

Violence. Roots and Remedies: The Perspective of the Forensic Psychiatrist

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The role of the forensic psychiatrist is described in this paper. This role is unique in that it applies the research findings of the neurologist, the neuropsychologist, the criminologist, and other behavioral specialists to courtroom proceedings. The possibility that medical malfunction such as brain damage, endocrinological problems, toxicity, infection, or neurological disorder may be associated with violent behavior is discussed. The forensic psychiatrist has several functions to perform in the courtroom. He or she must be able to assess the likelihood that any type of malfunctioning such as those mentioned may have had a part in the defendant's violent behavior, assess the defendant's state of mind at the time of commission of the crime, and determine whether the individual is competent to stand trial. The five phases of the criminal justice system are reviewed as they bear on the work of the forensic psychiatrist.

The forensic psychiatrist is in a unique position to apply the research findings of the neurologist, the neuropsychologist, the criminologist, and other behavioral scientists in the practical arena of the courtroom. Most forensic psychiatrists do not conduct original research on the matters on which they testify. The law considers them to be experts because of their training and special knowledge of medicine, particularly psychiatry. The weight of their testimony will be determined on the basis of the information revealed to the court.

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Organic brain syndrome, medical causes of violent behavior, and organic illness leading to psychological disturbances are especially reminiscent of the Meyerian period of the early twentieth century, when psychiatry was a true branch of medicine and behavioral aberrations were viewed as manifestations of medical illnesses and not as "factitious or feigned" diseases. Forensic psychiatrists must be able to distinguish between the bona fide and the deceptive. They must be aware of the various causes of behavioral disturbances and violent behavior. They must consider the possibility of deception practiced on a conscious level and unusual behavior related to unconscious conflicts. Yet they must never lose sight of the possibility that such behavior is caused by

organic etiology, including brain damage, or endocrinological, metabolic, toxic, infectious, neurological, or other medical malfunction.

Most psychiatrists are aware that temporal lobe epilepsy may result in violent behavior. However, in the absence of specific testing to demonstrate the lesion in the temporal lobe and to relate the lesion with observed seizure behavior, the forensic psychiatrist must not overlook the possible presence of a dyscontrol syndrome, as described by Elliott,¹ in which there exists tissue damage in the temporal lobe that may not be detected by electroencephalogram, computed axial tomography scan, or other specific tests. A careful history is an extremely important diagnostic tool in these cases. Unfortunately, the law has often looked askance at such histories as being self-serving declarations by defendants who are in trouble with the law. The law often gives little credence to histories related by defendants to forensic psychiatrists who are not the defendants' physicians. That is, patients are seen by the court as being more likely to be deceptive toward the examining psychiatrists than toward their personal physicians from whom they seek relief of symptoms.

Role of the Forensic Psychiatrist

The forensic psychiatrist has several duties to perform in assessing an individual with prospective organic brain syndrome or medical causation of violent behavior. Initially, the psychiatrist needs to determine whether there is organic or tissue damage that may be connected

with the unusual or aberrant behavior. Such association must be ruled in or ruled out as a part of the comprehensive examination. Next, the psychiatrist must consider whether such a lesion, once its presence has been confirmed, is related to the behavior at issue. There have been cases in which silent brain tumors might have been causally linked to violent behavior that ended in death; nevertheless, autopsy has revealed that the tumor and the violent acts were unrelated. (A well-known case in point is that of Charles Whitman, who climbed a tower at the University of Texas and from the vantage point shot and killed a number of persons at random and then killed himself.)

