Part II: Sex Differences in Persons Found Not Guilty by Reason of Insanity: Analysis of Data from the Connecticut NGRI Registry

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Thirty-one female insanity acquittees from Connecticut were matched to a group of 31 male NGRIs. The samples were compared with regard to demographic, criminal, and clinical characteristics. Logistic regression analyses were used to determine predictors of criminal recidivism for the sample. Results indicated that women NGRIs were older, more likely to be married, less likely to be substance abusers, had less extensive criminal records, and were released from hospitals sooner than the men. A significant racial difference was noted: white women had less extensive criminal records and were hospitalized for shorter periods than minority women. Results of the logistic regression analyses showed that the strongest independent predictors of criminal recidivism were race and having a diagnosis other than psychosis (schizophrenia, affective or organic disorders). Findings support recent APA policy guidelines on the insanity defense.

Although the insanity defense has been part of our legal system since its inception, it is not without controversy.1 Periodically, medical and legal experts have advocated reform or repeal of these laws.2 This controversy usually surfaces after well-publicized criminal proceedings in which a defendant is found not guilty by reason of insanity (NGRI), for example following John Hinckley's acquittal in 1982.3 Understandably, this type of notoriety has sparked demand for more systematic research into the insanity defense with the suggestion that reform has been hampered by lack of empirical data.3,4

An appropriate way to begin building a scientific base for assessing these defense systems might be with studies that characterize NGRI defendants and acquittees, particularly with regard to variables which might be useful in generating meaningful public policy decisions (for example, those related to diagnoses.

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types of crime, prior and subsequent criminal behavior, hospitalizations, etc.). Indeed, this has been the norm during the past 15 years. Two dozen studies are currently available for review and consideration (see Pasewark\(^5\) for a review of the earlier research; Steadman\(^4\) for a thoughtful review of more current studies).

New York\(^6,7\) and Oregon,\(^8,9\) in particular, have been sites of intensive research into the insanity defense. Less comprehensive studies have been undertaken in several other states—among them Connecticut,\(^10,11\) Hawaii,\(^12\) Illinois,\(^13,14\) Maryland,\(^15\) Michigan,\(^16\) Missouri,\(^17,18\) New Jersey,\(^19\) and Wyoming.\(^20\)

The results of these descriptive studies have been remarkably similar in characterizing the typical NGRI acquittee: a white male, in his early to mid-30s, with limited education and a poor employment history. He has had few prior hospitalizations but several prior arrests. He is likely to have committed crimes against another person and to be diagnosed as psychotic. There is high likelihood of continuing criminal behavior and interaction with the mental health system following discharge into the community. These latter few findings in particular seem to provide a basis on which to begin speculating on the dangerousness, recidivism, and optimal treatment for these individuals. This would, in turn, provide a framework for considering policies concerning, for example, institutionalization versus supervised community care.

Despite recent interest in the subject of NGRI in general, the topic of female NGRI is still mostly neglected. Because there are few female NGRI (Steadman\(^4\) estimates women to represent around 10% of these samples), women are usually not investigated separately from men. Are women NGRI different from men, particularly in regard to clinical and criminal variables that might be relevant to policy generation?

Female/male differences have been examined specifically only in New York,\(^6,7\) Oregon,\(^9\) and Hawaii.\(^12\) In New York and Hawaii, women were found to have fewer arrests (and fewer felony arrests) than men both before and after insanity acquittal. In Oregon, women were found to be hospitalized for shorter periods of time than men. Finally, women in all three states were acquitted of different crimes than men. For example, several women from these samples had killed their own children; none of the men had committed infanticide. Although these results are provocative, jurisdictional variations in legal standards and policies and inconsistent definitions of study variables make comparison of findings tentative (even for data as fundamental as psychiatric diagnoses of acquittees). Further research is needed to validate and extend results from earlier studies.

The present study was undertaken to quantify gender-related differences in Connecticut insanity acquittees and to compare these findings with those in other states. Specifically, we will provide descriptive comparisons of men and women insanity acquittees and examine differences in criminal behavior between...
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the two groups, particularly in tendencies to recidivate.

This research examines female/male NGRI differences in demographics, psychiatric history, criminal record, and length of hospitalization. Although data on some of these characteristics have been reported by other researchers, no other study has reported such complete findings for one state—particularly on women subjects.

