, women turn to prostitution, and men turn to crime. Usually these addicted people will not tell anyone how they support their habits. As a psychiatrist, I was taught early in my career to ask, "How do you support your habit?" I mentioned elsewhere in this book an early patient I met who had stolen his parents' dryer right out of their laundry room. People will steal anything. That dryer was from the days of crack cocaine, but to support a drug habit people will sell anything, even their own children. People like me who have never experienced that sort of craving cannot imagine how powerful it is. We judge, but we do not understand, and I think it is important to at least make an effort to understand what it might feel like before we judge. Here is my personal story of what I think it might feel like, and it is not the kind of thing you might be expecting at all. It's just an example of not being able to control something, no matter how much you might want to.

Two years ago I broke my knee skiing. I tore three ligaments and had a fracture of my tibial plateau. Also, saying I broke it skiing is really a euphemism, because I broke it falling. On a green. Also, I'm including this story in case anyone thinks I've been showing off that I'm a smarty-pants: I'm a terrible skier.

Two days later, I was due in court in Newark, NJ, on a Termination of Parental Rights case. Of course, I had to reschedule. The court was kind enough to adjourn to a few weeks later. By then, I was a little more proficient on my crutches, but still presurgery. I left home early that morning not feeling right, and I knew it was not my knee. I couldn't even drink a

cup of coffee. By the time I was sworn in I knew. It was stomach flu. And I had no warning, and because I was on crutches with a broken knee, I couldn't run. I said excuse me, stood up, and threw up right into my hands—my hands!!—in front of the whole courtroom.

Let me tell you my dear readers, there was no way I could have stopped myself. If I had to rank a list of things I never wanted to do in my life, I would have put "throw up in front of judge and everyone else in courtroom" way below "inject heroin." I was not given that choice. It happened. In my mind, that is my barometer for what those people experience when they HAVE to have that fix. They do things that they would have never dreamed of doing if they were not addicted. Things they could not conceive of anyone else doing. I once evaluated a woman who hid while she watched her house burn down with her children in it because she was high on heroin. I treated a psychiatrist from an elite Ivy League medical school who kept getting put on leaves of absence because she could not stop using heroin. I worked with a brilliant psychiatric resident when I was a young attending. I couldn't figure out why he was there—he was much older than I. A mutual acquaintance died (from cancer) and he asked me to convey my condolences. I got the story from the widow: this man had been an anesthesiologist who lost his license in another state forever—he couldn't stop using the drugs on his anesthesia cart. A religious, family man, smart and nice. I could go on and on, so many stories, personal and professional. Brilliant, motivated people. People who saved lives, many lives, who helped me in my own life when I needed them. When we talk about "Mad versus Sick," the concept of substance abuse has to be the star, because especially when it comes to opiates, we as a profession are in our infancy. I would just ask everyone involved with these cases to remember my story of how I could not stop myself from throwing up in that courtroom, and imagine how it feels for some people to not be able to stop themselves from doing something they really don't want to do, like procure and use heroin, no matter the personal cost.

In our interview, Lawrence Greenberg told me that his movie will tell its viewers that the Anonymous programs are no longer good enough. He thinks that judges want to see people get meaningful treatment for their addictions, and we need to come out of the proverbial closet and not be anonymous anymore. Different methods of treatment are okay, and the different types of treatment programs need to acknowledge each other's existence and work together because they are all fighting the same enemy. They are never going to win by staying separate and fighting with each other. The faith-based treatment places are never going to give out methadone, and they are not going to give you a medical professional, so maybe they need to treat the non-opiate addictions. The lawyers on both sides need to understand that withdrawal from some substances, particularly alcohol and benzodiazepines, can be fatal. Nobody expects a 30-day prison sentence to be a death sentence. Public defenders need to ensure that their clients get detoxed before they go into the jails, or the jails have to provide detox programs. There are drugs in the jails and prisons, but nothing in the quantities available on the streets.

I've worked in prisons. I know that patients who have dental abscesses have to treat the pain with ibuprofen. I know that tomatoes make the best "hooch" (prison liquor). I know that chapstick is contraband, because when I got there I was not allowed to bring it in.

The prison where I worked was not so picky—I was allowed to bring in my chapstick. This prison only allowed me to bring in my pen and my prescription pad, because they hadn't had a psychiatrist in a month, and one inmate had reportedly made a suicide attempt the previous Tuesday. The day I wasn't allowed to bring in my chapstick was a Friday, and that inmate was being discharged on Sunday and needed his prescriptions.

"A suicide attempt? On Tuesday? How?" I was astonished.

"Yes, he took an overdose of heroin."

"I don't understand. I thought this was a prison, not a jail. How long has he been here?"

"Ten years."

"Ten years. Wait. He's been here for 10 years and he took heroin on Tuesday and tried to kill himself? And no psychiatrist saw him? And you want me to write him some prescriptions and send him out the door with no aftercare on Sunday?"

"That's how we do it here."

"But where did he get the heroin?"

"Probably one of his visitors brought it to him."

"Okay, let me get this straight. The visitors are allowed to bring in heroin, but the psychiatrist is not allowed to bring in a chapstick?"

This story is true. I have no idea what happened to that inmate, and I did write him his prescriptions. He told me he no longer wanted to kill himself, nor use drugs. I documented it. I only think about him about once a week now, which I suppose is progress—it happened about 16 years ago.

You can't teach empathy to doctors or to lawyers, or to sex offenders either, despite treatment programs that claim they can. You either have it or you don't. But when you think about whether someone is crazy or if they are sick, or both, think about this chapter, and the previous one, before you think about how bad they really are. Mad versus sick. Is it possible to be both? Or is there another option? Are you reading this chapter thinking, these drug addicts are just bad people? Or maybe these are psychopaths, as we will be discussing in Chapter 11? Maybe some are bad, some are sick, some are psychopaths, and some are something else. Maybe some have been abused to the point where they cannot make any rational decisions at all. I hope that at least your minds are now open to the fact that there are different possibilities to consider when someone who looks crazy crosses your path.

10

Mental Illness v. Hearing Voices—Malingering, Its Copycats, and Its Implications

Malingering is faking sick. That's the simplest explanation, and the easiest to understand. It is also the easiest to spot, but probably the rarest of all the fakes to actually occur. Sure, kids malinger all the time when they need a day off from school, but the days when they are actually feeling sick but are there is really nothing physiologically wrong with them are probably much more frequent. Other types of disorders that do not have physiological bases may be more common than malingering, but we always tend to think of and look for malingering first.

Unfortunately, as a profession, the mental health field has not come up with a good test for malingering. Back in my forensic psychiatry fellowship days, people were trying to devise instruments that would identify liars. When I worked with the civilly committed sexually violent predators, we used to administer polygraph examinations to the sex offenders to determine whether they had withheld offenses during treatment or if they had actually made the treatment gains they had claimed to have made. Never mind that I personally had beat the polygraph when we did an experiment in psychology lab in college. I just now Googled "beat the polygraph" and obtained about 275,000 results in 0.44 seconds. While the federal government does not permit the results of polygraphs as evidence, wily attorneys have found all sorts of ways to get polygraph-enhanced evidence into trials. Law enforcement at every level and in every jurisdiction in the United States relies very heavily on polygraph evidence for everything from hiring new officers to interrogating suspects. The polygraph, for those who may still not know, is a pseudoscientific but high-tech-looking instrument (really a group of instruments) that measures primarily something called the galvanic skin response (a fancy word for sweating, or the electrical conductivity of sweat), which is thought to be indicative of lying—that is, you lie, so you sweat more, so the electrical conductivity of your sweat increases. It also measures associated vital signs like pulse and respiratory rate. Polygraphers seem to believe mightily in their craft. I've worked with and spoken to several, and I've never had the feeling that they were scam artists. But when we did the lab in college, it went something like this: we had to pick a card. Then, our lab partner showed us a bunch of cards while we were hooked up to the polygraph, and at the end, the polygraph was supposed to tell them which was the "right" card. These were ordinary playing cards, but we were not, if I remember correctly, playing with a full deck (no pun intended). I decided right up front that I could beat the polygraph, so I chose to focus on a different card in every round. Guess what? I "beat" the polygraph. This lab was years

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before Google and when the Internet was just a twinkle in some computer geek's eye. So if I, a meek psychology student in a school so nerdy that psychology was a lab science, could figure out how to beat a polygraph, you can believe that a bunch of psychopaths sitting around in prison with nothing to do but sweep the floor for five minutes a day can figure out how to beat a polygraph. Some of the ways I found just on the first page of my search: drink a lot of coffee, put a sharp stone or thumbtack in your shoe, squeeze your butt cheeks together hard, do those things while answering truthfully, and a whole bunch of other things. The idea is to mess up your resting heart rate and metabolism so that when you do lie, the instruments won't move much. These techniques are meant to work for "normal" people, and I believe they do. When we move on to psychopaths, in the next chapter, you will see that all of our assumptions about polygraphy, normal human emotional responses, and the ability to experience empathy and general autonomic arousal, are completely misplaced. Psychopaths are practically a different subspecies with their own characteristics and certainly with their own body of research literature to peruse.

In this chapter, let's focus as much as possible on people who are not psychopaths, but who either fake mental illness or who have mental illnesses which seem to fake other illness. This group of disorders is fascinating and weird. Malingering, as we mentioned above, is faking an illness for some sort of gain. Children pretend to be sick so they don't have to go to school. Maybe they have a test, maybe they didn't do their homework, or maybe there is a world premier of some Japanese anime show online at exactly 11 a.m. that they don't want to miss. Adults usually pretend to be sick so they don't have to go to work. Sometimes they hate their jobs; sometimes they just don't want to leave their cozy beds where their new partner will be spending the whole day alone. These examples are sort of entry-level malingering. These individuals are not actually faking any signs or symptoms—they are just calling in sick, except for some really creative children who might draw chicken pox on their faces with felt tip pens, back in the days when we had chicken pox. But I think that most people have occasionally at least felt the urge to take a "mental health day" and called in sick when they were actually perfectly healthy, physically. They might have really needed the "mental health day," but thus far, psychiatry does not have parity, remember, so we are not permitted to take days off for suicidal ideation or just for feeling emotionally lousy, even if those feelings are legitimate and deserve a day off. So the typical reader can understand the basic motivation for malingering.

Now, in the words of one famous television chef personality, let's kick it up a notch. Let's pretend that you are maybe not such a nice guy. Let's pretend that you are a nice-ish guy who has secretly harbored a sexual attraction toward prepubescent girls since you yourself were a prepubescent boy. Now you are dating a very nice, pretty enough, stressed out, single mother, and she happens to have a couple of daughters, one of whom happens to fit your profile: eleven years old, cute, friendly, and looking for daddy. (I hope this sounds awful, but please keep reading). And your new girlfriend is so happy that she can trust you, her new man, with her children, because you are so trustworthy, honest, a hard worker, a good provider, everything that son-of-a-bitch who actually fathered her children was not. She is thrilled every time you offer to watch the girls, so she can have a night out with her coworkers. What she

doesn't know is that every time she's out, the four-year-old is asleep by seven, and you and the eleven-year-old are getting it on, first on the sofa, and later on, right in the master bedroom.

Don't stop reading. I know this is horrible. I know you want to believe that the only people who do these terrible things to little girls are the psychopaths we are leaving until the next chapter. I know that you want to deny that the most likely person to abuse the children is the mother's boyfriend. I didn't have another good chapter to put it in, so I just stuck it here. So let's live with it, because it helps me to make my point: as soon as girlfriend/mommy walks in on her boyfriend and her daughter in bed together, and she cannot possibly deny what is actually happening there, boyfriend jumps out of bed, pulling on his pants.

"Oh, baby, oh my God, I'm so sorry—I don't know what happened to me! I don't know what came over me! I—I thought she was you! I swear! I feel horrible! I…(wait for it)…I'm going to kill myself!!"

Did everybody see that little trick? Who is the victim here? The first victim is the young girl. The next victim is her mother. The child molester is no victim. He's the perpetrator, and despite whatever desires he might harbor, he should know better. He made a choice to act on his desires—to seek out a woman with a child in his demographic, to groom that child, and victimize her. Are there other kinds of pedophiles? Absolutely. But in this particular anecdote, we are focusing on this one, the one who consciously and deliberately looks for a victim that suits his needs. In all other areas of his life, he is "normal." But as soon as he gets caught, he is suddenly a victim—or he plays one in front of his audience.

Sadly, I have had both many patients and forensic evaluees like this man—he is actually a conglomerate of many men I have evaluated over the years. I kept his victim's age at eleven in memory of the first victim whose abuser I had the honor of outing early in my career. That man, technically a patient (we all remember the difference by now, right?) tearfully told me he suddenly wanted to kill himself after molesting an eleven-year-old girl, the daughter of his girlfriend. I wrote his admission note and his discharge note in the same document, and I called it that: "Admission/Discharge Summary." I wrote about the incidents leading to his being brought to the hospital, how he told the police he was "suicidal" when they came to arrest him, how he had absolutely no history consistent with any signs or symptoms of any mental illness (beyond pedophilia, which I think at that historical point was not a *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnosis, although I really cannot remember). He was not at risk of suicide—he was at risk of jail, and possibly at risk of homicide, if the jail inmates learned what his charges were. What was this man doing? He was malingering, he was pretending to be sad and remorseful and even suicidal, in order to try to save his own butt.

I don't know the legal outcome of that case. I have worked with many sex offenders and sexually violent predators, and I will tell you right now that they are not all like this man. Some of their stories have literally moved me to tears. However, this story illustrates very clearly how someone can try to use a made-up mental illness or symptom (suicidal ideation) in order to prevent an undesirable outcome (incarceration). The lack of sophistication of his malingering was one point against him. Perhaps if he could have successfully malingered

schizophrenia, he might have had a shot. I can tell you about real schizophrenics who also molested children. Those cases were some of the heartbreaking ones, because even though they were truly psychotic, they were still dangerous. In one case, the man was in a forensic hospital on an insanity defense that he had won when I was still a child—so long ago that I had not been old enough to understand the news stories when they came out, or to remember them. He had told me with tears in his eyes how Jesus had told him to sacrifice the little boys. And I asked him if Jesus was still telling him to sacrifice boys and he whispered, crying, "*Si*." (Yes). He died of kidney failure not long after, without ever again feeling the rising morning sun on the beach in his home of Puerto Rico shine upon his face. Pedophile? Probably. Psychotic? Definitely. Tragedy? Absolutely. But a totally different type of case. No lying, no malingering, just psychosis and insanity.

Back to malingering. Often people will malinger in order to obtain some sort of primary and secondary gain. Those two concepts are a bit confusing, in my opinion, because their definitions seem to have changed over the years. Currently, primary gain is the first clear gain that a person obtains by doing whatever it is he is doing. For example, a person will say he is suicidal, and he gets medical attention and a hospital bed. That is his primary gain. But what is the purpose of that action? That purpose becomes the secondary gain—the hidden gain. The secondary gain is the avoidance, or at least the possible avoidance of legal consequences, in this particular case. Each case of malingering will have its own primary and secondary gain, and these are not always obvious.

As an attorney, you might not care if your client is malingering. Having a mental illness might help your case in some way. But I would argue, as a psychiatrist, that malingering of mental illness is not really that hard to spot. An experienced clinician will know when an individual looks authentically mentally ill and when he doesn't, and when certain behaviors look like they were committed during an episode of mental illness or deliberately, for some specific criminal reason. We discussed earlier how many criminal acts are a result of both some small mental abnormality—a predisposing factor or a disinhibitor—as well some underlying wish or impulse, that together result in the criminal act. You might be able to hire an expert who will buy your story and claim that your client's clinical presentation is totally consistent with some disorder. But the other side's expert might not see the case that way. Therefore, if your client really is malingering, you probably should know it. Nobody likes to look like a fool. There might be a different legal strategy that would help. Also, what I frequently see, even in really huge high-profile cases that make the national news, is a sort of either-or mentality, where someone is either completely cuckoo or otherwise a deviant psychopath. In reality, as we keep saying, many people fall somewhere in-between. Having the courage to say that your client is one of those in-between ones, who might qualify for, as an example, a diminished capacity defense as opposed to a full insanity defense, if you are a criminal defense attorney, might get you very far.

