

# Cross Examination of Mental Health Experts

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What follows is a set of guidelines and recommendations for attorneys to use in cross-examining mental health experts (psychologists, psychiatrists), who conduct evaluations, produce reports and testify in criminal cases. All of these recommendations are grounded in standard of practice as currently understood. Nothing that follows is unethical, unreasonable or “unfair”, and applies equally to whichever side is doing the cross-examining.

## ***Voir Dire***

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| <p>Get a copy of the expert’s <b>resume</b>; no valid reason for experts to object to having their CV made available to the other side.</p>   | <p>Ask for it when you receive the report or have it on file. Look for how they spend their professional time, what their professional affiliations are and whether they ever submit to Peer Review.</p>                          |
| <p>The <b>percentage of professional time</b> spent on:</p> <ul style="list-style-type: none"> <li>• Clinical work (therapy / testing)</li> <li>• Scholarship (writing / research, publishing)</li> <li>• Teaching</li> <li>• Forensic work (including testifying)</li> </ul> <p style="text-align: right;">_____</p> <p style="text-align: right;">100 %</p> | <p>Summary: <b><i>“What percentage of your time is spent on doing forensic work?”</i></b></p> <p>[Research suggests juries grant more credibility to experts who do not spend the majority of their time doing forensic work]</p> |
| <p>Of the <b>percentage of time</b> spent on forensic work, what percentage of that time is devoted to <b>referrals from</b>:</p> <ul style="list-style-type: none"> <li>• Defense</li> <li>• Prosecution</li> <li>• Judges/Court</li> </ul> <p style="text-align: right;">_____</p> <p style="text-align: right;">100 %</p>                                  | <p>Summary: <b><i>“What percentage of your time is devoted to <u>defense</u> forensic work?”</i></b></p>  |
| <p>What <b>percentage of your annual income</b> is derived from forensic work stemming from referrals from:</p> <ul style="list-style-type: none"> <li>• Defense</li> <li>• Prosecution</li> <li>• Judges/court</li> </ul> <p style="text-align: right;">_____</p> <p style="text-align: right;">100 %</p>  | <p>Summary: <b><i>“What percentage of your <u>income</u> is derived from testifying for defense?”</i></b></p>   |

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| <p>How often do you submit your work to be evaluated by a process of <b>PEER REVIEW</b>? (That is, by leaders and senior members of your field.)</p> <p>For example, how many times over the past year have you submitted your work for review:</p> <ul style="list-style-type: none"> <li>• For publication?</li> <li>• By a university faculty committee?</li> <li>• For presentation at a professional conference?</li> </ul>  | <p>Summary: “<b><i>In the past 5 years, how many times have you submitted your work for <u>Peer Review</u>?</i></b>”</p>   |
| <p>How do you stay abreast of what is going on in your profession?</p> <p><b>Memberships</b> in reputable, relevant organizations:</p> <ul style="list-style-type: none"> <li>• American Psychological Association (APA)</li> <li>• Division 41 of APA: American Psychology-Law Society</li> </ul> <p>(This is where breakthroughs in psychological tests, new laws, and important issues to the discipline are discussed. This is also where workshops, seminars, and CE opportunities are publicized.</p> | <p>Summary: This is the principal way to stay informed about goings on in Forensic Psychology. <b><i>If you do not belong to it, why not?</i></b> How do you stay abreast of what is going on in your discipline, if you are not a member?</p> <p>Look for and point out memberships in “Vanity Boards” with deceptive appearance. <b>American Board of Forensic Psychology (ABFP)</b> is the gold standard.</p> |
| <p>Which <b>journals</b> having to do with Forensic Psychology do you subscribe to?</p> <ul style="list-style-type: none"> <li>• Law and Human Behavior.</li> <li>• Behavioral Sciences and the Law.</li> <li>• Psychology; Public Policy and Law.</li> </ul> <p>These are the top 3 journals in Forensic Psychology in terms of impact; i.e. quoted in other publications.</p>   | <p>Summary: These are the leading journals in Forensic Psychology. <b><i>Which of these journals do you subscribe to?</i></b></p>  |

Do you have a **subscription** to any of the leading **research databases** in psychology?