Assessment Forensic psychiatrists are called upon to assess the behavior of persons intoxicated with alcohol or other drugs. Alcohol is known to be related to violent behavior, as is the abuse of amphetamines and other drugs, including psychedelic drugs. Generally speaking, marijuana, barbiturates, and other narcotics are not associated with violent behavior on the basis of their chemical effects, but rather on the addict's need to obtain money to pursue the habit. Some sophisticated defendants may claim that they have abused drugs for the purpose of "beating a rap," and the psychiatrist must search out the appropriate evidence. Subjective statements made by defendants must be verified by objective data to the extent possible. To cite one example, a person claimed that he was "out of his mind" because of his use of LSD. Careful questioning by the forensic psychiatrist elic-

ited the defendant's admission that he had never seen LSD and did not know what it looked like.²

History Psychiatrists must gain an accurate history of the defendant's medical status, including a family history of both mental and physical illnesses. Clinicians must develop and if possible correlate evidence of birth trauma or early childhood trauma that could have affected the defendant's nervous system. Childhood injuries, especially head injuries, accidents, high fevers, and unusual types of surgery may all play a role in subsequent violent acts. A history of any previous seizure experiences must be obtained, as must a possible association of recent head injury or automobile or other vehicular accident. A series of violent acts could have been triggered by any of those events. Have there been abrupt mood shifts or changes in personal relationships? These too might be related to the development of a chronic subdural hematoma.

Early indications of diseases of deterioration, such as Alzheimer's disease, must be assessed vis-à-vis their bearing on the mental state, because it all too frequently happens that bizarre or unusual symptoms are indiscriminately correlated with trauma, while the traumatic event may not be the trigger for the behavior under question. In a case known to the author, it was determined that a woman who had experienced a minor head injury in an automobile accident three years earlier was not suffering from posttraumatic stress disorder or postconcussion syndrome, but rather from an early stage of Alzheimer's dis-

ease that was progressive and unrelated to the accident. Even when definite signs of head injury are noted, one must take care to search for other causes of the psychiatric symptoms. In a second case known to the author, a young woman was hit on the head during the course of a barroom brawl and later suffered from depression. A careful history revealed that her depression was more likely to have been related to significant changes in her personal life subsequent to her mother's serious illness.

Crime and Heredity The genetic studies of Mednick and Kandel³ indicate the existence of a correlation between crime and heredity. This may be important from the standpoint of research, prevention, and scientific understanding. In the absence of an attendant organic illness having a genetic component, however, this correlation is not of great moment to the forensic psychiatrist.

Substance Abuse Perhaps the most crucial consideration in forensic psychiatry is the association of toxic substances and behavior. A thorough understanding of the effect of alcohol, street drugs, and even prescribed medications is important in assessment; treatment programs must be taken into account when the psychiatrist makes a recommendation for disposition of the case.

The Forensic Psychiatrist in Court

Psychiatrists have several courtroom functions. Not only do they evaluate the defendant with respect to the latter's state of mind at the time of commission

of the crime, and any association of medical, organic, or psychological forces, but psychiatrists need also to be aware of how those factors connect and mesh with the criminal legal system. They must be able to answer such questions as the following: Is the person competent to make a confession? Is the person competent to waive his or her rights at various stages of the criminal procedure? Is he or she competent to stand trial? Is he or she competent to be executed? What of the defendant who is found guilty or not guilty by reason of insanity—what recommendation will the psychiatrist make about disposition of the case?

The Phases of the Criminal Justice System

At this point it may be useful to view the criminal justice system in its five phases⁴: (1) the investigative phase, (2) the accusatory phase, (3) the pretrial phase, (4) the trial phase, and (5) the posttrial phase.

Phase 1: The Investigative Phase In Phase 1 the major issue is competency to give a statement to the investigating officers. The individual may be in such a state of psychosis or toxicity that he or she is not able properly to give a statement because the statement will not be voluntary or may be coerced. The individual may be under the influence of delusion or hallucinations as well and thus may give an invalid statement. An example is that of a young man who was present at a stabbing murder that occurred in a barroom. The knife that had been used in the killing was handed

around and finally was passed to the young man, who then discarded it. Because he was present at the scene and felt that he had been involved in the crime, he began to feel increasingly guilty. He showed signs of erratic and irrational behavior, and when asked about his knowledge of the crime he confessed to the killing. His confession was deemed invalid because of his psychotic behavior, which had developed as a result of the paranoid delusional system he was experiencing. His state of mind was also exacerbated by the effects of excessive alcohol and other drugs.