I interviewed criminal defense attorney Mark Barnum, who has been practicing this type of law for over twenty years. We had a very funny conversation. I asked him if he ever used psychiatric experts in his cases, and he said, "all the time." He felt that his experts were very useful, and he usually won his cases based upon diminished capacity defenses. He told me

he liked the reports, although he could not understand most of what was in them: "They do this battery of tests. I don't understand them. I just skip right over them and go right to the conclusions." Then he mentioned that he usually used one particular expert. I asked who it was, and when he mentioned the name, I was clueless. Then I remembered.

"Wait—he's a psychologist. Don't you know the difference between a psychiatrist and a psychologist?" "Umm…one's an MD?"

He said it in such an innocent way that I had to laugh. Yes, because psychiatrists are medical doctors and psychologists are not, but there are so many more differences. I happened to be acquainted with that particular psychologist, and I knew he was experienced and could do a good job. But what is the point of relying on a report that is incomprehensible? Psychological testing is not without its drawbacks, and while I do not wish to devote any time at all to discussing them, I do wish to say that the most obvious one is that no expert should ever wish to lose his audience. When people just talk, and talk, and talk, the listener is not going to just listen, listen, listen. Since we are talking about malingering, remember that there is no psychological test to prove malingering. It is a clinical judgment usually based upon years of clinical experience and also a good gut. Psychological test profiles can say that "people who score similarly may be malingering," but the testing does not definitively mean that they are malingering. When we talk about how to interrogate the other guy's expert, remember this little fact, because it might prove critical: psychological testing proves nothing. It only supports or does not support clinical judgment.

So back to malingering. We have established that malingering of mental illness is a deliberate feigning of mental illness. When it is done in a legal setting, it is generally utilized for a specific purpose of diminishing some charges or consequences or making the outcome less severe than it would be otherwise. Often, the malingering is initiated by the client himself (I would say always, but sadly I know that sometimes the feigning of mental illness or the presumption of some reason for the criminal behavior is put forth by the attorney and not by the client himself).

What about feigning of illness, mental or otherwise, that is not deliberate, or that is deliberate but without any clear gain, primary or secondary, or of any level? These disorders are so much harder to understand—and extremely weird. They are listed under several categories in the DSM, but I will discuss them here in the order that I have met them in real life, because I think that conceptually we are more likely to encounter them in any types of legal cases, whether civil or criminal, in this way.

Probably the most common nonexistent illness you will encounter is hypochondriasis. This condition is fairly common, but in their infinite wisdom, the people who made up the DSM-V did not include it as an official diagnosis. Instead, they decided that about seventy-five percent of the people who once would have met criteria are now included under the somatic disorders headings, while some of the remaining twenty-five percent could suffer from other anxiety disorders. For the rest of them, perhaps conversion disorders or some other diagnoses might do. I personally find that these almost endless breakdowns of diagnostic criteria are not particularly helpful. We as a society understand that there are some individuals who are over-worried about their health. Every time they see a little red

mark on their skin (perhaps their pants were too tight?), they are afraid they have skin cancer. When they get a bug bite, it wasn't a mosquito, it was some rare brown spider, and they plan to be dead within two days. You know these people—they are the ones who sit next to you at work and drop in at the end of the day to ask, "Do you have a minute?" and then regale you with their latest health scare. Those people are hypochondriacs, and it really does not matter if they fit the criteria for a specific Somatic Symptom and Related Disorder (the new DSM category for Somatization and Somatiform disorders, which I liked better, but nobody asked me). When their symptoms become so extreme that they are unable to leave the house, and they spend all of their time and money doctor shopping, you might meet them as legal clients, and the specific diagnosis might become important only because you have to put something at the end of the report. The really important part becomes, how can we treat them, and for that, the answer tends to be: medication. If psychotherapy were going to help, it would have helped already. I keep beating this poor dead horse because if just talking to the mentally ill were really so easy and helpful, we would not be facing this mental health crisis we are currently facing. A combination of meaningful psychotherapy and appropriate psychotropic medication is required to treat these patients, before or after they step into your law office claiming that their spouse is poisoning them.

Now here is the super crazy part: sometimes their spouses really are poisoning them. Do not rule-out the possibility. Such a case happened not far from my home. The alleged perpetrator was a scientist with a local pharmaceutical company. She systematically poisoned her husband over several years until he died. I could not find the outcome of the case online, although I believe she pled guilty. We are, theoretically, a death penalty state. In another case I knew of anecdotally, years ago, a friend's therapist, who was also my coworker, suddenly began exhibiting mysterious physical symptoms. I had set her up with this therapist (it was in the days when people routinely saw psychiatrists for psychotherapy, and it was considered a good thing). My friend was distraught, and I was mystified. We investigated. The psychiatrist was hospitalized in a medical unit, and the only people allowed to visit were his immediate family and his girlfriend, who was also a psychiatrist. The symptoms continued. Eventually it turned out that this psychiatrist girlfriend was poisoning him by putting antipsychotic medications into the food she was lovingly preparing for him. I almost did not include this story because I don't want anyone to be afraid of psychiatrists (any more that they already are), but I'm fairly sure she is not in practice anywhere anymore. I think she went to jail. The moral of the story: I'm not sure. Just get a LOT of information before you come up with any legal theories of any cases involving what seems to be really crazy information. We will discuss Munchausen's Disease below, the disorder that almost resulted in me not meeting my deadline for this book because I just had to keep reading about it, it is just that weird. Are these poisoners looking for attention, or are they murderers? And how can we tell? These questions can present all sorts of fascinating legal opportunities for defense attorneys, and if you get such cases, please call me to be your expert because I cannot get enough of this crazy stuff.

To recap thus far: We have hypochondriasis and a bunch of other diagnoses generally under the "Anxiety" heading that include people worrying about their health and their

body parts when they are not really sick. We also have the opposite, and the general public, the primetime news shows that I used to love before the explosion of the twenty-four-hour news cycle (yes, I'm *that* old), and the Special Civil Part all seem fascinated by these conditions. These, of course, are Munchausen's Disease and Munchausen's by Proxy. And new for the twenty-first century, Munchausen's by Internet, a disorder first described in 1998 by Dr. Marc Feldman as "Virtual Factitious Disorder," and then given its snazzy name in a paper published in 2000.

First of all, neither of these two conditions are actually DSM diagnoses either. Both are subsumed under the official and less fun-sounding title "Factitious Disorder," not to be confused with *Fictitious* Disorder, which is not a thing (unless you are driving around with my kids trying to explain this concept to them).

Why Munchausen's, anyway? The original Baron von Munchhausen was a German nobleman (Hieronymus Karl Friedrich, Freiherr von Münchhausen) who gained some minor celebrity in the mid-eighteenth century telling outrageous stories of his service in the Russo-Turkish war (a war I had never heard of until I researched the now-infamous Baron). A writer of the period then fictionalized some of the stories, and Baron von Munchausen's name became anglicized and popularized. Many years later, in 1951, Richard Asher, M.D. described a condition which he termed Munchausen's Syndrome in the British medical journal *The Lancet*. Dr. Asher said that every doctor has seen patients like this one, manufacturing illness where none really exists, and he was inspired by the stories of Munchausen to name this syndrome after the baron.

In Munchausen's Syndrome and its derivatives, Munchausen's by Proxy and Munchausen's by Internet (or Factitious Disorder Imposed on Self or Imposed on Other), actual medical signs and symptoms are often created by the sufferers. People have injected themselves with poison or feces, have caused themselves to have seizures, have poisoned their own children, have injected insulin, have broken their own or their children's bones, have created all sorts of medical emergencies requiring actual medical and surgical interventions, all presumably so they can assume the sick role, acquire sympathy, attention, care, flowers, and who knows what else. Taken to an extreme, cases have been reported in the literature of women who kill their own babies, with such deaths being repeatedly attributed to crib death, all because of the attention and sympathy showered on the grieving mother. The newest manifestation of factitious disorder, Munchausen's by Internet, occurs when someone pretends to have a serious medical condition and portrays himself online as a sufferer. Once you start searching for these cases online you can find literally hundreds, maybe even thousands. For people fascinated by the psychopathology (like I am), these individuals represent a black hole of weirdness, of people so needy and desperate for attention that they will tempt fate in the most bizarre ways possible, by inventing terminal illnesses and various personas and characters who suffer from them, by shaving their heads to show that they are undergoing chemotherapy, by engaging in behaviors as crazy as the ones their Munchausen's in-person comrades engage in, if slightly altered for the world of technology. Injecting feces into one's own body might seem more disgusting than shaving one's own head, but shaving one's head to mimic chemotherapy online has a far greater

reaching impact. The goal of these disorders is thought to be simply obtaining attention and nurturing from other people, a sort of metaphorical chicken soup from the world. Before psychiatry was taken over by serotonin, dopamine, and now glutamate, we were trained in the theory of ego, id, and narcissism. People were thought to have basic needs that needed to be met—needs of love, acknowledgment, libido, self-worth, even a drive toward death. These Munchausen's people appear to be driven by those most basic needs: desires for attention, nurture, to be touched, to be heard, to be present. They are willing to literally injure themselves or their children in order to get those feelings of attention and sympathy that they so crave. The idea is both fascinating and repelling.

To really understand these cases requires far more knowledge than a bit of armchair psychopharmacology. People do not develop factitious disorders because they have low serotonin levels. We have said repeatedly that the brain is far too complicated for a few molecules of serotonin to fix. That said, it is certainly possible that treatment with medication might play a role in helping some of these individuals. Unfortunately for the attorneys, in these factitious disorder cases, understanding of the psychodynamic motivations does have to play a role. I don't believe that just stating that the person (or most likely, defendant, if such a case gets into a courtroom) is going to have much leverage by crying "Munchuasen's." Someone is going to have to carefully explain what happened in this person's mind—mind, not brain—in order to convince a judge or jury that these truly bizarre behaviors were not completely under the person's full control. The line will be very fine.

Here is an illustrative case from my files, to demonstrate how courts mix up these situations, and how a little knowledge can be a dangerous thing. In this case, I was court-ordered to evaluate a woman for "Munchausen's by Proxy." I think the judge had probably watched one of the same primetime news shows of which I was overfond, but he did not have the same knowledge of psychiatry that I had. This referral occurred back in the days of DSM-IV (pre DSM-IV-TR), and I was court-appointed, so theoretically I was not working for either party, which is how I prefer to work. The original matter was, naturally, a divorce. The father had moved to another state (why would anyone want to leave New Jersey?), and the mother was terrified to let the young daughter go visit him. Throughout the many repeat visits to court, the mother kept citing concerns for her daughter's health. She provided voluminous documentation of trips to the emergency room and to the pediatrician. The little girl was about five years old, and she accompanied her mother to the psychiatric evaluation. She was adorable and had a runny nose—nothing remarkable. But here is the problem with the court order. It stated: "Dr. Shnaidman will evaluate Ms. Jones (not her real name obviously) for 'Munchausen's by Proxy.'"

How cool is that? Except—what if Ms. Jones had some other psychiatric disorder? How does a psychiatrist address that problem without insulting the judge who ordered the evaluation? I was a bit stymied. Eventually, what I did was I answered the question, and I said that Ms. Jones did not have Munchausen's, by Proxy or by anything else. She did have an anxiety disorder, and she was extremely worried about her daughter's health. I wrote that if there were such a diagnosis as Hypochondriasis by Proxy, she would have that, but since there was no such diagnosis, she could not have it. Therefore, she should seek some

treatment for her generalized anxiety disorder, and the court should find a way to work with her anxiety such that the little girl could have some summer visits with her biological father. I think it all worked out in the end. But I was sweating the proverbial Twinkies because I really wanted that judge to like me and send me more work! Just because he had seen Munchausen's by Proxy on a television show did not mean he actually knew what it was or that a case of it was going to saunter into his courtroom the next day!

Factitious disorders are probably the weirdest disorders in the DSM, except for the next and final category in this chapter: Dissociative Disorders. And here I will keep it brief, because there is so much controversy in the literature and so much to say and yet so little that anyone really knows.

Dissociative disorders comprise a group of disorders in which people lose their knowledge of their own identities. The most famous, Dissociative Identity Disorder, formerly known as Multiple Personality Disorder, was initially widely known in the seventies by some made-for-TV movies, which I actually could not stay up late enough to watch. Throughout my career I have bumped into a few, and they have always had a feeling of unreality. Various "alters"—different personalities—seem to come out at convenient times. These can be different ages and genders from the "host" personality. The theory behind Dissociative Identity Disorder is that when somebody experiences a severe trauma, such as sexual abuse, part of the personality splits off and develops separately as protection from the trauma. I'm oversimplifying, but for the purposes of this chapter, this explanation is good enough.

Other dissociative disorders currently include Dissociative Amnesia with or without Dissociative Fugue and a few other less dramatic dissociative states, such as Depersonalization/Derealization Disorder (more commonly a symptom associated with other disorders such as depression or borderline personality disorder), and Specified or Unspecified Dissociative Disorders. What they all have in common is a subjective feeling of unreality. In a legal setting, this subjectivity begs a question: how does an expert interpret a subjective feeling? A few famous cases pop up in a search for "Multiple Personality Disorder Legal Cases," most of which were later shown to be faked. When I learned about them during my training I personally spotted the flaws immediately, but I know I sound like a show-off, so I do not wish to continue to tell you why I spotted these flaws—only to tell you that if I spotted them, some other expert will too. There is something inherently off about these Dissociative Identity Defenses. If we believe that a part of the personality compartmentalizes and keeps separate that which is distasteful to the host personality, then we have to accept that the host personality still owns the distasteful part. When I write a novel, I make up all the characters, even the bad guys. They are all a product of my imagination, even the serial killers. I have to own them. Saying that the bad part of the defendant's personality is the one who committed the crime cannot be a defense, because whether or not the host is aware of the "alter" (or "alter ego") is irrelevant—that alter is still a part of the person, and the same brain inside the same biological organism is still in charge.

So do people ever have Dissociative Identity Disorder, and does it ever play a role in a legal matter? I had one case in which I am sure it did, to my own surprise and actual

embarrassment. The case concerned a mother who seemed to be a true wacko, except that she wasn't. Whenever anyone saw her in person, she was fine. She was appropriate, she cared for her children nicely; the children were clean, well fed, and well dressed. Then calls would come in from the house phone accusing her of all sorts of crazy things, like having a baby and leaving it for dead in New York City. Endless wild goose chases would ensue. Every time the mother would be brought in, she would present as authentically mystified. Family members would claim she had been unreachable during certain hours but nobody would have actually seen her. The kids were never actually harmed. There were two fathers with the same first name but one did not exist. Genetic testing revealed only one father. The story got weirder and weirder. I did not know what was wrong with her. My colleague saw her (and I was so disappointed in him when he took the cop-out route and called her "Rule-out Bipolar Disorder." You know who you are!!) But really, nobody could understand this case.

She came to my office once, and she was sort of angry, but rightfully. Nobody had ever established any abuse or neglect of her children, but the story was so weird that the state was moving forward with termination of parental rights. I felt bad for her. She was appropriate and polite during our interview. Then something happened, I forget what, but I think it was something really simple like her audiotape of our interview was erased (I always permit audiotaping, but I make my own recording as well if the interviewee wants to make a recording). Her lawyer was requesting another interview. I agreed to go to the local office of what was then the Division of Youth and Family Services to interview her again.

That day, she apparently was acting weird. First her lawyer called to ask if I could do the interview in Burger King (um—NO!). Then she finally showed up, and she was fine. We started talking, she was polite and appropriate, and then all of a sudden she looked down, then looked up, and she looked like a different person. She was wearing a baseball cap, which she had been wearing the whole time, but I swear she suddenly looked like a man. And she said to me, after just having been cooperative for half an hour, "What are you doing here? What kind of a doctor are you, anyway?" And she said these words right after having walked in and greeting me by name half an hour previously.

I did not make any kind of connection or assumption, at first. The moment was just weird, and as I've made abundantly clear to you, I'm a skeptic in the best of times. But that night I had one of those movie aha moments. I don't know if I actually sat up in bed in the middle of the night, but in the way I tell the story I did: I sat up, clutched my hand to my heart, and exclaimed, "Oh my God! She has Multiple Personality Disorder!" (I know it's really Dissociative Identity Disorder, but Multiple Personality Disorder sounds so much more dramatic!)