- PsychINFO,
- PsychARTICLES,
- Academic Search Premier

These research data bases allow you to search vast amounts of literature through computerized methods. They all require subscriptions.

Summary: If you have to research a topic for the relevant literature, **how do you conduct a literature search?** If you do not have access to these databases, how can you be confident you are not missing important publications?

## ***DSM-5***

A brief primer: The Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition is the official classification system for mental disorders used by *all* mental health professionals for determining whether a particular person is diagnosable with a particular mental disorder. The title tells you its 2 purposes:

- Diagnostic: what mental disorders are, their **diagnostic criteria** are detailed.
- Statistical: for research purposes

This pertains to the two pillars of our profession: research/scholarship and practice. The DSM-5 was published in 2013. There was a grace period for implementation of first 1 and then 2 years. So, since 9/15, psychologists and all mental health experts are required to abide by DSM-5 in all our clinical and forensic work.

The Manual has gone through 6 editions, because there was a DSM IV-TR, before it got to our current edition. What has been a consistent trend across the editions is that the number of disorders has gone up fairly dramatically.

- DSM I (1952) = 106
- DSM II (1968) = 182
- DSM III (1980) = 265 (first time diagnostic criteria specified)
- DSM II TR (1987) = 292
- DSM IV (1994) = 297
- DSM-5 (2013) = 400+ (depending on how you count)

This has led to an implausible increase in the incidence rates for disorders frequently found in criminal cases; notably, Bipolar Disorder, Schizoaffective Disorder, Schizophrenia.

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| <p>The diagnostic category consists of certain symptoms, periods of duration, disturbances in functioning, etc. The expert should be able to specify <b>where</b> in the records, interview data, psychological testing, etc. she derived the data to render the diagnostic opinion.</p>   | <p>Summary: <b>“Let’s look at the diagnostic criteria for the disorder you gave to the Defendant. Where did you find support / evidence for your diagnosis?”</b> Go through each of the criteria and ask where there is support <b>in the records</b> for that determination. It should not rely principally on the report of the Defendant.</p>   |
| <p>DSM disorders are diagnosed when individuals show the certain diagnostic criteria. For example, the criteria for <b>Schizophrenia</b> appear on page 99 of the Manual.</p>  | <p>Every one of the criteria must be met in order for the diagnosis to be valid. Criterion B is often disregarded: <b>“... level of functioning... is markedly below the level achieved before the onset...”</b> That means that there has to have been a clearly noticeable decline from an earlier level of function. It is key to differentiate between these disorder and Personality Disorders.</p> |
| <p>Most states and federal statutes require that the Defendant suffer from some manner of “mental disease or defect,” as a threshold or predicate issue for a possible insanity defense or diminished capacity. So, the expert has to come up with a DSM-5 diagnosis. (we can’t invent one; <i>Kelly Frye/ Daubert</i> questions).</p> | <p>There is however “The Gap” between a psychiatric diagnosis and its validity for something of legal relevance in a particular case. <b>The diagnosis by itself is necessary, but not sufficient to answer the forensic question.</b> Impairments vary widely within each diagnostic category, so that assignment of a particular diagnosis is not dispositive.</p>                                     |
| <p>Within <u>clinical</u> settings, you are likely to see patients with diagnoses having to do with anxiety, depression,</p>   | <p><b>Psychoses</b> represent a break from reality (e.g. see or hear things that</p>   |