Method

Subjects Three hundred seven (307) persons (including 30 [9.8%] women with 31 NGRI acquittals between January 1970 and January 1986) comprise the study sample. These persons accumulated 316 NGRI acquittals, the unit used for analyses in this research: 299 people were found NGRI once during the study period; seven people (six men and one woman) were found NGRI on two separate occasions; and one individual (a man) was found NGRI on three separate occasions during the study period.

Records for these persons were taken from the NGRI Registry—a comprehensive, detailed census database collected by the Law and Psychiatry Division, Department of Psychiatry, Yale University School of Medicine. This longitudinal database was compiled by means of a systematic, chronological search of all available docket books from the superior courts and mental health records from state hospitals in Connecticut dating back to January 1970. Information on NGRI cases in Connecticut is available from this registry beginning with patients acquitted in January 1970. For this research, the date of January 1986 was selected as an endpoint for case identification because it closely followed the establishment of the Psychiatric Security Review Board in the state. Following the establishment of the PSRB, a new system for monitoring insanity acquittees was introduced which has affected some aspects of the confinement and discharge procedures.

Procedures

Data Collection Demographic information (age, gender, and ethnicity, as reported to hospital personnel by the subject) and summary details on sentencing, disposition, and diagnoses were abstracted from the NGRI Registry for a majority of persons in the sample. Information in this database is updated regularly. However, because there is often substantial delay in recording relevant information in court and hospital records, data continue to accumulate for this group of individuals. Data used for this study were those available through January 1987.

Variables Used in Analyses: Diagnoses For all subjects, an evaluation diagnosis (using DSM III, Axis I, or Axis II diagnoses) or post-NGRI diagnosis (taken from the hospital record) was obtained. This is distinct from the trial diagnosis used for acquittal. We compared trial diagnosis (as recorded by the state’s attorney’s office)* and evaluation

* When there was a difference of opinion between clinicians working for the defense and those working for the state with regard to trial diagnoses, we elected to use the one provided by mental health personnel working on behalf of the prosecution (state).
diagnosis for all persons in the matched subsample for whom we could obtain both (68% of sample). Almost all of these subjects had received a trial diagnosis of "paranoid schizophrenia." Because there was so little variation in trial diagnosis among subjects and because evaluation diagnosis is more related to hospital course and treatment, this (evaluation) diagnosis is the one used for this research.

For four subjects the primary evaluation diagnosis was substantially different from diagnoses made later in the commitment period. After review of hospital records an effort was made to determine which diagnosis most reflected the hospital course and treatment. This "more representative" diagnosis was used in the analyses.

For the analyses reported here, diagnosis were categorized as follows: schizophrenia, affective disorders, personality disorders, substance abuse disorders, organic disorders, retardation, miscellaneous disorders, and no mental disorder. Most diagnoses clearly fit in one category or another, but some were more difficult to characterize. For example, paranoia was classified as schizophrenia, and one case of atypical psychosis with pregnancy was also categorized as schizophrenia. Impulse disorders were grouped with personality disorders, and one subject with borderline intellectual functioning was categorized as retarded.

**Crimes and Arrests** When reporting aggregate data, crimes were grouped as crimes against persons (e.g., murder, manslaughter, attempted murder, assault, rape, injury or risk of injury to a minor, sexual assault, and robbery); crimes against property (e.g., arson, burglary, and larceny); or other (e.g., harassment, escape, and trespassing). Unless otherwise indicated, "crime" stands for the principal crime for which the individual was tried and acquitted.

Only those arrests and convictions recorded by the State Police Bureau of Identification were included in this study. Five subjects were arrested for crimes committed while hospitalized under court commitment. These were also included.

**Hospitalization** Time hospitalized under court commitment was determined from the date of insanity acquittal to the time of release to community. Some subjects were released to the community on "extended visit" status without being discharged from their NGRI commitment. Because they were no longer hospitalized and therefore were at risk to commit other crimes, these subjects were treated as if they had been officially discharged.

**Matching** For these analyses, each of the 31 women NGRI's (one woman was acquitted twice during the study period) was matched to the man whose date of NGRI finding most closely approximated her own. This matching procedure was adopted to control for possible broad changes in judicial dispositions of NGRI cases that may have occurred between January 1970 and January 1986. There was not enough justification shown by previous research to recommend matching on the basis of obvious variables such as age and race. Also, to attempt to match on more than
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one variable might have led to elimination of female subjects for whom a male match could not be found.