I went with that diagnosis in my report because it was really the only one that could explain the story of the case: the phone calls, the referrals of herself for things that never happened, the missing blocks of time, the lack of any actual child abuse or neglect, the missing dead babies that were never born, and the total lack of guile when she was interviewed, in combination with the bizarre transformation I witnessed with my own

eyes. This woman was not happy. She thought I was the crazy one. She fought the diagnosis. I think she would have preferred to be bipolar and might have preferred to lose her children than to be considered someone with this obscure disorder popularized on cable television.

All of these disorders I've discussed here do exist. They are not as common as depression or schizophrenia. Despite my concerns, and the concerns of the American Psychiatric Association, with the overdiagnosis of bipolar disorder, these diagnoses are far less common than bipolar disorder, too. These clinical presentations are very dramatic, and the disorders might not be real every time you encounter them. Using these factitious and fictitious disorders in legal settings might be extremely challenging. You don't ever want a court order to read "Rule-out Dissociative Identity Disorder," just as you don't want it to say "Rule-out Munchausen's by Proxy." Please be careful with the wording on those court orders—we will get to that in the final chapter of this book. I just want all of you lawyers to know that you might, one day, encounter something like one of the cases I've mentioned here—or something I haven't even thought of yet—and you might be the one who has to take it to court and win.

11

Psychopathy v. You

What is a psychopath? Although people seem to have their own definitions and gut feelings, psychopathy is not an official psychiatric diagnosis. It is not in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). It is not Antisocial Personality Disorder, and it is not sociopathy, a word that is thrown around in fiction but is not whatever it is that the psychopathy literature describes. The word "psychopath" first entered the collective conscious around 1941 with the publication of the book *The Mask of Sanity: An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality*, by American psychiatrist Hervey Milton Cleckley. Dr. Cleckley postulated that psychopaths present as normal, but their presentation masks a mental disorder consisting of a triad of no moral code, a need for high stimulation, and low fear. These same features have been renamed and recategorized by other authors in slightly different ways but to essentially the same end: psychopaths are people who have no inner moral compass, who need high levels of stimulation in order to feel anything, who obtain satisfaction from hurting others or taking advantage of others (not necessarily in a sadistic way, but sometimes), and who therefore enjoy taking risks. Landmark advances in the study of psychopathy have been made by a variety of researchers. Possibly the best known is Dr. Robert Hare, who studied primarily incarcerated psychopaths. Dr. Hare determined that despite their propensity for criminal behaviors, most incarcerated criminals are not psychopaths. He devised an instrument to identify which incarcerated inmates might be psychopaths according to his specific criteria. This PCL-R, or Psychopathy Checklist-Revised, is widely utilized in clinical corrections settings for a variety of things, but it is not foolproof. It is kind of fun to use, and the training is fun too (plus, when you get trained in the workplace, it is a paid day off. Now I work for myself, so I'm lucky I got trained when I worked for the state!).

Psychopathy is a fascinating area of research. People get mixed up about the PCL-R and who is a psychopath. I have not personally interviewed Dr. Hare, but he did coauthor a book with Paul Babiak called *Snakes in Suits: When Psychopaths Go to Work*. The point of that book, and this chapter, is that not all psychopaths end up in prison. Most probably do not. Many psychopaths seek high stimulation, interfere with the rights of others, are smart but not quite as smart as they think they are, get caught, and go to jail. Many more do not. Those who do not get caught end up managing hedge funds, going to law school, or becoming orthopedic surgeons. You can't throw a rock without hitting a psychopath.

The early days of studying psychopathy revealed certain traits and concepts, some of which have since proven to be untrustworthy, but which pointed toward a biological basis of psychopathy, which is getting a lot of research time today. One of these is the famous, or maybe now infamous, Macdonald Triad of bed-wetting, fire setting, and cruelty to animals. This trio of behaviors was for a long time thought to be a predictor of violent tendencies later in life. Psychiatrist J.M. Macdonald published his paper, "The Threat to Kill," in 1963, and for years people believed it. Today this triad seems to have been demoted to urban

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legend status, but what is interesting about it is that these behaviors do seem to have neurological correlates. So it is certainly possible that there is some connection between some other neurological predisposition to psychopathy, these behaviors in early life, and psychopathy itself. It may not be that cruelty to animals primes a child to become a serial killer—it may be that the same neurological predisposition toward psychopathy primes an individual to both.

Here is the critical point we have to consider, though. Remember that wild beast test of right and wrong? The lion does not know that a zebra has feelings and a family, and maybe he does not want to be dinner. But a psychopath, even if he cannot *feel* any empathy for the person he might be killing, or the cat he might be killing, still *knows* he is not supposed to be cruel to animals or people. The concept of a psychopath having a different brain that is not capable of experiencing empathy does not work in the arena of insanity defense because it is not a difference of *feeling* right and wrong—it is a difference of *knowing*. The whole concept of psychopathy is that psychopaths can fake normal. They are capable of faking normal human emotions. They pretend to love in order to get into favorable relationships where they can swindle heiresses out of millions. They pretend to have the best interests of their company at heart so they can embezzle from it, and so forth. Not only are psychopaths capable of pretending to have normal human emotions, but they enjoy this pretense and utilize it for specific gains. The whole concept of psychopathy is based upon these individuals' desires to take advantage of others and to get something from the whole paradigm—not just to win something for themselves, but to lose something for their victims. The con only works when there is a winner and a loser, because the whole adrenaline rush only works that way. A "regular" criminal, one who is simply trying to gain advantages for himself by stealing, killing, etc., does not really care about the other person's outcome—the other person can be hurt or not hurt, and the criteria for antisocial personality disorder say as much: a pervasive pattern of disregard for, and violation of, the rights of others, and so forth.

The difference between psychopathy and regular old antisocial personality disorder, and the part that many people struggle to understand, is the part about not caring about the rights or feelings of the victims. A new wrinkle is that the DSM-V writes about the pattern of antisocial personality disorder being referred to as psychopathy or sociopathy in the literature, remaining vague as to what that literature might be. Unfortunately, this reference in the DSM is incorrect, and I am waiting to see what happens next, because the actual criteria are very different. Psychopathy is not a diagnosis and does not cause distress to the people who have it. Many psychopaths meander through their lives very happily, never ever coming to the attention of law enforcement. I refer you again to the wonderful book *Snakes in Suits*, by the inventor of psychopathy, Dr. Hare, and urge the DSM people to do their homework a little better next time. Calling psychopathy antisocial personality disorder does nobody any service at all.

People who qualify for antisocial personality disorder must come into that diagnosis through a previous diagnosis of conduct disorder. These are the kids who begin stealing and lying from an early age. They often begin with early oppositional-defiant disorder. These are the rule-breakers, the school-skippers, the troubled kids from chaotic

households, the ones who never knew or responded to any sort of discipline. These are the young adults who never knew any stability, who bounced around among different foster homes, who found their first acceptance in gangs of hoodlums, or plain straight-up gangs, like the Bloods, Crips, or Kings. (Those are the ones I learned about in gang training a few years ago. I have no doubt that in the vast Midwest, there are many Caucasian gangs—I just don't know their names). A lack of remorse is one of the possible criteria for antisocial personality disorder, but it is not a requirement. You can be extremely remorseful when you commit a crime and still qualify for this diagnosis. In my own experience, I have interviewed many men, and not a few women, who demonstrated a long criminal history with all the specific requirements of early conduct disorder and later antisocial personality disorder, and even though I couldn't write it in my reports, in my heart I knew that what they really needed was a good mom. That's not a psychiatric recommendation, and I had to find more professional ways to write my opinion (i.e., firm limit setting in an environment of unconditional love, including excellent psychotherapy with a qualified doctoral-level therapist, residential treatment, gradual reentry into society, vocational training, blah blah blah). How many people would ever actually be provided with these interventions as their treatment after committing a felony? Exactly none. But psychopaths do not respond to these treatments. Psychopaths will, however, pretend to respond to these treatments, and very masterfully. They will pretend to respond to any treatment. They will convince their therapists at a sex offender inpatient facility that they no longer fantasize about raping and killing anyone because their therapist has been so amazing. They might even convince that same therapist to help them escape because only she really understands how much he has changed. You might sit here now reading these words thinking no possible way, but it happened to a former colleague, who was such a nice and intelligent person, that even as I type these words I continue to be stunned.

Psychopaths roam amongst us in every walk of life. While, of course, none of the attorneys reading this book is a psychopath, the law of averages dictates that you all know at least one, and have probably been supervised by one at some point in your careers. I know I have. Psychopaths are generally not common criminals. People get confused by the idea that Dr. Hare did his research on incarcerated psychopaths, and they think that the PCL-R should be applied to people who are not in jail. While I am not an expert on psychopathy, except in a life experience sort of way, I know enough, have researched enough, and have attended sufficient trainings and conferences to be able to tell you that it is critical (that word again) to know the difference. When you are defending someone in court, finding that he has a diagnosis of antisocial personality disorder is not going to help you much. The generally accepted treatment for antisocial personality disorder is incarceration—the only way to stop the manifestations of the disorder. Despite plenty of anecdotal evidence, like viral Facebook posts about muggers who end up giving the victim back his watch and tending the garden at the church, or movies in which the street urchin becomes the queen, or whatever, in real life most people who are raised to live a life of poverty and crime end up doing exactly that, at least in the United States. I wish I could solve this problem, but I can't, and to even discuss a solution is so far beyond the scope of this chapter and this book

that I do not know why I am even mentioning it, except that to say that it is my opinion that perhaps antisocial personality disorder is less of a disorder than a human condition.

Psychopathy, however, is a true disorder. Abundant evidence exists to support a biological basis for psychopathy. But let me be very clear: biology does not equal destiny, and these traits do not exist on an all-or-none spectrum. Unlike pregnancy, it is possible to be a little bit psychopathic. Certain traits, like low resting heart rate, are associated with psychopathy, but can be associated with non-psychopaths as well. Some people crave an adrenaline rush, but do not seek it by swindling others. I live with a houseful of these people—I used to joke that when my boys were growing up, we had a punch card for the emergency room. (It was only a joke because they did not actually give out punch cards.)

In his book *The Psychopathic Mind*, psychologist Reid Meloy gives a slightly different but extremely useful description of psychopathy. He begins by defining psychopathy as a deviant developmental disturbance characterized by a large amount of instinctual aggression, combined with an absence of the ability to bond with others, another way of describing a lack of empathy. Dr. Meloy believes that psychopathy is a lifelong process that evolves throughout the lifespan, which can also influence other psychological and psychiatric disorders. Recall that in a previous chapter, I mentioned a noncustodial parent who had threatened a judge with death, in writing. My diagnostic impression of that person was schizophrenia as well as psychopathy. I know I said that psychopathy is not a DSM diagnosis, but it needs to go somewhere if it is relevant, so I put it in the diagnostic impression section with a note saying it is not a DSM diagnosis. Thus far nobody has complained, and we know from all the lawyers I've interviewed that they (you) do tend to skip over the report and jump to the impressions and recommendations.

Why is psychopathy an important clinical impression in a forensic setting? It is important because first of all, there is no treatment. Yet the psychopaths, as mentioned above, are the people who will convince you that they are so much better. They have learned the error of their ways. They have repented and found Jesus. They have done whatever it takes to convince you or their therapists or their parole boards that they are ready to leave confinement and go out into the world as law-abiding citizens.

The only thing is, these psychopaths are lying, and they are loving and enjoying their own lies. The very act of deceiving excites them. The Hare PCL-R is a proprietary instrument that I cannot duplicate here, but one of the hallmarks of the Hare psychopath is a veneer of glibness and superficial charm. These people love passing for normal. They get a huge high out of it. Remember, they have low resting heart rates and need huge doses of adrenaline to make themselves feel excited. People with only a little bit of the genetic mix required for psychopathy become adrenaline junkies, but they don't get a kick out of taking advantage of others—they simply enjoy sliding down mountains really fast or other similar adrenaline-producing activities. Talk to any ski instructor and he will tell you about that adrenaline high. He probably will not tell you about the high he feels when he takes some unsuspecting suburban mom up a mountain and she falls down and breaks her knee, because he probably will not feel good about it. About one to three percent of them, though, will. About one to three percent of them will also arrange to get a tip, or an inheritance, or

sex, from those same suburban moms. Why? Because it is sneaky, devious, and exciting, and their adrenaline rush does not stop with sliding down the mountain fast. It includes a lack of empathy and no moral code, a desire to take advantage of others, a need to manipulate, a need to profit from the misfortunes of others, and a sense of mastery and satisfaction that arises out of all of those machinations. Those people are psychopaths.

Now, I just threw out that number of one to three percent. In reality, the number is probably higher, because logically, the number of people who thrive on risk should include a higher proportion of psychopaths than the general public. I could not find any reliable data, and I do not know if anyone has ever been able to look. In general, the psychopath experts say that about one to three percent of the general population is psychopathic. Perhaps up to 15 percent of incarcerated sexually violent predators are psychopaths. The actual data are not reliable. People will not volunteer this information, and no blood test has been developed. And like everything else we have discussed in this book, as much as we would like for psychopathy to be an either/or condition, it is not. It exists on a continuum. Some people are super psychopaths who also have considerable sadistic and obsessive-compulsive tendencies. They are the serial killers, who must keep acting on their deviant violent sexual fantasies until they get them right. Some people merely seek an adrenaline rush once in a while. Maybe they have a sexual fling on a business trip (I have to stop using skiing as an example for everything, but I suppose skiing fast is preferable for this particular example). In between lies every other possibility. A psychopath who is not sexually deviant is not going to rape and murder just because it will hurt someone else—he also has to enjoy what he is doing and get his own personal adrenaline rush out of his misdeeds. One problem I find in fiction is that the sexual offenders are so—fictional. Their inventors have no understanding of the specific requirements of actual sexual deviants. They create rapists who do not discriminate between little girls and grown women. While readers of fiction might not care, those of us who have worked with actual deviants know that perverts are extremely specific in their likes and dislikes. Sometimes they will take second best, or third—as do nondeviant people. Beer goggles work on deviants, too.

So each psychopath will do what works for him or her. The literature suggests that psychopathy is more common among males than females, and different authors have proposed various mechanisms. Some propose that women's internal hormonal environments make them less likely to be unable to experience empathy. This double negative is confusing, I know—what it means is that because of our hormones, women are naturally empathic. That's a theory, not a fact, but it may be supported by biology. Nobody is really sure yet.

Just because someone is a psychopath, does that mean that anything he does is automatically suspect? Is anyone who buys into a psychopath's worldview a victim? Here is a case I was involved in a couple of years ago in which my testimony was used to help the psychopath. I can't say I loved it, but the way the lawyer asked the question, I had to answer truthfully. The case was really interesting. And I'll tell you what happened at the last minute to sort of renew my faith that maybe he was an incomplete psychopath.

The case involved an elderly woman whom we'll call, naturally, Rose O'Grady, since she was of a generation where there were quite a few Rose O'Gradys (but not actually her). I never met Rose—she died of cancer before I entered the picture. Rose had worked for many years as a teacher. She had been a single lady, never married, no children. She had initially planned to leave all her money to a Catholic University in a neighboring state. Rose was too old to have actually attended that particular university, which had been all men in her day, but she was loyal to her church. And she had a PhD from somewhere, although she had taught in a regular Catholic school (As an aside, I find that quite a few of my testamentary capacity cases involve old Catholic schoolteachers who die in possession of millions. Interesting, if nothing else).

Rose lived alone and was having difficulty getting around. At some point she needed a new roof for her house, and found a roofer. I want to say she found him on Craigslist, although she may have found him in the local newspaper or through an ad, I can't remember, but Rose was a pretty hip old lady by all available accounts. She found Gianni Roma, who replaced her roof, and then offered to drive her to the doctor when her Medicare cab failed to arrive. Thus began the relationship between 80-something retired PhD Rose O'Grady and 30-something roofer-swindler Gianni Roma. Because Gianni was most definitely a swindler. He already had a conviction for taking someone else's money and *not* fixing her roof. But Rose did not know about that, and Gianni *did* fix Rose's roof. He *did* drive her to that doctor's appointment and to many more. He kept Rose company. He visited her and took care of her. He spent so much time with her that the neighbors began to worry. They called Adult Protective Services. Adult Protective Services called Rose's doctor, who tried to have her declared incompetent to manage her own affairs. But Rose was stubborn. She insisted that she knew what she was doing. She knew that Gianni was not really her nephew (because some of the medical records prior to the involvement of Adult Protective Services referred to Gianni as her nephew). She told the court psychiatrist, "I just thought it would be easier to say he was my nephew than to explain how I met him and why he was driving me around." She met with an attorney—not her usual attorney—to change her will. She transferred money into Gianni's name. She made him her heir. Eventually she got sick, and then she could not manage her own affairs anymore. Then she died. No relatives appeared out of the woodwork, no long-lost children appeared from anywhere. They had never existed. The only person who had ever really cared for her at the end of her life was this reported psychopath, the roofer who had swindled elderly people out of their life savings, but who had actually put a solid new roof on Rose's house once, and who had driven her to her doctors' appointments before she developed the cancer that ended her life.