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| <p>eating-disorders, sexual dysfunctions. In <u>forensic</u> settings, the disorders are more often encountered include:</p> <ul style="list-style-type: none"> <li>• Personality Disorders: Borderline, antisocial</li> <li>• Substance Use Disorders: Amphetamines, alcohol, marijuana,</li> <li>• Psychoses: Schizophrenia, Bipolar Disorder, Schizoaffective, substance-induced psychoses</li> </ul>   | <p>are not there, believe ideas that cannot have a basis in reality, or disorganized behavior, thoughts, or emotions). These are the ones necessary for insanity or diminished capacity, of some sort.</p>   |
| <p><b><i>Personality Disorders</i></b>, on the other hand, do not serve as the bases for these same forensic judgments. These are people who are always dysfunctional, make life miserable for others, externalize blame and do not learn from experience. These are especially prevalent:</p> <ul style="list-style-type: none"> <li>• Antisocial (pg. 659)</li> <li>• Borderline (p. 663)</li> </ul> <p>You should definitely consider these two diagnoses, in particular, and have the expert persuade you as to why they are <u>not</u> warranted.</p> | <p>Personality Disorders refer to deeply embedded, chronic and maladaptive patterns of personality (not mental illness), in which the person continuously has trouble getting along with others, functioning adequately on the job, has tumultuous relationships, fails to learn from experience, etc. They are <b><i>not out of touch with reality</i></b>, therefore not the basis for Insanity, diminished capacity, etc.</p> |
| <p><b><i>Antisocial Personality Disorder (301.7)</i></b>; has to meet 3 of the 7 listed features.</p>  | <p>Probable with <b>“career criminals”</b>: repeatedly violates the law (does not have to have been arrested), basically dishonest, impulsive, aggressive/ violent, disregard for others, irresponsible, lacks remorse.</p>  |
| <p><b><i>Borderline Personality Disorder (301.83)</i></b>; has to meet 5 of the 9 criteria.</p>  | <p>Probable with <b>DV, violence, “acting-out”</b> cases: anger problems, drug problems, impulsivity, unstable relationships, recurrent suicidality, “cutting”, identity problems, stress-related paranoid ideation.</p>   |
| <p><b>Malingering</b>: It is not the same as “lying”, it is the faking of a mental disorder. In DSM, it is the: “...intentional production of false or grossly exaggerated physical or psychological symptoms,</p>   | <p>There is no <b>fool-proof</b> litmus test for malingering: the most persuasive evidence is the presentation of preposterous, inconsistent, absurd symptoms</p>  |

motivated by external incentives such as...evading criminal prosecution..." It is not uncommon.

Malingering should be strongly suspected if any **combination** of the following is noted (pages 726-727).

- 1 – Medico-legal context (e.g. criminal charges are pending)
- 2 – Marked discrepancy between the claimed disability and objective findings and observations
- 3 – Lack of cooperation
- 4 – The presence of an antisocial personality disorder.

Auditory Hallucinations (hearing "voices") are the most frequently feigned symptoms of psychosis, delusions and visual hallucinations are also frequently claimed.

which are not validly associated with known diagnoses.

**Richard Rogers, Ph.D.** is generally recognized as the leading authority on this subject, from a psychometric (testing) perspective.

Research estimates it at about 19% in criminal cases are found to be Incompetent (**have the expert offer an estimate**). Mittenberg et al. (2002)

These symptoms are typically **asserted** rather than **displayed** by the malingerer, who tends to over-report and campaign to be thought of as having major problems with psychopathology. Ask the expert how they determined that the claimed hallucinations and other symptoms of psychosis were genuine. **Phillip Resnick, M.D.** is the leading authority on these issues from a more clinical perspective.

## ***Psychological Testing***

This is a very broad and complex area, in which there are literally hundreds of psychological tests. These are all described and reviewed in the ***Buros Mental Measurements Yearbook (20<sup>th</sup> Edition, 2017)***, which I recommend you have a copy of. Psychological testing is an area where without a good consultant, you may well end up in "enemy territory" where the expert witness is going to have the clear advantage, but don't get overwhelmed with the enormity of this subject. The importance of psychological testing in criminal cases is often over-stated by experts.

Psychological Tests are useful for diagnosing mental disorders, primarily in clinical settings. They offer hypotheses to be checked against a person's history. Only **once** in the entirety of the DSM Manual is the use of a psychological test **required** to diagnose a mental disorder: Intellectual Disability (pg. 33). History **trumps** psychological testing; so, an expert **cannot claim that test findings establish** that a Defendant has a given disorder, or that the test was necessary for making the diagnosis (otherwise psychiatrists, who are not

trained in testing, could not make a diagnosis). You still have to match the person's history with the diagnostic criteria, in order to assign a particular disorder.

There is a basic distinction between clinical tests and Forensic Assessment Instruments (FAI). The former were developed for arriving at diagnoses that orient treatment. The latter to address psycho-legal issues of relevance to the Trier of Fact.