The demographic characteristics of the matched sample of men used in this study are similar to those of the total population of 254 males found NGRI in Connecticut (during the time frame under study) who were not included in the analyses. The population of males had a mean age of 31.2 years ($t = 1.61$, $p < .12$) and was comprised of 69 percent white and 31 percent minority men ($x^2 = 0.685$, $df = 1$, $p < .710$).

Further, there were no differences between the two groups of men NGRIs (those selected for these analyses and those not selected) when comparing types of crime (categorized as felony or misdemeanor, $x^2 = 0.507$, $df = 1$, $p < .477$) diagnoses ($x^2 = 2.03$, $df = 2$, $p < .33$) or term of commitment as set out by the court following the NGRI acquittal ($t = 1.01$, $p < .34$). Therefore, the matched sample of men NGRIs used for these analyses appears to be representative of male NGRIs in Connecticut.

One female subject was found NGRI twice during the period of study for crimes committed several years apart. Two men were paired with this woman—one to match each NGRI adjudication.

Analyses are reported for the matched pairs using matched sample techniques (e.g., McNemar's chi-square; $t$-test for matched data). In the section reporting data related to recidivism following release, data were not analyzed as matched pairs (there were 21 women and 19 men in this subsample).

Results

Demographics Data were collected concerning age, race, marital status, and substance abuse history for the 31 matched female/male pairs of NGRIs. The group of women were older, on average, than the comparison sample of men at the time of NGRI finding (36.4 years for women vs. 28.5 years for men [$t = 3.33$, $p < .002$]). There were proportionately more minority females than minority males in the matched pairs—42 and 28 percent, respectively. Significantly more women than men had been married at least once: 74 percent ($n = 23$) of women had been married one or more times compared to 42 percent ($n = 13$) of men ($x^2 = 6.67$, $df = 1$, $p < .01$).

Ninety percent (90%, $n = 28$) of men were abusers of drugs, alcohol, or both (abuse was determined by an indication in the clinical chart, which unequivocally distinguished between "abuse" as opposed to "use"). Although the proportion of women abusers was significantly smaller than among men, nearly one in three—32 percent ($n = 10$)—was a substance abuser ($x^2 = 13.14$, $df = 1$, $p < .001$).

Clinical Variables Table 1 presents summary data on diagnosis. Diagnoses for each subject were made during the hospitalization period immediately following the NGRI finding (within 90 days of the adjudication). In comparing women and men, the data show that significantly more women were diagnosed with a psychosis—i.e., schizophrenia, affective disorder, or organic psychoses. Seventy-four percent ($n = 23$) of
women were diagnosed with one of these disorders compared with 52 percent (n = 16) of the matched sample of men (x² = 5.88, df = 1, p < .05).

Only 26 percent (n = 8) of females and 35 percent (n = 11) of males had no psychiatric hospitalizations before the NGRI finding. This difference is not significant. The mean number of hospitalizations for the women was 1.9 (median = 2; range = 0 to 9); the mean number for men was 2.4 (median = 2; range = 0 to 26). The difference in mean hospitalizations was not statistically significant.

**Crimes**  Table 2 presents summary information on crimes committed by the acquittees. Twenty-seven men (or 87%) committed victim-contact crimes, that is, crimes directly against the person. Of these 27 criminal acts, 10 (37%) involved victims who were family members of the offender (i.e., spouses, significant others, and/or relatives no matter where they were living in relation to the acquittee; or other persons living in the household).

Twenty-two women (71%) committed crimes with a victim. Family members were victimized in 17 (77%) of these crimes.

Although the subsample sizes are small, white women victimized family members more often than minority women did (92% vs. 63% of crimes involved family members). The opposite relationship held for white men compared with minority men: 63 percent of crimes with a victim perpetrated by minority men involved family members. Only 26 percent of these types of crimes committed by white men involved family members.

Data were collected concerning the arrests and convictions of women and men prior and subsequent to NGRI finding. The trend is for more men (64.5%, n = 20) than women (32%, n = 11) to have a previous history of one or more arrests (x² = 3.71, df = 1, p < .064). These 20 men had a total of 128 arrests (range = 0 to 28). The 11 arrested women had accumulated 99 arrests, although two women together accounted for 48 of this total. Twenty-four percent of all prior arrests were for felonies. Fi-
nally, women were less likely to have any prior convictions than men ($x^2 = 4.05$, $df = 1$, $p < .05$).