I don't remember exactly how Gianni ended up arrested for fraud, but he did. I had done a previous case for his attorney, a totally different type of case, but the attorney remembered me and called me. When I heard about this case, I was skeptical. I doubted that I would be able to help.

What the lawyer asked me was simple: "Did Rose O'Grady have the mental capacity to transfer her assets into Gianni Roma's name on the date in question and then to make him the beneficiary of her will on the date in question?" Ultimately the case was a basic testamentary capacity case, which, as we discussed elsewhere in this book, is a fairly

limited capacity issue. The question was not whether Gianni was swindling her or if she knew it, but I felt uncomfortable with the whole thing. Still, this particular attorney had been good to me; we had done a great and ethical job together with his previous client, and there was nothing inherently unethical about his question.

I started, as always, with the medical records. I wanted to know when Rose had begun her cognitive decline. And during this process I learned something interesting. Perhaps Gianni had been a thief or a swindler at some point, but his relationship with his adoptive aunt Rose had actually blossomed into a real thing. No doctor had actually been suspicious that he was using her. No lawyer had written that he behaved suspiciously. As I mentioned above, Rose herself told the state psychiatrist that of course she knew that Gianni was not really her nephew, but that it was easier to say he was than to explain to her doctors why a stranger was driving her to appointments. All kinds of people were deposed, and nobody thought there was anything in their relationship that seemed inappropriate. Gianni really was driving her around to doctors' appointments. He really did fix her roof. He really would come over and help her around the house, much like a real nephew might if he were her only living relative. Yet after she transferred her assets to him, and he visited her in the hospital when she was on her deathbed, and then she died, the state stepped in and arrested him for fraud.

Was Gianni a psychopath? Did he get some sick pleasure from defrauding a lonely old woman? I received some additional documents that surprised me. I knew after going through all the medical records and the pleadings that Rose knew exactly what she was doing. I received an affidavit from Gianni's wife, which might have been suspect, but she spoke about how much time Gianni had spent away from her and with Rose at the end of Rose's life. That part was true. People had witnessed Gianni behaving as if he cared about Rose, even when Rose could no longer possibly know if anyone was there caring about her or not. Whether Rose fell for Gianni as a nephew or a man or something else, she had been perfectly capable of making the decision to transfer her assets to him. That part of the story was crystal clear, and the university who did not receive her money is still doing fine (don't forget that the Catholic Church is the next biggest landowner in the United States after the federal government). But the part where he had a prior history of defrauding the elderly was troubling. Was he a psychopath? Was he desperate? Was he just a terrible businessman?

Some time later the attorney sent me an email with the following message: "My client decided to plead guilty against my advice. I will use your report at the sentencing hearing." I don't know what the sentence finally was. But I wrote him back: "I guess he finally developed a conscience."

So was Gianni a psychopath? Perhaps he had some psychopathic traits and tendencies. Perhaps he was simply greedy. Perhaps he was capable of empathy after all. I never actually met him, so I can't possibly know. But clearly he had some guilt about the whole thing—and that guilt, and his desire to plead guilty, even against the express advice of his own attorney, seems to prove to me that he was not actually a psychopath. Maybe he was someone with antisocial personality disorder, according to the DSM. Or maybe he was someone who loved the adrenaline rush, which might be why he liked working on roofs.

But here is a real psychopath: An incarcerated sex offender who is too dangerous and violent to be in the general population. He knows that every Monday the female psychiatrist

makes her rounds in the close custody unit, so that is when he waits behind the door with his erection, timing his masturbation to ejaculate just as she arrives at his door. That is super fun for him, especially because it is super gross for her. Especially when she was pregnant, when it was especially extra super fun for him and extra super gross for her. Then he would spend an inordinate amount of time telling her how *distressed* he was with all his recent dreams about setting her on fire. Was there anything she could do about that? Some medication, maybe? I don't think I need to continue with this particular vignette to convince you that the guy was a psychopath. And here is another psychopath: the psychologist who says to the same psychiatrist: "Oh, that's not really about *you*. His original victim was a six-year-old. He's not interested in adult women. Don't let it bother you." I can't possibly continue with this story, but trust me. Psychopaths appear in all walks of life. As I said, you can't throw a rock without hitting one. There are days when I want to throw a lot of rocks.

So where might we find psychopaths? Or, to put it another way, what types of social structures might support them, and what types of social environments might confuse them or repel them? If you are a lawyer, you need to know your audience and your comfort zone. In general, the less functional, or maybe the less psychopathic psychopaths will gravitate toward the lower ends of the criminal spectrum. The bottom-feeders are always less functional, less capable, and less dramatic than the success stories. So successful psychopaths are going to be the ones at the very top of the pyramid schemes, the ones making billions, not thousands. We can't name names, obviously, since we didn't evaluate them, but let's think of people who, for example, took the money of investors and pretended to make huge profits while keeping all the money for themselves. Who does that? Only a psychopath can get a thrill out of robbing his own clients (and dare I say, his own people) for fun and profit.

One of my favorite fiction writers, Jonathan Kellerman, was a practicing psychologist in his previous life. He wrote an amazing little book called *Savage Spawn: Reflections on Violent Children*. When I first read the book, I did not want to agree that some psychopaths are born, not made. I was a big believer in the nurture versus nature controversy—I had small children and I thought that anyone could just raise their kids right and prevent their going off into the world of psychopathy or sociopathy or whatever you might wish to call it.

Now I know differently. The research is there and my life experience is there, too. Some psychopaths are just born that way. They are born *Without Conscience*, as Dr. Hare's other famous book is called, and they find places where they can thrive without a conscience. They seek thrills without a conscience, and because they have no conscience, the price of a thrill is expensive. People who have a strong moral code might get a big thrill from having ice cream for lunch. Psychopaths—not so much. They might need to have cocaine. Taking advantage of people seems to have a special place in the hearts, or what passes for hearts, of psychopaths. If you suspect your client is a psychopath, be sure to get paid up front and make sure that check clears, because your psychopathic client is the one who is going to make you feel like his best friend, make you confident he is good for every penny, make you convinced that he is going to make you rich and he is innocent, and then skip out on the bail that you personally put up your house for. That is a psychopath. He is not going to do it because he is desperate. He is going to do it because it is *fun*.

12

Your Expert Witness v. the Other Guy

When I first started testifying in court, I used to be kind of resentful that I was only qualified as an expert in "psychiatry." I was a forensic psychiatrist, dammit! I worked hard to get those added qualifications. I thought that being an expert in forensic psychiatry would somehow make me a better, more respected expert and that people would listen to me more.

I learned very quickly that the legal system, in its own unique way, is doing something really good and appropriate by qualifying experts in psychiatry. I'll explain.

In the late 1980s and early 1990s, several things happened in quick succession that changed the face of psychiatry forever. One thing was the invention of Prozac, the first serotonin-specific reuptake inhibitor. This medication revolutionized psychiatry and was followed within a couple of years by the atypical antipsychotics, which revolutionized psychiatry even further.

Simultaneously, the health insurance revolution started. The health insurance that I grew up with reimbursed its participants for 80 percent of their medical expenses. The system was pretty simple. If you went to see a psychiatrist for psychotherapy weekly, or even for psychoanalysis four days a week, you paid your money to the doctor, sent your bills to the insurance company, and the insurance company sent you a check for 80 percent of what you paid. Easy, right? While I was in psychiatric residency training, something was happening behind the scenes. The health insurance industry was deciding that doctors were making too much money and they, the insurers, traditionally a huge for-profit business and the second-oldest profession, were not making enough. Managed care began to rear its ugly head.

Today, there is no such thing as a doctor who makes too much money (with the possible exception of the orthopedist who fixed my knee), or a health insurance that pays 80 percent of what the doctor bills. The insurance payers decide what is "reasonable and customary," and this amount is a fantasy number that nobody can live on if they spend enough time with each patient. Medicine is no longer a golden parachute but a difficult, annoying, stressful profession requiring years of training, sacrifice of one's youth, untold sleepless nights, all to be told by some insurance company that we should consider treating our depressed patients with—you guessed it—antidepressants. Because, you know, they are a few steps behind and do not wish to pay for the best medications, so they are completely and blissfully unaware that we are providing samples to their patients so they can actually get better.

Why am I back on this horse? Because I need you to understand that as a result of the current situation in psychiatry, there are a lot of so-called experts out there. And many

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of them are just not experts. You need to be very, very careful. I have come across some so-called reports that in my opinion were works of pure performance art, in the comedy category. For the attorneys and clients who paid a fortune for them, though, I don't think anyone was laughing.

So first of all, how do you find an expert? Let's start by deciding if you need one. I personally recommend using a psychiatrist if there is any chance at all that there is a hint of anything with the word fragment "schiz" remotely related to the case. If anyone took medication, if anyone was in a hospital, if anyone saw a psychiatrist—use a psychiatrist. There are some perfectly good psychologists out there, but you don't want to be caught with your pants down when they end up recommending a psychiatric evaluation at the end of the day. I would estimate that two-thirds of my work comes to me after having been filtered through a psychologist. I guess it's your money, or your client's money, but—hey, now it's the psychologist's money!

Second of all, try to figure out what the legal statute is before you call your expert. This step is not always possible, and sometimes you will want to ask your expert for help. One good example is the case I mentioned earlier in which the statute was simple—it was one in which the insurance company would have to pay for wrongful death if the death was caused as a result of a mental disease or defect. However, the original attorney wasted valuable time looking for a psychiatrist who would say that the disease or defect was caused by antidepressant medication. If you don't know anything about the case, it is totally worth it to have someone review the file and tell you what she thinks. Don't shop for an opinion when you know nothing about what caused the crazy behavior. That way lies madness. We have repeatedly discussed this concept. You cannot, as an attorney, look for an expert to lie and say that your theory of the case is the truth. Your theory of the case might be totally crazy. We are not going to lie for you. If what happened in a case looks crazy, smells crazy, and sounds crazy, then chances are good that something crazy actually happened. Find an experienced expert to examine the file, examine your client if there is a living client to be examined, and give you an opinion. Here is where the experienced expert comes in. The fact that "expert" and "experience" have the same root is not a coincidence.

I told you that I always wanted to be qualified as an expert in forensic psychiatry, but they were always making me an expert in regular psychiatry? Well, find yourself an expert in forensic psychiatry anyway. The difference is huge. It does not matter what I get qualified as in court. You want me qualified as an expert in psychiatry in court. The forensic part does not matter, except perhaps to my ego (I spent a lot of time and money on those added qualifications). But I know stuff that non-forensic psychiatrists do not know. In that same case with the two dead guys suing each other, the opposing expert opined that the man who murdered the other man and then committed suicide knew what he was doing; therefore, he could not qualify as mentally ill under the statute. Did she even read the statute? I don't know if she read it or if it had been provided for her, but I do know that she ignored it, and I suspect she had not read it or if she had, she did

not understand what it was there for. Let me remind you of this statute, because it is important in this discussion:

> *…[I]f the insured was suffering from a derangement of his intellect which deprived him of the capacity to govern his conduct in accordance with reason, and while in that condition acting on an irrational impulse he shot and killed [the victim in the case], his act cannot be treated as 'intentional' within the connotation of defendant's insurance contract.*

As you can see, nowhere in this case law is the insured's awareness of what he is doing even mentioned. The reference is quite clear. His intellect must be deranged in a way that deprives him of the capacity to govern his conduct in accordance with reason. For a so-called expert to opine that because he knew what he was doing to make this act "deliberate" is to either willfully misunderstand the meaning of the case law, or worse, to misunderstand it because of no psychiatric-legal training or experience.

Clearly, if you are the attorney in this matter, and you are facing an opposing expert who thinks that this case law means something other that what it means, you do not need me to explain it to you. Knock yourself out. Go ahead and make a fool of her. Sad but true—lawyers are constantly hiring experts who do not know what they are talking about. The reason I began this chapter by talking about the tragic state of psychiatry is because there are a bunch of psychiatrists running around calling themselves experts and yelling things like "low-potency antipsychotics" in courtrooms around America, and they really do not know what they are talking about. And if they do not know what they are talking about, the chances are pretty high that you also will not know what they are talking about, the judge, and jury, if there is one, will not know what they are talking about, and the whole effort will be an expensive waste of time and money.

From a legal perspective, the point of a psychiatric expert is to help you win your case. From a psychiatric perspective, the point of a psychiatric expert is to help you explain your case, which is also the point of this book. You need to understand what your expert is talking about, and so does the court. A report should be informative, not bossy, or so complicated that it is a bunch of multisyllabic meaningless words. For me, every time I go to court is fun. It is my opportunity to teach something about what I do to people who probably know nothing about it.

Now, I happen to be the kind of person who values fun. I know that not everyone does. I know that there are plenty of serious psychiatrists. There are plenty of people who find pleasure in stoicism and deep voices. A good fit between lawyer and expert is important too—if you are one of those kinds of lawyers, then I am probably not the expert for you. I can tell you right now that I will use my hands, I might raise my voice a little, I will use metaphors and examples, and I have been known to blurt out an "are you kidding me?" now and then. On the other hand, I have also evaluated a father and mother for the same case and come up with two totally different results on the same court order for the state,

leaving everyone fairly speechless and leaving the public defender completely unprepared and without a case. Usually, the public defender's case for the parents they represent is: "Doctor, have you ever found that a parent is fit to care for his or her child when you did an evaluation for the state?" Since I evaluate everyone the same way, and I often find that one parent is fit and the other one is not, that particular defense does not work with me, but it does provide for a bit of humor in the courtroom, especially when the public defender has only pretended to prepare for the trial (hence the tragic but sometimes true name, public pretender).

So you've found an expert you like. How did you find him or her? You asked for recommendations, you Googled, perhaps you tried LinkedIn, or you met someone at a conference. Please don't pick someone because they are cheap or related to you, or because you are intimately involved with their relative. That is not the way to pick an expert. You can certainly check their credentials and talk to them, but please do not automatically hire someone's psychiatrist brother just because she happens to be your latest squeeze. Or even her, if she is a psychiatrist, and she squeezes good. Sorry to be so blunt, but you are hiring a forensic expert. Other talents are not required. A certain amount of chemistry with your expert is good. Chemistry alone is insufficient. You need someone who understands the case, who understands you, who has some experience (it does not have to be a lot of experience, but it has to be the right kind of experience), who can write a good report, who can meet a deadline, who understands the rules, who is a member of at least one professional organization, who has passed at least one board examination, and who looks normal. Trust me on this. You do not need an expert who is stunningly beautiful or who looks like a presidential candidate (the old-fashioned kind of tall, male presidential candidate), but you do need someone who looks presentable, clean, and well-groomed. A good grasp of the English language is important (or whatever your local language is), although a charming foreign accent can actually be a plus, as long as the expert's English is fluent. Unfortunately I don't think the opposite holds true—I think an American accent in other languages usually sounds stupid. I could be wrong. The mad scientist look might work for an engineer or statistician, but for psychiatrists—no. People are already too suspicious of us. And fluency in English is more than a primary language thing. You need an expert who can speak with confidence. Notice I said confidence, not arrogance. An expert who speaks with arrogance is worse than no expert at all. Juries do not like to be talked down to. Judges do not like to be talked down to. Think about it—do you like to be talked down to? (And did that just hurt your ears, ending three sentences in a row with prepositions? I checked, and in this particular case, it's allowed.)

So we've hired your psychiatric expert from central casting. Now what? Although we are not actually making a movie, back when I was doing my forensic psychiatry fellowship, we used to have these mock trials, and we learned much of what we did from shows like *L.A. Law* and our childhood memories of *The Paper Chase* and even *Perry Mason*. I've been in other trials, for other purposes, with relatively inexperienced attorneys who totally rocked because they watched a lot of lawyer shows. So I find that viewing the process as a performance is extremely useful. Everyone has a role, and should play it to the absolute

best of his or her ability, up to and including costumes, hair, and makeup. You don't have to look beautiful. You have to look *right*. And looking right means looking right for you. I personally don't look quite as right in a severe black suit as I do in a colorful dress. Everyone has a style that works for them. That's a whole other topic, but give your expert a little leeway. Just make sure he or she is appropriately dressed and groomed.