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| <p>There has been an explosion in the development of <b>Forensic Assessment Instruments (FAI)</b> in the past couple of decades. They have been developed for use in forming opinions about Competency, Insanity, Psychopathy, etc.</p>   | <p>These instruments are not tests, but clinical checklists that catalogue the criteria associated with these constructs and decisions; they <i>force</i> the clinician to consider the factors or variables associated with these dimensions. If the expert does not use them, ask: <b><i>“How do you know if you have considered all the relevant factors, if you do not use one of these instruments?”</i></b> Go through one of these instruments with them if they considered each variable</p> |
| <p>Traditional, clinical psychological tests include:</p> <ul style="list-style-type: none"> <li>• <u>Personality, psychopathology:</u><br/>e.g. MMPI-2-R, PAI, MCMI-III, Beck Depression Inventory (and literally <u>hundreds</u> of others).</li> <li>• <u>Intellectual, Neuropsychological:</u><br/>e.g. Wechsler Scales (IQ tests), Halstead-Reitan Neuropsychological Test Battery.</li> </ul> | <p>If the expert seems to be relying unduly on test findings, ask: <b><i>“You would agree that a person’s history is <u>more important than test results in determining their diagnosis?”</u></i></b></p> <p>Ask of Psychological test results: <b><i>“They are not like MRI findings, which are more definitive than a doctor’s observation or the patient’s presenting complaints, right?”</i></b></p>   |
| <p>In sex and violence cases, <b>Actuarial Instruments</b> have become increasingly commonplace because of their value in estimating the level of <b>recidivism risk</b> a particular Defendant poses. These are <b>not tests</b> in the sense of their having right v. wrong answers, but <b>clinical-checklists</b> of personal characteristics (factors, variables)</p>                          | <p>In 288 PC cases, certainly SVP evaluations and all sentencing discussions, ask the expert: <b><i>“How did you assess the recidivism risk a particular Defendant poses?”</i></b> You can argue that they are practicing below the standard of practice if they offer estimates of recidivism risk and they did not use an actuarial instrument. Ask: <b><i>“Which actuarial instrument did you use? Why did you choose <u>this</u></i></b></p>   |

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| <p>that have been established by longitudinal research to be associated with <b>recidivism in sex and violence cases</b>. The more of these characteristics a Defendant shows the higher the risk of recidivism he represents.</p>  | <p><b>particular instrument?”</b><br/>There are a number of these instruments:</p> <ul style="list-style-type: none"> <li>• Static 99-R (Hebamus, Hanson, &amp; Thountan, 2009)</li> <li>• RRASOR (Hanson, 1997)</li> <li>• VRAG, SORAG (Quinsey, Harris, Rice, &amp; Comier, 2006)</li> <li>• Ohio Risk Assessment System (Latessa, Smith, Lemhe, Makarias, &amp; Lousen Ramp, 2009)</li> <li>• HCR-20-V3, (Douglas, Hart, Webster &amp; Belfrage, 2013).</li> </ul>  |
| <p><b>Abel Assessment for Sexual Interest – 3<sup>rd</sup> Edition (AASI-3):</b> This is an important advent in risk assessment and the evaluation of Defendants who have committed sexual crimes against minors. The test is not without controversy. The “Abel,” as it is commonly known, is a computer-based, objective measure of a respondent’s persisting sexual interests, as detected through their Visual Reaction Time (VRT); the <b>proportion</b> of time a person spends looking at a particular category of person, relative to others.</p> <p>It cannot be used to determine whether a Defendant committed a particular crime he is charged with, but it has been used as part of <i>Stohl</i> testimony. It has been adopted by the California Department of Corrections (CDC) for use with their parolees.</p> | <p>It is becoming increasingly more difficult to argue against the use of the AASI-3 in cases of sex offenses against Minors. As I’ve written, the AASI-3 is best used for <b>sentencing and plea bargaining</b> purposes, because it gives you information on whether a particular respondent has persisting sexual interests in children.</p> <p>If an expert has conducted an evaluation in a molestation or other sex crime involving minors, ask them: <b>“Why did you <u>not</u> use the AASI-3, when the CDC requires it for their parolees and the Association for the Treatment of Sex Abusers (ATSA) recommends it?”</b> The AASI-3 does not rely on the veracity of the Defendant to detect a person's persisting sexual interests.</p> |

## ***Reports Themselves***

By the time you get to the report itself, you may have already raised considerable doubt about the expert’s credibility, based on improper or inadequate adherence to best practice standards. My experience has been that Prosecutors typically do an excellent job of impeaching expert witnesses for; failing to consider additional records, consider the

testimony of all witnesses, pointing out facts from the records inconsistent with or left out of the expert's opinion, etc.