Phase 2: The Accusatory Phase During Phase 2, individuals are accused by the police of being the perpetrators of the crimes. They may have been read their Miranda rights indicating that they have the right to remain silent, to have an attorney present, and to end their statements at any time. At this time the question is whether the individuals understand the Miranda warnings. Organically mentally retarded persons may lack a clear understanding of the warnings, especially if the questions are read at a rapid pace. The persons might be so intoxicated that they cannot give a voluntary statement at this time. With respect to alcohol, the main question is whether the individuals are under the influence at the time of the interrogation. With respect to drugs such as heroin, the question may revolve around the person's susceptibility to undue influence by the interrogators because of implied promises to help the persons withdraw from the drug or drugs. The psychiatrist must understand the timing

of withdrawal and the peak period when withdrawal will affect the capacity to give a voluntary statement. For example, a man claimed that he was unable to give a voluntary statement because he was in the midst of an acute withdrawal phase from heroin. He indicated that he had had his latest injection about eight days before the interrogation. Most psychiatrists are aware that the vulnerability period for withdrawal has already passed by that time, and the person would not be in such a desperate state of mind as to willingly give a false statement in order to be medically treated.

The accused individuals may also be intoxicated with LSD, PCP, or methamphetamine. They may be hallucinating and thus not competent to give the statement. It is important for police officers to be aware of the subjects' mental state so that police do not unwittingly violate the rights of the accused by attempting to elicit a statement that may later be thrown out of court as being invalid.

Should the psychiatrist be present when the subjects give their statements if the police suspect that the individuals are either psychotic or under the influence of an intoxicant? The police surgeon, having had some training in psychiatry, is occasionally called to witness the confession or even to study the suspect's state of mind before the declaration of competency to give the statement.

Suspects may have been involved in a shooting or a physical altercation with the police and as a consequence may have sustained a head injury. It would

then be essential to examine them for evidence of brain damage, subdural hematoma, or other effects of acute trauma that could bear on the confession.

Phase 3: The Pretrial Phase In this phase, the most important issue is the defendants' competency to stand trial and to work with an attorney in preparing a defense. If suspects have a chronic organic, metabolic, or toxic syndrome they may not be able to participate effectively in preparing a rational defense. The criterion for competency is whether the accused individuals understand the nature and consequences of their legal situation and can cooperate with counsel in preparing a defense. For example, a seriously ill person was not competent to stand trial. He was a patient at Pennhurst, a Pennsylvania institution for the mentally retarded. Not only was he retarded, he was also hearing impaired and unable to speak. He did not learn sign language and could not communicate with other persons. Hence he could not be competent to stand trial and was regarded as being incompetent for the foreseeable future. Based on the case of *Jackson v. Indiana* in 1972,⁵ the patient could have been placed in a hospital for treatment until he became competent; if this did not occur in the foreseeable future, the charge would be suspended and the patient treated in a civilian hospital for as long as necessary.

Other chronic debilitating illnesses, including organic psychosis, which is not likely to remit even with the use of psychotropic drugs, exemplify the types of problems relevant to the pretrial phase with respect to competency to stand

trial, to waive one's rights, to waive a jury trial, or to plead guilty so as to expedite a particular disposition or sentence.

Phase 4: The Trial Phase Perhaps the single most important phase is Phase 4. It is the stage that receives the broadest publicity. The issue here is criminal responsibility for the act charged. The two means of dealing with the charge are pleading and defending. Can a person plead guilty or guilty but mentally ill to a charge even if suffering from a serious organic brain disease? The answer depends on competency to understand the nature and consequences of the situation. If the defendants can understand what they are doing and the consequences of their decisions, despite the presence of the organic disease, they may be competent to plead either guilty or not guilty, or guilty but mentally ill (depending upon the jurisdiction).