The first part of the psychiatric involvement in your evaluation is the determination of whether or not you need a psychiatrist. That starts with identifying your expert, which you've already done. As we discussed, you want to pick an expert based upon recommendations and credentials. I want to mention something else here, that many of you might have not considered. Often when I go to court, I am approached after the trial by the other side's attorneys and asked for my card. Sometimes the attorney I have just worked for totally flips out when this happens: "They are manipulating you. They want you to say something off the record. They want to use you for evil." (Maybe not in those exact words.)

Nobody can use you for evil in a case that is already over. When an opposing attorney asks for your card after the trial is over, that is a huge compliment. It means they are impressed with your performance (because it was a performance), and they might wish to consult you in the future. Remember I said right at the beginning that you should not rely on experts that work only for one side or another? A psychiatric opinion—or any expert opinion—should be unbiased. Your expert should have a resume (or CV—I have been informed that these are actually two different things, although I am not exactly clear on what the differences are) that indicates that she is unbiased and that she approaches each case with an open mind. When you cross-examine an opposing expert (we'll get to that), you should determine if he also approaches each case with an open mind, and one way to do that is to ask if he ever does any cases for the other side, be it fathers if he is working for the mother, plaintiffs if he is working for the malpractice defendant, the state if he is working for the public defender, etc. I am routinely asked these questions in virtually every trial in which I testify, and each time I watch the lawyers deflate as if they were popped with a pin. It's hilarious. They have my CV, which says clearly that I have contracts with the Division of Child Protection and Permanency as well as the Office of Parental Representation and the Child Advocate, but they don't bother to read it or to understand what that actually means. And I don't think I am under any obligation to specify what contracts I hold on my CV—I do it for exactly this reason—so I can make fools of them, because it's totally fun, and as I keep saying, the only reason I keep doing what I do is because it's fun. The bottom line is, I'm a doctor. There are a lot of ways for doctors to make money if we don't care whether or not it's fun. It's not the kind of money our parents made back in their day, if they were doctors, but we won't starve to death, either.

On to the report. Some psychiatrists like to write their reports in the form of a letter to the lawyer. I find this format silly, pretentious, and unprofessional. Why would anyone include a letter as a piece of evidence in a trial? The American Academy of Psychiatry and the Law (AAPL) has a decent Web site, numerous publications, and an official format for forensic report writing. Ask your experts to use that format. That's the "correct" format. It makes everything easy to find and follow. It makes finding information easy, asking

questions easy, and comparing your expert's report with the other expert's report easy. It also makes your expert's report look really professional in comparison with another expert's report that might be in some other less professional format.

I'm going to share my report format with you, but in this part, the "you" I'm referring to is the forensic psychiatrist and not the attorney. I couldn't figure out a better way to use pronouns here. So read this section as if you, the lawyer, were you, the psychiatrist. Then share this part with your expert. You'll both know what to do.

The format is basically as follows:

Use your nice psychiatrist letterhead. Since people make their own on their computers, refrain from ugly or hard-to-read fonts.

At the very top center I always write:
CONFIDENTIAL
Of course it's not really confidential, but it's confidential in that you can't just leave this report on a train and let anyone read it. Pay attention to who gets a copy and where it goes.

PSYCHIATRIC CONSULTATION REPORT
or you can write **FORENSIC PSYCHIATRIC REPORT**, which I actually prefer, but a few years ago this total moron from a nearby town wrote a horrible report in which he kept writing "forensic" in quotes when referring to my reports, and I never got to rebut him in court or anywhere, and never got to explain to any judge why he was an ignorant idiot, so I just decided to stick with Psychiatric Consultation Report in case the word "forensic" was too inflammatory for the competition in Central Jersey.

Then you use a Header, which should include:
DATE OF EVALUATION:
DATE OF REPORT:
NAME: (of the person you are evaluating)
ADDRESS:
TELEPHONE #:
SOCIAL SECURITY#:
DATE OF BIRTH:
DOCKET #:
JUDGE:

This part serves a dual purpose. Not only do you have all the identifying information at the top, which prevents the report from getting mixed up from a report on someone else with the same or a similar name, but it also checks if the person is capable of providing his address, date of birth, social security number, etc. Then you don't have to make a show of asking for the information later and making him feel awkward, as if you are checking to see if he is smart, alert, oriented, or all those things we talked about in the mental status examination. If he got himself to the appointment and can answer all those questions, you

can be pretty safe in assuming that he is "awake, alert, and oriented to time, place, and person." If he cannot provide these basic details, then you have a big clue that something is not right.

ANY OTHER CASE-SPECIFIC INFORMATION SUCH AS CASE NUMBER, CASE MANAGER, ETC.

Identifying Information

Who is this person, and why are you writing a report about him?

Purpose of the Evaluation or Psychiatric-Legal Question

What is the question you are supposed to be answering?

Legal Statute

If there is one, it goes here.

Statement of Non-confidentiality

You have to inform the person you are evaluating that your interview is not private or confidential, that you are going to be writing down what they tell you, and that the report is going to go to their attorney and eventually to the court. You also have to inform the person that you are not her doctor and that this interview is not a psychotherapy session, and you are not here to help her to feel better or to treat her—that there is no doctor–patient relationship.

Sources of Information

This part is a list—often a very long list—of every document you reviewed in order to get the information you used to write your report. The more information, the more likely your report is to be detailed and accurate.

Lawyers, take note. If something important is missing, and the opposing attorney says, "Doctor, did you review this amazing document explaining how your (they always say 'your client,' even though it's the attorney's client) client was convicted of multiple homicide 25 years ago?" your psychiatric expert will look at the list and say, "No, I was not provided with that document," and you, Counselor, will be the guy under the bus, not my esteemed psychiatric colleague. Such a thing happened to me exactly once. That attorney and I are still friends, believe it or not (because I am such a likable person) but she no longer calls me to be her expert, because under the bus is not her happy place.

Relevant Data

This section includes the whole story of the case. Here is where your expert gets the first chance to strut his stuff. Many reports include a dry list reiterating a summary of every document without any clear connections between them. Often this part of the report is dictated. Often, it is dictated by someone other than the doctor. I too sometimes use some magic elves to help me with this part, but I train them well. They know how I think and how I write. I review everything myself and make sure that it makes sense. What I am looking for is a cohesive narrative of the events leading up to the person's appearance across the desk from me. A disjointed group of summaries of documents is not a narrative summary.

I find that even paralegals do not always have a good grasp of how to do this task. My brief career as a fiction writer has served me well in this capacity, however. The point of the Relevant Data section is twofold. The first should be obvious: it sets up the background of the case and explains why the person needs a psychiatric evaluation—what happened in his or her involvement with the legal system that necessitated a closer look by a psychiatrist? The second part is perhaps a little subtler, but just as important. You want the person reading the report to actually *read* it. Most readers jump to the recommendations. They skip the meat of the report, the part that explains how the person got there, what are the factors that led to the crisis, and the subsequent legal consequences and the report they are reading today. But the story is really important. The story they might have heard in court may not be the real story. Stories can be very biased anyway. When I tell a story I tell it my way, because I want a certain effect—and that's when I'm telling a story to a group of friends over dinner. Imagine if I were telling a story to a jury for money. You'd better believe I'd be telling a specific version of that story. That bias is what lawyers do for a living. Obviously—you, dear reader, are a lawyer, and you know that much better than I do. What I try to do when I write my report is to take all the bias out of the documents I've received and just try to figure out what actually happened. Who did what to whom, when, where, and how? And then how did all of that stuff led to this one person sitting here with me today?

The Evaluee's Version (or More Politely, Interview with Mr. or Ms. XYZ, the Person You Are Evaluating)

Now that you've written up the official version of events, it's time to find out what the person you are evaluating thinks happened. This section might be long, might be short, might be reliable, or might be the part that shows you and everyone else that "your client" (the lawyer's client) is a megawackadoo. I generally do this part prior to writing up the official history, for a simple reason: if the person never shows up, or the case never moves forward, I have not invested a ton of time which might never be reimbursed (I do a lot of work in the public sector). But if you do mostly private work, and can get paid up front,

or if you work in a forensic hospital or in a setting where you have the luxury of doing the background work first, that way is preferable.

I have worked with many doctors who use this section as a chance to confront the person they are evaluating about the details of their story. In one hotly contested and famous case, which I am saving for my next book, there was a small detail which I found unimportant to the rest of the horrifying story—whether the perpetrator hit one victim with his fist or with a piece of cement. He said he used a broken piece of cement; the victim, who had been knocked unconscious, recalled only that she had been punched. Well, one of my colleagues became unhinged over this piece of cement. He was an amazing psychiatrist—brilliant, experienced, and perfectly understood the case and the risks. But for some reason he became obsessed over this discrepancy between the official record (the victim's statement) and the perpetrator's account. There were at least 10 legitimate explanations for this discrepancy that I could think of on the spur of the moment, and none of them had anything to do with the guy's reoffense risk, which was enormous, and we all knew it. But some doctors, for some reason, get extremely bogged down in some detail and spend much of the interview trying to convince the person they are interviewing that they know better. Remember my mother's expression, a mute wouldn't have said it in a thousand years? The equivalent English saying might be, no poop, Sherlock. Of course the psychiatrist knows more than the criminal. Why some psychiatrists get into these pissing matches with the people they are evaluating, especially in criminal matters, is not exactly beyond me, but definitely an issue for Dr. Freud and company, and not something that we should consider here. But let me promise you that your psychiatric expert should not be spending much time or money on proving to the plaintiff or defendant or to anyone else he is interviewing that he knows that there is a discrepancy between the official version and the interviewee's version. If that discrepancy proves to be important to the outcome, the psychiatrist should discuss it later. We have a section for that at the end. If it is not important, or if it is important because it shows the person is crazy or intellectually impaired or something else, we have a section for that too. If that section proves, to the psychiatrist, that the person is innocent—well, that's a different story. We cannot suddenly change the game. There are ways to bring in that information in an appropriate way, but an expert witness cannot write a psychiatric report saying, "Mr. XYZ is actually innocent." Such a determination would involve a whole bunch of other issues, discussions with the hiring attorney, changes to the report, and motions that would not involve us at all. And really, those types of Matlock moments happen on television far more frequently than they do in real life.

Past Psychiatric History

As much as you can get. Include any past hospitalizations, therapy, outpatient treatment, suicide attempts, self-mutilation, or treatment with medications. If you are lucky enough to get any actual records, summarize them here.

Past Medical History

Any past medical history, including dates, diseases, operations, chronic illnesses, etc. You can, of course, leave out colds and food poisoning, unless it starts to sound weird. Remember our Munchausen's and factitious disorders.

Medications

All of them.

Substance Abuse History

All substances. "When was your last drink?" is a good way to elicit information about alcohol. If someone admits to any type of opiate abuse, be sure to ask if they used intravenously and if they have been tested for HIV. Ask how they support(ed) their habit. This part is generally either really short or the bulk of the report, and when it's the bulk of it, you'll have already obtained all of this information up in the interview part. That's okay. You can write, "see above," and you won't get in trouble. Just make sure you cover what needs to be covered.

Social and Family History

"Were you raised by both your parents?" I learned this question a long time ago, and I love it—it opens up the whole dialogue in a totally nonthreatening way and gives the person a way to discuss everything that ever happened in his life. In this section, you want to ask about the person's early life, education, current life, relationships, history of abuse, domestic violence (both as perpetrator and victim), special education, learning disabilities, family relationships, work history, future plans, and also family history of mental illness, substance abuse, and suicide. Some people have a separate section for those last three, which is fine. If there is a significant medical problem which you think contributes to the person's mental condition and current issues, you might want to get some family medical history as well. But this section is quite open and gives you an opportunity to obtain all sorts of information about the person's life and lifestyle that does not fit exactly or neatly into any other category. With kids, especially, I use this part to ask about future plans. If you think someone might have posttraumatic stress disorder (PTSD), also ask in this part about future plans, since one of the hallmarks of PTSD is a sense of a foreshortened future, and that symptom is bizarrely pathognomonic. I don't know of another disorder that has this particular symptom. Asking about future plans is also a good way to assess if someone is manic. When someone is manic, he will have a lot of future plans. I'm working with one patient right now, who actually just got out of jail for something he did while psychotic, and I just recite the criteria for mania to him, and we both crack up. Then we negotiate the dosage of his mood stabilizer and antipsychotic and he calls me "dude." He knows I'm

right and he is manic, and I don't want him to be sad and depressed, but really, 10 projects all at once? Dude.

Legal History

What is says. All legal history. There is a whole thing about juvenile offenses being "sealed." I don't really know what that means, because if the people you are evaluating don't tell you, they are lying, or at least lying by omission. Certain diagnoses require certain childhood diagnoses in order to make them. To have an adult diagnosis of Antisocial Personality Disorder requires a juvenile diagnosis of Conduct Disorder, which requires some juvenile offenses. The court cannot use these self-reported juvenile offenses to convict someone or to change his sentence or anything. In fact, anything anyone tells you in his psychiatric evaluation goes to his mental state and is otherwise generally considered hearsay (except when it isn't, and I cannot possibly tell you when that happens, because unfortunately in many of the cases with which I get involved, it happens a lot. But New Jersey is very close to the Twilight Zone in this regard, and the Chancery Division—Special Part seems to be its capital, so the best rule to follow is that any legal information to obtain in your psychiatric evaluation is mainly useful for diagnostic and mental state purposes only).

Military History

Find out which branch, how long the person served, and what type of discharge. If it proves to be relevant, you might need to do some research to find out if what the person has told you is actually true. I read a study once, which of course I can't find now, that said that something like 20 times more veterans claimed to be Green Berets than could have possibly served in that division in all the wars put together. A dishonorable discharge might speak to a long history of criminal or psychopathic tendencies, while a medical discharge under honorable conditions might hint at a long history of mental illness. These are clues, and you get to be the detective.

Mental Status Examination

This is where the mental status examination goes. Now that you, the lawyer, have learned how to do one, you won't be freaked out by what the psychiatrist writes, and you will even be able to notice if it is incomplete or silly. Psychiatrists, please don't skip this crucial component, or skimp on it, or mix it in with other parts, because now the lawyers know what belongs here.

Diagnostic Impression

Speaks for itself. Watch out for multiple rule-outs or wishy-washy diagnoses. Also watch out for V-codes, which mean nothing. These are diagnostic codes that were once used for

billing and are now used for nothing (like "victim of childhood sexual abuse"). They can be misleading and do not have diagnostic criteria, nor do they imply anything about the person's mental state.

Stressors

Once we used a five-axis diagnostic system with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). That five-axis system has been eliminated and you should not see it in any report. I have continued using a separate section here for stressors, since people have been used to seeing an axis four (roman numeral IV) for stressors, but strictly speaking, this section is not required. I think it's a nice touch, though, and serves as a little summary of the most important stressors that were included in the body of the report, for all those people who refuse to actually read the report.

Social Functioning

Same as the Stressors section—once included in the DSM five-axis diagnostic system, the Global Assessment of Functioning has been eliminated from the Diagnostic Criteria section, and its elimination is actually quite a good thing, in my opinion. You should never see a numerical value for GAF, or Global Assessment of Functioning, anymore. This number was a random, misunderstood, and capricious thing in the olden days (prior to May of 2013). But again, a little synopsis of the individual's social functioning can serve well here, for the casual or lazy reader who is not going to bother to read the whole report and who wants to obtain all of his information about the case and the person from a quick perusal of the end.

Prognosis

Do your best. In medicine we tend to use words like guarded, poor, critical, good, excellent. A range generally works best. I also like to say things like: guarded to poor without treatment, fair to good with appropriate treatment, in order to underscore the need for the court to read and enact my recommendations.