I will not dwell on those strategies here since you seem to do quite well in that regard. Instead, the focus will be on 3 additional, principal areas to address within the report itself: disclosures, benefit-of-the-doubt and "other" examples of the relevant behavior.

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| <p><b>Disclosures:</b></p> <p>Our Ethical Guidelines suggest we fully disclose the following information:</p> <ul style="list-style-type: none"> <li>• Date(s), place where the evaluation was conducted.</li> <li>• Amount of time spent interviewing / testing the Defendant.</li> <li>• Tests administered.</li> <li>• Referral Source.</li> <li>• Confidentiality Disclosure.</li> <li>• Records / materials reviewed.</li> </ul>  | <p>Ask the expert what she disclosed to the Defendant <b>before</b> beginning to interview him. Was this included in the report? How might have this influenced the Defendant's accounts?</p> <p>Did the expert read the records before or after interviewing the Defendant? If they say they read them afterward, then ask: "<b>Then, how would you know if he was telling you something at odds with what the Police and witnesses are reporting?</b>"</p> <p>Ask the expert if he had any communications with the Referral Source after interviewing the Defendant or after submitting the report. "<b>Did you make any changes to your report after speaking with the referral source?</b>"</p> |
| <p><b>Benefit of the Doubt:</b></p> <p>In cases where the Defendant fully admits his crime, there is an essentially unitary, consistent history for the expert to work with in analyzing the Defendant. If the Defendant admits to the charges or <i>Corpus Rea</i> has been established (such as in an <b>Insanity</b> case), then there is no conflict; the history has been agreed to and the expert can work from there in formulating and opinion about the Defendant.</p> <p>However, if the Defendant denies the charged offenses and the case is headed to Trial, there are at least two, incompatible</p> | <p>Since we cannot comment on the <b>Ultimate Issue</b> in such contested cases, the most defensible position for the expert to take is to remain agnostic as to what actually happened and defer to the Trier of Fact</p> <p>In many such instances, experts give the <b>benefit-of-the-doubt</b> to the Defendant and offer their opinions on the assumption that the charges against them are not true (you can infer that in their opinions section of the report). Ask the expert: "<b>Why give the benefit-of-the-doubt to the Defendant? In so doing, are you not lending credibility to the Defendant? Are you not arguing in</b></p>   |

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| <p>accounts for the expert to work with:</p> <ol style="list-style-type: none"> <li>1- The Defendant's, or</li> <li>2- That of Witnesses / Police.</li> </ol> <p>In sex or violence cases, the Defendant often denies / minimizes his culpability, even when the evidence is persuasive or even overwhelming.</p>  | <p><b><i>favor of one side on the Ultimate Issue?</i></b></p> <p>Why not give the <b><i>benefit-of-the-doubt</i></b> to the Police or the Witnesses? How would your opinion change if instead of the Defendant, you had given the <b><i>benefit-of-the-doubt</i></b> to the Police?</p>   |
| <p><b><i>“Other than the crime” examples:</i></b></p> <p>Experts focus on how the behavior of the Defendant at the time of the crime was consistent with their diagnosis. For example, in an Insanity case, they will argue how the Defendant did not know right from wrong or the nature and quality of their actions because of their Schizophrenia.</p> | <p>These conditions are chronic and ongoing, and the diagnostic criteria typically require a specific duration. It is perfectly reasonable and fair to ask: <b><i>“When else did the Defendant act this way other than during the crime?”</i></b> Ask for examples of such behavior over the course of the time this disorder is supposed to have manifested itself, and where they state that in their report.</p> |