The major plea in the case of an organic psychosis would be not guilty by reason of insanity. The question to be asked is whether at the time of commission of the crime defendants were suffering from mental illness such that they did not comprehend the nature and quality of their acts at the time they committed them, or that they did not understand that their actions were wrong. The test is a cognitive one, not related to the traditional volitional test of the American Law Institute Model Penal Code.⁶ The more recent Omnibus Crime Code⁷ has been operative in all federal jurisdictions since 1984. It is based on the finding of whether defendants had such an illness that they could not appreciate the nature and quality of

the act or acts or could not appreciate the wrongfulness of them. If they could not meet the test, they would then be found criminally irresponsible for their acts and would be hospitalized.

Since the Hinckley decision of 1982, a number of states have accepted the finding of guilty but mentally ill. It was introduced in Michigan in 1975.⁸ In Pennsylvania, the definition of mentally ill includes the traditional American Law Institute Model Penal Code as well as the volitional element. That is, did the individuals, at the time of commission of the criminal acts, as a result of mental illness lack substantial capacity to conform their conduct to the requirements of the law? The M'Naughten rule is cognitive and deals primarily with the inability to comprehend the nature and quality of the act and its wrongfulness. If the etiology of the mental illness is organic, the defendants would be more likely to be found insane provided the jury could be convinced of the organic basis. The forensic psychiatrist could demonstrate to the jury the evidence for an organic basis more persuasively than for a functional one. Such tests as computed axial tomography scans, electroencephalograms, and cranial films may reveal areas of damage.

One other aspect of organic etiology at the time of commission of the crime involves the presence of acute toxic psychoses or brain injuries that could give rise to violent behavior beyond the defendant's control. If the question is merely a matter of control, the rule in most jurisdictions is that the person might be found guilty but mentally ill or found guilty. If the question is one of

control in addition to capacity to understand what one is doing at a specified time, then the person might be found criminally insane under any of the various rules in the different jurisdictions. Examples of toxic psychoses or acute brain syndromes include infectious processes, ingestion of toxic substances including alcohol and drugs, and head injuries suffered before the acts in question. A blow to the head subsequent to the criminal act may cause amnesia for the period of time during which the act occurred, but the amnesia would not be relative to the state of mind that prevailed when the act was committed. It should be noted that the toxic effect alone is not sufficient for a plea of insanity, unless the drug was ingested involuntarily or there is a proven pathological intoxication (a rare occurrence). If it can be ascertained that a person does not remember what happened at the time of the act, was suffering from a mental illness at the time of the act, and was not hit in the head subsequent to the act causing the amnesia, one may be able to determine (1) whether the amnesia is bona fide and (2) the origin or cause of the amnesia. Special tests may help in developing the defense of insanity in these cases.

Polygraph examination to verify the presence of amnesia can be used. Only after this should an interview under hypnosis or one conducted after the administration of Amytal sodium be done to determine the cause of the amnesia or to test whether the defendant can recollect the events surrounding the offense. The forensic psychiatrist may then be able to learn what the individual was

thinking or feeling at the time of the act in question and may help in resolving the question of insanity based on McNaughten.⁴

Phase 5: The Posttrial Phase The ultimate disposition of the case occurs in this phase. If seizure disorder, dyscontrol syndrome, or toxic psychosis is present, treatment must be specific for that condition. In some other less specific organic conditions treatment may be more generalized. Control of behavior is often an issue, rather than the specific medical treatment, when the cause is not known.

Are there appropriate treatment facilities for persons found guilty or found not guilty by reason of insanity? There are few community facilities for impaired epileptics, mentally retarded persons, or violent adolescent offenders. Although effective drug and alcohol treatment programs exist in the community and in some correctional systems, the forensic psychiatrist must continue to plead for expansion of facilities for those whose violent acts have organic roots.

Summary

Forensic psychiatrists may enter the criminal justice system at any of the five phases noted. They may use the research findings of other specialists. They must continue to keep abreast of research into organic roots of violence and be prepared to apply the findings in presenting testimony.

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