Formulation and Recommendations

This section is the one that everyone jumps to, of course. The case formulation should, like any good summary, begin with—you guessed it—a summary. Do not reinvent the case, and do not introduce new information here. You'd be amazed how many doctors seem to have failed freshman English. They are unaware of the fact that you do not suddenly dump new information into the summary paragraph. A forensic report is like a college paper. You introduce all of the information in its specific area, and then when you get to the end, you write a summary explaining what you found. That summary then becomes your case

formulation, in which you use your special knowledge of psychiatry (which is not in the paper, but in your brain and your CV) to interpret the information you have acquired and assimilated. But be careful. Nobody likes a show-off, and nobody wants to have to look up the words you use. The goal of the formulation is to explain in simple, elegant language what happened to this person to make him the way that he is. The recommendations then *recommend* interventions to help resolve these issues.

I like to make my recommendations in the form of a list, but to explain each one. So I don't just write "psychotherapy," but I write something like:

- Psychotherapy with a PhD level therapist skilled in working with children who have been victims of sexual trauma. Psychotherapy should occur for about an hour, weekly. Please note that psychotherapy is an ongoing intervention. It is not something that is "completed" or "finished" in order for reunification to occur. Jane will probably expect to be in and out of therapy throughout much of her life. She will probably have relapses and may have severe recurrences of her symptoms throughout her lifetime. A mature and skilled therapist will be capable of understanding her disorder and its presentation and working with her, even given this expected outcome.

I write a similar little paragraph for every recommendation. That way when the same case comes back next year, I can just copy and paste. Just kidding. When the case comes back, I can know exactly what I recommended and I can compare it to what the person actually received. Also, the court and the other people involved know exactly what I mean. There is no mystery about what I mean when I recommend psychotherapy, pharmacotherapy, or anything that I recommend.

I get pretty specific in my recommendations, right down to what antidepressants I like and don't like and what I consider an unacceptably high dose of medication. I talk about side effects, and I include articles about what works and what the federal government says is the right treatment for PTSD. I include position papers from the American Academy of Pediatrics on the use of atypical antipsychotics in children. I've included position papers from the same American Academy of Pediatrics on breastfeeding. Some social services agencies feel justified in removing two-year-olds from their mothers because two is too old for breastfeeding, in their opinion. Are the pediatric guidelines for breastfeeding technically a psychiatric opinion? Not at all. But if the mother is being considered mentally ill for nursing her baby to age two, and the foremost authority in the country says that age two is perfectly fine, then I have to use that document as support for saying that particular mother is not crazy, or at least not any crazier than J.D. Salinger said that all mothers are. At the very beginning of this book, I introduced you to a distant colleague, Dr. Sneaky, who wanted to always side with the child welfare agencies and who would pull any random piece of garbage off the Internet in an attempt to mislead and obfuscate his audience into believing he is an authority on things he knows little about. I don't do that. What I do is find actual information to support my opinions of reality as well as my psychiatric opinion, and use that information in my reports. On several occasions I have had judges wave my reports over their heads in court and say: "I want every psychiatric report to be just like

this one." I know I'm bragging, but I also know that I am doing it right, and I am sharing my proprietary secrets with you.

Certification

Often when you go to court, you have to certify your documents. I avoid later hassles by including a Certification section in every report that goes to court. For my state, it looks like this:

> I, Vivian Chern Shnaidman, MD, being of full age, upon my oath do certify:
>
> 1. I am the record keeper for Vivian Chern Shnaidman, MD, and Jersey Forensic Consulting.
> 2. This report concerning name of person I just evaluated was written in the regular course of business.
> 3. This report concerning name of person I just evaluated was made at the time of the condition and/or occurrences reported therein or within a reasonable time thereafter and accurately reflect the condition and/or occurrence.
>
> I certify that the foregoing statements made by me are true. I am aware that, if any of the foregoing statements made by me is willfully false, I am subject to punishment.
>
> Respectfully submitted within a reasonable degree of medical certainty,
>
> My signature above my typed name

The funny part is that at least half the time I will later receive a copy of my report along with a separate certification page to sign, proving, at least to me, that nobody bothers to read my reports until five minutes before court.

Diagnostic Criteria

This part is my own invention. When I worked in the sex offender prison, and then later in the special facility for involuntarily civilly committed sexually violent predators, I went to court all the time, sometimes several days a week. The very first time, one of the attorneys asked me for the diagnostic criteria for some common disorder, probably Antisocial Personality Disorder. Well, I did not have them memorized to the point of all the words rolling right off my tongue. I felt uncomfortable. I don't like feeling uncomfortable. So I started copying and pasting the diagnostic criteria right out of the DSM and into my report.

That system worked great for years. First I had an electronic version that a friend procured for me. Then I found one online. When the DSM-V came out, I bought the hard copy and then I bought the electronic copy. And guess what? You can't cut and paste! So

now I sometimes take screenshots and paste them in, and sometimes I don't, depending on how important I feel the case is and how much I like the attorney or the case-worker. You, as an attorney, could do your experts a huge favor by somehow digitalizing this document for them. I've complained to the DSM people, but so far, there is no easy way to get those diagnostic criteria into the reports. The screenshots don't look nice. If anyone reading these words does not know what a screenshot is, it's a picture of what you see on your computer screen (or phone or tablet screen). I'm relatively old for our youth-obsessed society, but I've noticed that lots of young people seem square and unhip when it comes to technology, so including diagnostic criteria might prove to be an obstacle for many of your experts. Try to help them. It looks great in court when they can just flip to the end of the report and read a list of criteria out loud.

References

Here is where your expert can look like a million bucks, compared to Joe Blow expert who writes a letter saying (and I see this letter at least once a month):

> To whom it may concern:
>
> Mrs. Smith was taking a variety of medications on the dates in question. All of these medications can impair her consciousness, so she obviously was not competent to write a will and all her millions should go to your client. Thank you for paying me a thousand dollars for this two minutes of mindless work.
>
> Sincerely,
>
> Some random family doctor

When I write a report, I write a report. I look things up. I rely on documents. I interview people. I don't have a Ouija board (my sister got to keep that), so I don't interview the dead, but I know how to figure out what their mental statuses were at the time they wrote their wills, entered into their divorce agreements, or signed their homes over to their pool boys. I use references. I read package inserts, which are all available online. I once had a case in which the grandmother who was being considered as a permanent guardian for an infant had a morphine pump. She also smoked like a chimney. The state was ready to put this little baby with her because the cigarettes and the morphine pump were both legal. So I put in all these references about the effects of secondhand cigarette smoke on babies' lungs and the side effects of morphine on people's brains and behaviors. I knew all that stuff, of course. It's not rocket science. Even rocket science, to a rocket scientist, is not rocket science. But when you put in references, then suddenly what you say carries weight. The fancy word is gravitas (which means weight). The back of this book has a bunch of references in it. I have actually read most of them, which is one of the reasons I needed an extension to finish this book. I can get very distracted by extraneous information.

There is a lot of information out there, and sometimes it can be very useful in supporting your expert opinion. You are allowed to use your computer for looking at things other than pictures of cats. And, you know, that other stuff. So ask your expert to use some references in his report. You'd be amazed what a difference those references will make to the outcome of your case.

So that's how your expert writes a psychiatric report. A few more caveats for expert report-writing and the care and feeding of your expert, before we move on to the other guys:

Quotations

I love using quotations. I type really fast and rarely make a mistake. I read things back to the person I'm interviewing to make sure I got it right. Most lawyers like the way I quote the person and never nitpick what I write. But a few years ago I worked with one particular lawyer who drove me crazy. He did not like the direct quotations at all. He wanted me to paraphrase. I paraphrased. It was difficult for me. It changed my rhythm and the voice of the report. I felt it diminished the impact of the story. We had two cases together, both sexual harassment cases, and that type of case is very near and dear to my heart. I really felt for those girls and really wanted them to prevail (even though I know that's not really my job). I think that the attorney's interference in my report made my work much weaker than it was when I did it my way. I will tell you that when I was in court with one of the victims, I literally had tears in my eyes. I wanted to scream at her attorney—the guy I was working for—to tell him that he was a jerk for making me change the words in my report. Remember this fact: we psychiatrists are experts in human behavior and human emotion. When I write words, I know what emotions they will evoke, and I know the emotions that I felt when I wrote them. I am at a point in my career when I don't get too many wishy-washy cases. I get the cases that have strong emotions associated with them. Let me express those emotions for the plaintiff, or victim, or whoever, the way I know how. Not just me, but whoever is writing the report. We are the emotions experts. You are the legal experts. If necessary, let your expert audio record the session for accuracy and then go back later to fill in some of the blanks. I personally have no patience to do that, but many people do, and it's fine. But get the emotions right. Emotions are the facts of psychiatry.

Which brings me to—Audio Recording

Sometimes people want to audio record their interviews. I have never had a problem with permitting them to make these recordings. I've had friends and colleagues who actually insisted on recording every interview, for a variety of reasons. Some male psychiatrists and psychologists record every session, even treatment, because they want to be protected against future claims of sexual harassment or inappropriate behavior. Sadly, these situations do occur. False accusations happen every day. But what about doctors and experts who refuse to allow recordings? I worry about those people. To me, someone who does not

permit an interview to be recorded has something to hide. Of course, make your own recording—manipulating an electronic file is so easy a child can do it. In fact, a child can probably do it better than you or I can. So make your own recording, use an old-fashioned tape recorder, have someone sit in, make a video recording, or do whatever it takes to ensure that the person you are evaluating does not have the only existing recording. But if that person wants to record the interview, my opinion is that he or she has that right.

I'm not exactly sure what the legal right is, and I think it might be different for different cases and in different jurisdictions. I've had people come to their interviews writing furiously in their notebooks. I've also had people insist I said things I never said. I've had people post things online accusing me of saying things I never said, or even of writing things I never wrote. We are dealing with people who are often psychotic, who live in their own delusional worlds. Remember?

Psychosis is the presence of a thought disorder resulting in an alternate reality in a clear sensorium.

So your person might be "hearing" you saying something you are not saying, and you might never know it until he posts something about it on Facebook years later. And not even then, because you are a professional, and you are certainly not Facebook friends. If you are doing your job ethically, an audio recording of your interview will never be able to come back and bite you in the butt. It can only help you when your wacko turns around and makes a complaint about you.

Speaking of Facebook…

When you are a psychiatrist, you obviously attract some unbalanced people. Unbalanced people tend to do abnormal things. When I worked in the prison, all the staff members were paranoid about the inmates learning our personal information. We all had post office boxes and unlisted home phone numbers (I'm talking close to 20 years ago when people still had home phones). I understood right from the beginning that if someone really wanted to find me, it would be fairly easy to have a friend, or "confederate" as they are known in the jargon, follow me home from the parking lot, and that I would probably never even notice. That said, we do encounter people who do inappropriate, intrusive, and scary things. I had a patient who said to me that he wanted a prescription for a therapy pet. He was quite psychotic and the story is quite complicated, but at one point he unzipped his backpack and pulled out a rabbit. I'm not joking. A black rabbit. Her name, unoriginally, was Midnight. I also learned that I am apparently allergic to rabbits. I further learned that Midnight could have been a gun, and it never crossed my mind that a crazy person could have brought a gun into my office. But really, anything could have been in that backpack. And, in the interests of full disclosure, I walked out of *The Sixth Sense* because I was so freaked out that Bruce Willis had been attacked by a patient. So something that I was already scared of, and knew could happen, sort of happened, and I never saw it coming.

When a super manic woman started harassing me for double doses of medications so that she could give some to her unemployed and uninsured husband, I declined. I did not expect that this husband would start inventing online identities and bombard my personal and professional Facebook pages with nasty messages. I did not expect him to come to my office and threaten my assistant. I did not expect him to go to the local police department to try to file charges against me for some crazy delusional thing which I still don't understand. Fortunately, the police told him that if he did not stay away they would arrest him, but not before he took a photo of my assistant's car and emailed it to me, with the very threatening message of "We know where you live." I'm sure he thought it was *my* car, but still. I did not want anything to happen to either of us, or to any of our children, or dogs, or homes, or anyone. Maybe this particular guy's rabbit really was a gun. And getting rid of those nasty comments proved to be extremely difficult, and expensive—and now I can't accept any comments on my professional page. Plus, it was scary.

It's okay to have a life when you are a forensic psychiatric expert, or when you are a lawyer. I know there was a prosecutor killed in Philadelphia and one in Buenos Aires. Probably there were many more that I didn't hear about. It happens. But in general, you can have friends. You can leave the house. Just remember that people are going to harass you sometimes. Do what you can to minimize your exposure and potential damage. Do not become Facebook friends with your patients, or with people you evaluate for court, no matter how nice they might seem or how much money they won because of you. Don't play golf with them, assuming golf is your thing. I should not have to say this next thing, but please don't date them! There are no prohibitions against dating forensic referrals that I could find, but it seems like good common sense. Just because there is no doctor–patient relationship does not mean that you should throw all caution to the wind. If you really want to screw up your life, there are much easier and safer ways.

What else do we need to know about our own psychiatric expert? I turned to a few more attorneys to get their takes. Sasha Miller practices family-based immigration law, so she has never used an expert herself. Part of her reluctance to expand her practice is her wariness of experts. "The jury has to figure out which expert is correct, but they are laypeople. They have to pick who is more believable or better looking." Sasha feels that the expert's success rate is important, but she wants to know how they relate to other people. She wants to make sure that her expert, when she finally has to use one, will be able to explain information in a way that people can understand. As an example, she told me that she tries to write her briefs in plain language because she wants to be understood clearly by the court. For the same reason, Sasha wants an expert who is really "relatable." She thinks that most people who work as experts are able to testify, but what is important to her is if they can convey what they mean to the judge and jury.

Sasha and I both laughed when she compared her requirements for choosing an expert to her requirements for choosing a nanny for her children. I completely understood. She said, "Anyone can watch your kids for a while. Anyone can learn the basics of child minding. But not anyone can communicate with you and your kids in a meaningful way. Anyone can take care of a child. But not anyone can take care of *your* child." Sasha described what she

thought might be a conundrum: she would like to pick an expert who is compassionate and empathetic, but she fears that more experienced experts might have lost those traits, and she feels if they are too practiced and seasoned, they will no longer have the ability to have empathy with her clients. However, if they are less experienced, they might not be able to do a good job. So for now, Sasha sticks to the family-based immigration cases that do not require psychiatric experts, and the few asylum cases she does also don't require us. However, I think that after our interview, her mind might now be more open.

I also checked with Leslie Rodell, who clerks for a senior federal judge in an undisclosed (to you) location. She sees expert reports and opinions all the time, but although her judge, and therefore, by extension, she, can hire her own experts, they never have. Generally, the parties can and do hire their own experts. So what types of cases use experts? Complex civil litigation, and sometimes in the sentencing phases of criminal litigation, she says—rarely in criminal litigation. I'll mention here that the one federal case in which I was an expert was an amazing case in which I worked for free in an attempt to get on the federal expert witness list. I may be on that list, but clearly, given the insider information I just obtained from Leslie, nobody actually uses it. My case involved a very crazy guy who was suing the state for implanting nanobots in his brain, and my job was to opine on whether or not he was capable of representing himself in court. You should all know my answer by now: A mute couldn't have said it in a thousand years…

So back to Leslie's take on experts. I asked her how she would be able to tell the difference in different psychiatric experts' reports. She says that there are different layers of analysis and that the case itself determines whether or not the expert report can even be admitted. In a civil case, the report has to be "reliable and helpful," based upon Federal Rule of Civil Procedure 702, which she actually had on her desk while we were speaking. I was impressed. Further, the expert has to be qualified and his opinion has to be helpful. Then the judge "just" applies the standard rules for burden of proof and evidence, according to the type of case, whether it is clear and convincing evidence, preponderance of the evidence, or clear and convincing proof. In a jury trial, the use of expert testimony is entirely up to the jury in federal cases, just as in civil cases, and the judge never weighs credibility. Leslie had no opinion that she could share with me, even using a pseudonym, on how to deal with the credibility issue, but she will make sure her judge reads my book. She did tell me that rarely in criminal cases, the judge has to weigh the reports and make a decision, but often only one report is part of the information provided to the court. So, we see that attorneys would probably like more guidance in how to pick experts and deal with them, but the guidelines and available information are very scant, and as many people I spoke to have noted, the experts are judged primarily on how they look and speak, and their testimony is not well understood. And that, ladies and gentlemen, is really why we are here.

So let's move on to the reason you bought this book: how do you destroy the opposing psychiatric expert in court? I would recommend starting at the very beginning. Don't stipulate to the doctor's qualifications. Why do I recommend not stipulating? Because many times, the expert is no expert at all.

Earlier in this book, I mentioned a case in which a woman had been shot five times when she walked into the path of gunfire not intended for her. She had damage to her hand and to her neck, resulting in multiple problems, including permanently slurred speech, known in the jargon as dysarthria. This dysarthria caused her to be repeatedly accused of abusing illegal substances. When no traces of illegal substances could be found anywhere in her urine, blood, or hair follicles, she was accused of bringing in adulterated samples for testing. Both of her children were removed from her custody. Nobody involved with her case, including multiple medical professionals, made the connection between the injury and surgery to her neck and the resulting dysarthria.

At some point, she was evaluated by a so-called expert in psychiatry. I know most of the experts in this state, at least by name, so when I encountered an unfamiliar name, I did what any self-respecting red-blooded American psychiatrist does: I Googled it. I found a very strange combination of information. Apparently this "expert" had tried a couple of different training programs in both psychiatry and neurology but did not stick to either. He left his original state and moved to New Jersey, where he now worked in a clinic. He called himself a consulting psychiatrist, so I moved onto the American Board of Psychiatry and Neurology's Web site, where it took me about two seconds to learn he was not board certified in either psychiatry or neurology. This expert was clearly not an expert. He was a pretender. So before you go to court, check the opposing expert's CV. Google him. I heard of a case where the so-called expert had actually made up all his credentials. He presented himself as a psychologist with a PhD, but he was actually a nothing—just some guy from a self-help group in the Bronx.

Often in the voir dire, I hear questions that I consider ridiculous. They are sometimes directed at me, sometimes at some other expert. Things like, how many people with schizophrenia have you testified about? I don't know, and who cares? What psychiatrist has not seen, I don't know, 5000 schizophrenics in her career? It's like asking a mechanic how many tires he has changed. Why would he even think to keep track? How many papers have you written about the placement of children in group homes? Um, none. So what? That's not what this case is about, and again, who cares? I'm here for my psychiatric expertise, not for my knowledge of group home architecture or whatever you might be asking about. For sure, I've been in more group homes and have more experience with children who have been placed in them than you have, my dear cross-examining attorney.

Asking how much money the expert has been paid for his testimony is a surefire way to get the expert angry, but it also is a surefire way to make yourself look bad. Every expert knows to say that he is being paid for his time and professional expertise, "just as you are being paid right now, Counselor," so that approach is unlikely to make you look good. On the other hand, in certain cases, eliciting a dollar amount might work in your favor, like in the case we discussed in a previous chapter when the expert earned 250,000 dollars and still lost the case for the plaintiff. Save and savor those moments. Nobody is going to be impressed with the state's hourly rate, believe me. In New Jersey we have not even had a cost-of-living increase in about 10 years (from the same state that brought you Bridgegate and the Secaucus Junction

Train Station). However, if you can prove that a certain expert made so much money from the state that his billing had to be fraudulent, that could theoretically help your case, but far be it from me to name names.

The take-home message, though, is not to automatically stipulate to an expert's qualifications. I know that often everyone stipulates, especially in the public sector, where everyone is either employed or has a contract, and theoretically those qualifications have already been vetted, and the government is trying not to waste time and money. It is possible for the attorneys to do their homework and check out the qualifications ahead of time and get right to the problems in the expert's CV without wasting a lot of the court's time. I do not wish to imply that not stipulating should serve as a way to waste time or to detract from the case itself. I really think that there are experts who are not capable of rendering the professional decisions they are rendering, and you, as the responsible representative of your client, have the duty to ensure that those experts do not have the same claim to the court's ear as your far more knowledgeable expert.

So we've permitted the other expert to testify. He has submitted a report, and the other attorney has questioned the expert and the report has been submitted into evidence. Now what?

There are a million different ways to attack a report. Sometimes the problems in the expert's report are so clear, so obvious, that you just need to start at the beginning. Many lawyers, for want of anything better, love to nitpick. Nitpicking—by which I mean, errors in pagination, typos, or the like—rarely gets you anything but an annoyed expert and at best a chuckle from the judge or jury. People make typos. Autocorrect can be hilarious but is rarely intentional. Those types of issues might delay the outcome of the trial but rarely do they actually change anything. A defensive, angry opposing expert will look defensive and angry, but since he is not *your* defensive angry expert, you cannot count on him getting confused, misspeaking, and helping your case. I personally am good at using anger to my advantage. When someone tries to make me look stupid, I can generally make him look like he needs to repeat third grade. I don't recommend this tactic for my colleagues, who, after all, did manage to get into and graduate from medical school.

A far better tactic is to question their reasoning. You should go through the regular questions that you learned in law school: is this the way that someone in your profession writes an expert report? Are these the customary sources that people in your profession rely upon to gather information? Blah blah blah. I highly recommend making the opposing expert comfortable, rather than uncomfortable. They don't expect it. They expect confrontation and hostility. You can kill them with kindness. Also, try to get a feel for their personality, which you should have by now. If your expert was permitted to be in court during the opposing expert's testimony, ask your own expert for his opinion. What are the weak points in the testimony and report? What is their guy's personality like? What are his insecurities? (Generally these guys have no obvious insecurities, which is an insecurity all by itself.)

I have found three main problems in opposing experts' reports, and if you know where to look for them, you will find them too.

Relying on Hearsay Information Rather than on Primary Sources

This tendency amongst experts to get their stories from the reports of other experts or from legal pleadings is widespread. It is also wrong. Remember what I told you about how we spin a story? Your story, as the lawyer on one side of a case, is going to be different from the other attorney's story. That's how the legal system works. It is an adversarial system, where both sides pick and choose facts and position them in ways meant to display their own bias and goals. Experts are not permitted to be so biased. While of course an attorney hires an expert to help win his case, he cannot withhold information, ask his expert to lie, manipulate the discovery, or do any of the things that we have already discussed are not permitted. Therefore, if you notice that the opposing expert has not been handed a full deck, start with the facts.

"Doctor, were you aware of this document, which is in evidence as Plaintiff's exhibit P-153 (or whatever)?"

The good doctor, if he did not list this document in his Sources of Information section, is most likely not familiar with it. But you know that he should be familiar with it, and if he is not, you can give it to him and ask him to read it. I don't know what the appropriate rule of evidence is, but if that piece of paper is in evidence, Dr. Opposing Expert can be asked to consider it. And if there are 20 such documents that were withheld from Dr. Opposing Expert, well, it sucks for him. But ask nicely. Remember, it is probably not his fault that he was duped and misled. Your ultimate goal here, in the best-case scenario, is to have Dr. Opposing Expert end up agreeing with your expert (see *My Cousin Vinny*). If you alienate him right up front, agreement will never happen, on principle. So try to keep everything as pleasant as you move in for the kill. Remember the famous quotation from *The Godfather*: "Keep your friends close, and your enemies closer." (I too thought that the original quotation came from Sun-tzu's *The Art of War*, but it doesn't.)

The way to destroy the opposing expert's report is to show that the expert took the same information as your expert and somehow made an error in interpretation. This sleight-of-hand is going to be difficult, because you are a lawyer, not a psychiatrist, and you don't really know how he uses the available information—or you didn't, until now. Now you've read this whole book, and you have a much better grasp of the whole concept of what psychiatry is and how it works. You have a better understanding of how the diagnostic process works. You understand that we cannot simply pull a diagnosis out of thin air and magically apply it to the person we are evaluating in order to fit an attorney's theory of the case or need for a specific individual to have a certain diagnosis. So look at the story that the opposing expert is presenting. That's the first step. If he screwed up the story, find out why. Is he deliberately withholding information, or did someone withhold it for him? Get him to admit that in cross-examination. But do it in a nonthreatening way, because we are not there yet. We are just laying a foundation. Remember that psychiatric-legal question. The point of this exercise is to get him to give a different answer to the psychiatric-legal question than the one he gave initially, or if you can't do that, at least get him to stick

stubbornly to his original answer with a clear lack of support. Sometimes, you won't be able to do that. Sometimes, you are just backing the wrong horse, and hopefully when that happens, you will figure it out way ahead of time and settle before you ever get to this point. But when you are backing a winner, try to stick it through for the win. Let's approach this win in a systematic and elegant way.

In order to be systematic and elegant, you must have your expert read the opposing expert's report ahead of time and figure out what's wrong with it. This task might cost you a few bucks, but the advantage it will give you in court will be invaluable. Every lawyer I spoke to described how focusing on typos and errors is pagination was "theatrics." They all used the same word. While I can totally enjoy a night out at the theater, the courtroom drama does not belong in the actual courtroom. Be smarter than your competitor. First of all, when you get your expert's report, check it for typos and errors in pagination before you pass it on in discovery. With the magic of technology, it takes a minute. There is no reason why these errors should exist, at least not for your experts' reports. When your expert reads the opposing expert's report, it's fine to take note of those errors. But the reason they are important is only as a general piece of information. Sometimes when there are a lot of typos, there are other errors also. Look for the multiple rule-out diagnoses and V-codes. Those are things to focus on in cross-examination when you get to them.

Take the report in order. Errors in basic information and in the basic story, like multiple names, dates of birth, and spellings for the characters in the story without any note of explanation does not mean that the expert is an idiot, but it does suggest that he lacks a certain curiosity or interest in the case. When I read records that have multiple identities for the same person, I always want to find out what is causing the discrepancy and if it is significant. Usually it is insignificant, but occasionally, you will find someone else's criminal history mixed up in the file, as we discussed elsewhere in this book. Those types of errors are very important. The opposing expert needs to notice those errors. So showing no curiosity or interest in aberrations in the records suggests, but does not prove, a lack of interest in the history. You can, as the questioning attorney, use this lack of interest to your advantage. How exactly will depend on the case. Missing information, missing documents, reliance exclusively on hearsay evidence, reliance only on the self-report of the person they have evaluated and not at all on official documents—these are all big no–no's and definitely open for questioning and interpretation in court, by you.

Eventually, after you go through all of that amassed information, and there is a lot, or supposed to be a lot, you get to the opposing expert's diagnostic impression. Here is where you get to ask him how he reached his conclusions. Here is where they tend to drop the ball. Often there is little to no information in the body of the report to support the diagnostic criteria for the diagnosis. And often the diagnosis is unsupported by diagnostic criteria anywhere that the expert can access. That is, the expert will be unable to recite the diagnostic criteria in court. You, the attorney, should have copied or printed out the diagnostic criteria to all of the opposing expert's diagnoses prior to entering that courtroom. Don't bring the whole DSM, or bring it, but don't flip pages. It might look good on television, but it takes time,

is distracting, and makes you look unprepared. Have copies for everyone. You want to admit those diagnostic criteria into evidence. As much as the DSM creators say to use caution for forensic purposes, it's all we've got. You can't have a psychiatric disorder that isn't in that book. It's stupid, and from a medical perspective it's not even true, but from the way that medicine and psychiatry are practiced in the United States today, you've got to make it fit one of those diagnoses, or something else that has been described and published in the literature. So if it's psychopathy, better have a printout of that. Let the expert hem and haw on the stand, unable to describe it, or to quantify or qualify his diagnosis. Then, you walk up there with Dr. Hare's description. You walk up there and say that it is not a DSM diagnosis and does not qualify for an insanity defense (or whatever the issue is). You will have previously consulted with your expert, and you know exactly what to do, and it is NOT dissing him for having two page 10s. That's just silly. You can point it out to make him look silly AFTER you've made him look silly for not knowing that psychopathy is not a DSM diagnosis.

V-codes

These are just stupid. They are useless and serve only to get the insurance companies not to pay you for anything. Psychiatrists who continue to use them are merely dating themselves. Ask them why they are using these V-codes, what their purpose is, what they mean, and how they influence the case.

Rule-Outs

I cannot emphasize this fact enough. Two rule-out diagnoses might be necessary, for example, bipolar disorder versus schizoaffective disorder. More than two and the expert is just asking for trouble, and you are going to be his trouble. The DSM people want us to list ALL the diagnoses for which the person meets criteria. The expert can list many diagnoses, but if he lists a whole bunch of rule-outs, then he is not comfortable with the case or the history. He, in those proverbial words of the guy who hit us on the George Washington Bridge all those years ago, "doesn't know where he is going." Use that. Let him go there. Let him tell the court that he does not know what is going on with this individual. You get a closing argument. You get to say: "Dr. Opposing Expert was unable to even make a diagnosis. He was therefore unable to make a logical and reliable case formulation. We cannot rely on anything he told us. We must therefore rely on Dr. Shnaidman's reasonable, thoughtful, and elegant psychiatric evaluation, case formulation, and recommendations."

Here are a few more things I want to mention about the opposing expert's report.

Medications

Look up all the medications and medication recommendations, and ask your expert for recommendations. If your expert is not extremely familiar with psychotropic medications, get a new expert. I'm serious. A friend of ours just took his son to the pediatrician to get attention deficit hyperactivity disorder meds. He asked me if it was true that stimulants

restore the normal balance of dopamine to the brain, because that's what the pediatrician told him. Well, no, they don't. That pediatrician is not an expert. He is also not our pediatrician, fortunately. Get multiple opinions. You can ask Dr. Google. There's lots of garbage online, too, but presumably the idea behind making psychiatrists get recertified every 10 years was so we would know something about how the medications work. Make sure that your experts know which ones are antidepressants and which ones are antipsychotics. If they don't, get new experts. I'm not kidding; I don't care how many publications they have and how far apart their pinstripes are—you might have me on the other side, and I will destroy your famous expert. No offense. Haldol and Ativan are so 20th century.

The Blood–Brain Barrier

I just realized this term did not come up anywhere else in the book, but it might come up in an expert report or opinion. The blood–brain barrier is a concept, more than a thing. It is a barrier between the general circulatory system and the brain. Not all medications get into the brain. Many side effects in the body are a result of needing high doses of medications so that some of them get into the brain to do their work. Other medications never get into the brain at all, and work only in the periphery (the rest of the body), but may have effects there. Some medications work in both places, and if that's how they work, the doctors who prescribe them should know exactly that there is a dual mechanism involved. Know this term, because you might want to ask about it in a malpractice case, like when your client attempts suicide after being abruptly withdrawn from a megadose of an antidepressant being marketed as a pain reliever. Hypothetically speaking.

Corrective Emotional Experience

Okay, this one really does not belong here, but we are almost at the end of the book, and it did not come up again, but I brought it up at the beginning and I promised. The Freudians would probably have a more complicated explanation, but in its essence the corrective emotional experience is exactly what it sounds like. Something bad happens in your life and wounds you emotionally. It can be short or long, super painful or mildly painful. It can be bad mothering or a rape, an insult or a tragic loss. It doesn't matter. The idea is that later in life, you experience a similar situation but with a positive outcome. That's the corrective emotional experience, when you come out better at the end. The idea is that the second experience "corrects" the damage caused by the first.

Obviously I'm oversimplifying. We non-analysts who had some basic training in psychoanalytic theory joke about the corrective emotional experience a lot, but there is definitely something to this concept. Leaving a bad job for a good one, or a bad marriage for a good one, can be a corrective emotional experience. In day-to-day life, examples might be not getting food poisoning from the same sushi restaurant where you once did. Or something like that. This concept might come up in a case or a report. It probably won't, but at least now you know what it is.

Prognosis

Pin down your expert. We said earlier, waffles are for maple syrup. Not very original, maybe, but psychiatric disorders do have reliable prognostic information associated with them. In general, something with the word root "schiz" in it is going to have a worse prognosis than something without it. A neurocognitive disorder will have a poor prognosis. Depression and anxiety? Not so bad. Obsessive–compulsive disorders? Treatable but variable. You can read the statistics. Remember that DSM stands for Diagnostic and *Statistical* Manual.

Some of you might be thinking I dropped the ball on our friend Mo, the quasi-terroristic podiatrist whom we last met in a holding cell in some midwestern state. His public defender, Jessica Zhang, was in the process of transferring him to the local county psychiatric hospital where he was about to get a psychiatric evaluation. What did Jessica learn, and what happened with Mo's case? Let's find out, and let's see what we can learn from this tragic story. By now you are familiar with the format of the forensic report, so let's pretend you know the beginning. I'll give you a little info, just for completeness. I'll skip the things you know belong there, such as the confidentiality part, sources of information list, and the legal statute, especially since I would just have to make one up. In addition, I'm not including any dates or places. Obviously, when you read or write a real report, this sort of information is very important. For our purposes, we have to assume that this information is in there, but clearly, it's not there because the case is not real and I don't have real sources of information. So for the sake of clarity and making the psychiatric information easy to read and follow, I'm not making up details—I'm just leaving them out. But in a real report, I wouldn't leave them out, and they would be very important. I hope everyone understands this point, because I'm not going to belabor it any further.

Identifying Information

Benjamin Goldstein, aka Mohammed Abu-Amy, is a 43-year-old white male who is currently undomiciled and is an inpatient on the forensic unit at the North Nowhere County Psychiatric Hospital, where he is awaiting trial on 15 charges, including one indictable offense: Terroristic Threats.

Psychiatric-Legal Questions

1. Is Benjamin Goldstein competent to stand trial (fit to proceed)?
2. Did Mr. Goldstein understand the consequences of his actions when he committed the instant offenses?
3. Does Mr. Goldstein need psychiatric treatment, and is he competent to refuse treatment?
4. Is Mr. Goldstein capable of actually making child support payments?
5. Is Mr. Goldstein capable of managing his own financial, legal, and medical affairs?
6. Does Mr. Goldstein qualify for disability payments?

7. Where should Mr. Goldstein live—can he live independently?
8. Did Mr. Goldstein change his name legally, and if not, which name should be used in the legal documents?

Relevant Data

According to the documents listed above, Mr. Goldstein first came to the attention of the North Nowhere Sheriff's Department after creating a disturbance in a local Waffle House. He cursed at the staff, made statements that the staff interpreted as threats, and was mistaken by staff as an Arab terrorist. Later, after his arrest and transport to jail, he was determined to actually be a Jewish podiatrist from New Jersey. He reportedly had some mental health issues dating back several years. The records show that he had some previous issues with making threats to the president of a local synagogue in his previous New Jersey town. He either lost or voluntarily left his job, lost his home, and moved with his wife and two children to his wife's parents' home in a neighboring state. He began fraternizing with Muslim students at the local state university, and his father-in-law asked him to leave that home.

Prior to his threats and downward decline in New Jersey, Mr. Goldstein seems to have had no previously criminal or psychiatric problems. His previous legal involvement was adjudicated at the municipal court level and was resolved with fines and "counseling."

Past Psychiatric History

Mr. Goldstein has never had any psychiatric treatment prior to his hospitalization at North Nowhere County Hospital. While on this unit, he initially refused all treatment with medication, although he eagerly attended group treatment. Eventually, we petitioned for treatment over objection and began injections with long-acting injectable antipsychotic medications.

The results of treatment were dramatic. Mr. Goldstein's mental status cleared up immediately. He became pleasant and cooperative, although somewhat sad and despondent when the significance of recent events became apparent to him. He stopped asking to be called Mohammed and no longer referred to himself as Muslim. He began reaching out to his family, both to his nuclear family—wife and children—as well as to his parents. He expressed remorse about his actions but also appeared mystified and embarrassed about his behaviors. He insisted he must have a brain tumor, which was investigated and ruled out.

Currently, Mr. Goldstein is stable on oral medication, which he is taking voluntarily every day. He attends group and individual therapy and is ready to be transferred back to jail.

Past Medical History

Unremarkable.

Medications

Some oral antipsychotic medication.

Social and Family History

You already know most of this part. Here is the part you don't know. Mo/Ben's maternal grandmother was institutionalized for most of her life in a psychiatric hospital. His sister is reportedly bipolar and alcoholic. His maternal cousin committed suicide after several psychiatric hospitalizations.

You also do not know that Mo/Ben never actually converted to Islam or changed his name. Also, he was taught to be very suspicious of Muslims in his family of origin.

Substance Abuse History

Mo/Ben experimented with a nice variety of illicit substances during high school, college, and podiatry school, but stopped using anything, including alcohol, over five years ago, when he discovered Islam.

Legal History

Just what you know.

Military History

None.

Mental Status Examination

Benjamin Goldstein is a 43-year-old white male who looks his stated age. He is awake, alert, and oriented to time, place, and person. He is pleasant and cooperative with a somewhat flat affect. Speech is logical and coherent. Currently there is no formal thought disorder. Thought content is relevant to the context. Psychomotor behavior is within normal limits, with possibly some mild jitteriness of his extremities (akathesia). Mood is "regular."

Sleep is "good." Appetite is "enormous." Ben denies anxiety, phobias, obsessions, or compulsions. He denies suicidal or homicidal ideation or intent. He denies auditory or visual hallucinations, although clearly he has experienced these in the past and he recalls them (with embarrassment). No systematized delusions are elicited. Intelligence is estimated to be high-average to superior. Cognitive functioning is grossly intact. He could spell the word WORLD forward and backward without difficulty, suggesting adequate attention. He was able to count backward from 100 by sevens, suggesting good concentration as well as

good memorization of math facts. Abstractive ability is adequate. Insight and judgment are currently adequate, although both have been severely impaired in the past.

Diagnostic Impression

Chronic Paranoid Schizophrenia, currently under control with medications.

Formulation and Recommendations

Benjamin Goldstein is a 43-year-old man whose decline into mental illness is typical for a certain type of chronic paranoid schizophrenia. Mr. Goldstein was able to complete his education, work in his profession, and marry and start a family, all while harboring strange thoughts and ideas—delusions. He experienced auditory hallucinations, which he did not identify as such. Being intelligent and organized, he continued to work, all while incorporating his delusional ideas into his daily life. Around age 35, as is typical, his delusions became so prominent that he was no longer able to function appropriately. He became so paranoid and felt so threatened that he started to lash out and to allow his strange beliefs to affect his everyday life.

At some point, he began to identify with Muslim terrorists, a group which he had been raised to see as his own enemy. He took a Muslim name, never legally, and incorporated his Muslim identity into his delusional system. His thinking became disorganized. His grandiosity became so pronounced that he no longer understood that he needed to work in order to support his family. He donated his assets and defaulted on his mortgage. He made threats against the president of his synagogue and incurred municipal charges. However, nobody recognized that he was psychotic; therefore, the case remained at the municipal level and resulted in the payment of a fine and referral to so-called "counseling." His counselor, a young woman with unclear credentials, also did not recognize that he was psychotic, and did not refer him for a psychiatric evaluation. Therefore, Mr. Goldstein became more and more paranoid and delusional. Eventually he was forced to leave his home, on which the bank had foreclosed, and move with his family to his in-laws' home in a distant state.

Mr. Goldstein responded well to treatment with antipsychotic medication. He currently has some insight into his condition and understands that he has a mental illness. He has been in touch with his family, and they agree to allow him to move in with them. His recovery process will be difficult. He has no license to practice podiatry in their current state, and it is unclear if he can even deal with the stress of such a practice, given his current condition and the effects of the mediation. We do not know if his mental condition will worsen, or if he will comply with treatment. Most patients do not comply with medication indefinitely.

Let us now address the referral questions:

1. Is Benjamin Goldstein competent to stand trial (fit to proceed)?
   Currently, Benjamin Goldstein is fit to proceed with the current pending charges against him.

2. Did Mr. Goldstein understand the consequences of his actions when he committed the instant offenses?
   At the time of the events in question in the Waffle House, Benjamin Goldstein was unaware of the consequences of his actions. He believed that the employees of the Waffle House were deliberately trying to poison him by giving him bacon.
3. Does Mr. Goldstein need psychiatric treatment, and is he competent to refuse treatment?
   Mr. Goldstein is currently compliant with psychiatric treatment. He was initially noncompliant with treatment, and we had to go to court to obtain treatment over objection, because he did not have the capacity to refuse treatment and did not understand that he was severely mentally ill and out of touch with reality.
4. Is Mr. Goldstein capable of actually making child support payments?
   Mr. Goldstein currently is not employed and has no ability to make child support payments. He is also still legally married, and therefore, no child support statute applies.
5. Is Mr. Goldstein capable of managing his own financial, legal, and medical affairs?
   As of today, Mr. Goldstein is capable of managing his own financial affairs; however, this situation could easily change. The question is fairly moot, however, since he has no income and is currently receiving emergency Medicaid to cover his current hospitalization. Mr. Goldstein should appoint a power of attorney while his mental status is clear, in case he later decompensates and becomes incapable of managing his own affairs, as we know that chronically mentally ill individuals usually become noncompliant with medications, psychiatrically decompensate, and require additional hospitalizations and treatment.
6. Does Mr. Goldstein qualify for disability payments?
   Mr. Goldstein should probably apply for SSI and could use a good disability attorney to assist him in this matter.
7. Where should Mr. Goldstein live—can he live independently?
   In an ideal world, Mr. Goldstein would live at home with doting family members and something to do all day to keep him busy and interested. Since we do not live in an ideal world, he should, with the help of his therapists, social workers, etc., try to negotiate for his family to take him back. If they refuse, he may qualify for some sort of supervised housing program for the chronically mentally ill, but first he has to be approved for some so-called "entitlements," such as SSI, Medicaid, and Medicare, which could take a very long time. He will also need to get divorced (requiring another lawyer) in order to qualify for these entitlements, or else his wife will be financially responsible, and we know that she does not work.
8. Did Mr. Goldstein change his name legally, and if not, which name should be used in the legal documents?
   Mr. Goldstein never changed his name legally, and since he was psychotic and delusional when he called himself Mo Abu-Amy, in no way should that ever be considered his real name.

In conclusion, Mr. Goldstein is fit to proceed with the matter against him. It is my opinion that any so-called Terroristic Threats were uttered during a psychotic episode, and that this man's life as he once knew it is over. He is now homeless, unemployable, and has a shuffling gait. He will soon be overweight and have diabetes from his medication. However, he is now able to work with his attorney in a rational and factual manner, and the court should feel free to waste its time and money sending him to prison, or fining him money that he does not have.

Respectfully submitted within a reasonable degree of medical certainty, Your fictional expert.

I hope this fake report, with its perhaps slightly sarcastic formulation and recommendations, has helped you to understand and interpret your real experts' reports. This invented case is a sad one. I made it up, so I made up a guy who was not going to get much better. He will be okay, but he will never be Dr. Goldstein again. He will be sort of okay. I could have made up someone else, but I wanted to get every possible type of legal case into one story. I got everything but immigration in, and I think I could have fit that in too if someone thought Mo/Ben should have been deported for being a real terrorist. My point is that anywhere along the legal spectrum, you might bump into crazy. You've read this book, and now you know you can always call a psychiatrist, and ask for some help. And if the clients make you really crazy, you can call a psychiatrist to ask for help for yourself, too. We don't mind!

Good luck in your future endeavors as enlightened attorneys. Thanks for taking this journey with me. I've really enjoyed it, and I hope you did too!

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Glossary

AAO×3 Awake, alert, and oriented to time, place, and person
AAPL American Academy of Psychiatry and the Law
ADA Americans with Disabilities Act
ADHD Attention deficit hyperactivity disorder
Akathesia Mild jitteriness of the extremities, restlessness
Alzheimer's Disease A disease of the brain that causes people to slowly lose their memory and mental abilities as they grow old (Webster's def.)
Antisocial Personality Disorder A pervasive pattern of disregard for, and violation of, the rights of others
APA American Psychiatric Association
Ataxia Unstable gait
Blood–Brain Barrier Barrier between the general circulatory system and the brain. Used for understanding how some medications affect the brain, body, or both
BOCES Boards of Cooperative Educational Services
Comorbidity The simultaneous occurrence of more than one psychiatric disorder
Delirium Being generally disoriented to time, place, and/or person
Dementia A mental illness that causes someone to be unable to think clearly or to understand what is real and what is not real (Webster def.)
DHS Department of Homeland Security
Dissociative Disorders A group of disorders in which people lose their knowledge of their own identities
Dissociative Identity Disorder When somebody experiences a severe trauma, such as sexual abuse, part of the personality splits off and develops separately as protection from the trauma (formerly Multiple Personality Disorder)
DSM *Diagnostic and Statistical Manual of Mental Disorders*
DTs Delirium tremens, the syndrome of medical withdrawal from chronic alcohol dependence
Dysarthria Physically unclear speech
Facies Facial abnormalities
FAE Fetal Alcohol Effect—lifelong problems (behavioral and cognitive) that develop after exposure to alcohol as a fetus
FAS Fetal Alcohol Syndrome—lifelong problems (behavioral, cognitive, and facial abnormalities) that develop after exposure to alcohol as a fetus
Fitness to Proceed Competency to stand trial
Forensic Psychiatry When psychiatrists are trained to evaluate individuals for a third party
GAL Guardian at litem
GED General Education Diploma
Harm Reduction Model Idea that addiction cannot be eliminated, only managed, and that addicts might require different solutions, different treatment plans, and different lifetime interventions
Hebephrenic Schizophrenic A schizophrenic whose delusions had not yet congealed, or become "systematized"
Hypochondriasis Fear of having serious disease
ICD International Classification of Diseases

Insight A person's knowledge about himself or herself; a person's understanding of his or her own mental illness, knowledge about personality or personality traits, knowledge about one's behavior, or simply the understanding that he or she needs to take medication to help with a problem (see Chapter 6)

IOP Intensive outpatient program

Korsakoff's Amnesia A late neuropsychiatric manifestation of thiamine deficiency in which the damage to the brain becomes permanent. It presents with memory loss, including both anterograde and retrograde amnesia, and confabulation

Lupus A disease that affects the nervous system, joints, and skin (Webster's def.)

Macdonald Triad Set of early behaviors that were believed to be an indicator of later violent psychopathy—bedwetting, fire setting, and cruelty to animals

Malingering Deliberately feigning (as can be seen with mental illness)

M'Naughten Rule A traditional "right and wrong" test of legal insanity in criminal prosecutions

MOC Maintenance of Certification (exam)

MRSA Meticillin-resistant *Staphylococcus aureus*

Munchausen's by Internet When someone pretends to have a serious medical condition and portrays himself online as a sufferer

Munchausen's by Proxy A syndrome in which actual medical signs and symptoms are created by someone in another person, usually by a parent in a child

Munchausen's Syndrome A syndrome in which actual medical signs and symptoms are created by the sufferers

NGRI Not Guilty By Reason of Insanity

NMDA *N*-Methyl-D-aspartate

Nosocomial Infection Infections that are created in the hospital

OCD Obsessive–compulsive disorder

Ophthalmoplegia Eyes that do not move properly

Parkinson's Disease A disease that affects the nervous system and causes people's muscles to become weak and their arms and legs to shake (Webster def.)

PCS Post-concussion syndrome

Personality Disorder An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

Polygraph Test A pseudoscientific but high-tech-looking group of instruments that measures primarily the galvanic skin response, which is thought to be indicative of lying

POTS Postural tachycardia syndrome

Prozac The first serotonin-specific reuptake inhibitor; antidepressant

Pseudopsychopathy The apparent psychopathy of people with right frontal lobe damage—"a condition of personality following frontal lobe lesion in which immature behavior, lack of tact and restraint and other behaviors symptomatic of psychopathology are apparent but are not accompanied by the equivalent mental or emotional components of psychopathology"

Psychiatry Branch of medicine that incorporates biological, psychological, and social information and constructs for assessing and treating patients

Psychopaths People who have no inner moral compass, who need high levels of stimulation in order to feel anything, who obtain satisfaction from hurting others or taking advantage of others (not necessarily in a sadistic way, but sometimes), and who therefore enjoy taking risks

Psychopharmacology The study of the effect of drugs on the mind and behavior (Webster's def.)

Psychosis The presence of a thought disorder resulting in an alternate reality in a clear sensorium

PTSD Posttraumatic stress disorder

Rule-out Diagnosis Considering a diagnosis among many possible diagnoses

Schizophrenia Mental illness in which someone cannot think or behave normally and often experiences delusions and hallucinations, must include a thought disorder

SLE Systemic lupus erythromatosus

Somatic Symptom and Related Disorder Mental disorder where physical symptoms cannot be explained by medical tests

SSRI Serotonin-specific reuptake inhibitor

Tardive Dyskinesia A neurological disorder characterized by involuntary uncontrollable movements, especially of the mouth, tongue, trunk, and limbs, and occurring especially as a side effect of prolonged use of antipsychotic drugs (as phenothiazine) (Webster's def.)

TBI Traumatic brain injury

TPR Termination of Parental Rights

Wernicke's encephalopathy Disease caused by thiamine deficiency that presents as an acute state of mental confusion, ataxia, and ophthalmoplegia

WHO World Health Organization

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