Analyses of factors associated with subsequent (to date of NGRI crime) arrests were performed using the subsample of NGRIs who had been discharged during the study period. Data for these persons represent those available through January 1987. As of that date, 21 women and 19 men had been released. Average time in the community was 6.8 years (range, < 1 month to 16 years).

Significantly more men (63%, $n = 12$) than women (24%, $n = 5$) were arrested at least once after release ($x^2 = 6.32$, $df = 1$, $p < .05$). (There was no difference in proportion of women and men having at least one subsequent conviction $x^2 = 0.82$, $df = 1$, $p < .40$.)

Of the 37 arrests accumulated by these 12 men, only eight were felony arrests. These felonies included one arrest for homicide (a man found NGRI for killing his first wife was later convicted of killing his second wife), two arrests for assault, two for escape, and one arrest each for sexual assault, robbery and burglary.

Only five women were arrested after release from hospitalization. These women were arrested a total of 38 times. (Two women alone [diagnosed with personality disorders] were arrested 31 times. Of these crimes, only two were felonies—all weapons charges. These two women had been arrested a total of 39 times [29 times for misdemeanors]

before insanity acquittal). Two other women had felony arrests: one woman was arrested twice for assault, and one woman was arrested once for risk of injury to a minor.

Distribution of number of prior arrests for white men and nonwhite men are similar, but white women have significantly fewer arrests than men or nonwhite women (Wilcoxon two-sample test, normal approximation, $z = 2.3739$, $p < .017$ in comparison with minority women; $z = -2.55$, $p < .01$ in comparison with white men; $z = 2.85$, $p < .004$ in comparison with minority men). There were no differences between any of the four gender/race groups when comparing (the distributions of) number of subsequent arrests.

A two-way analysis of variance was performed to determine whether the observed variation in prior arrests was due to a race effect, a sex effect, or the interaction of the two variables. Only the race effect was significant ($F = 3.99; p < .05$), indicating that white women have fewer prior arrests because all whites tend to have fewer arrests than all nonwhites.

To determine which factors were the best predictors of subsequent arrests, a logistic regression analysis was performed using data from persons for whom we had complete information. Because of the small sample and subsample sizes, the number of variables used in this part of the analyses was limited. Although substantial measurement error in the predictor variables was not expected, the outcome variable, subsequent arrests, was highly skewed.

This variable was dichotomized and a
minimum case-to-variable ratio of 10-to-1 was adopted for the final model. The (predictor) variables considered as possibly contributing to a subject's likelihood of being rearrested are shown in Table 3. This list was assembled following a review of the NGRI research literature. Other variables were added to examine some of our own assumptions concerning the role of diagnosis in subsequent arrests.

Initial analyses showed prior arrest to be correlated with subsequent arrest ($r = 0.46$). Therefore, a hierarchical regression model controlling for prior arrest was selected for these analyses. In addition to prior arrest, the predictive contribution of diagnosis was evaluated in all of the regression models.

Setwise regression techniques were used to reduce the number of remaining predictor variables for use in the final models. The subsample of 39 NGRIs was divided (at random) into two samples to cross-validate the results of the setwise regression ("best possible regression" technique looking at all possible pairs of variables shown in Table 3). The final regression equation consisted of prior arrests (covariate), diagnosis, race, and marital status.

Table 4 displays improvement x² values, beta coefficients, coefficient standard errors, ratio of coefficient to standard error, and odds ratios for predictors of subsequent arrest for all released NGRIs.

The addition of race and diagnosis improved the overall fit of the model. This is shown by the likelihood ratio x² values and the beta coefficient/standard error ratios ($b/se$—a value $> 2$ reflects significance). The odds ratios suggest that minorities are 27 times more likely to have a subsequent arrest than whites. Persons with a nonpsychotic diagnosis are 5 times more likely to be rearrested. Marital status did not significantly contribute to the model ($b/se = 1.80$); however, results suggest that single persons are more than 4 times more likely to have subsequent arrests as married persons.

Length of Hospitalization  
Length of hospitalization was measured from the date of NGRI finding to the date of hospital release into the community. Table 5 presents data for the 21 women and 19 men who were released during the study period. Women were hospitalized for fewer days on average than men ($t = 2.83, p < .02$). White women were hospitalized for an average of 240 days, and this mean is significantly less than

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### Table 3

<table>
<thead>
<tr>
<th>Factors Predictive of Subsequent Arrest</th>
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<tr>
<td>1. More prior arrests</td>
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<td>2. DX other than schizophrenia, affective or organic disorders</td>
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<tr>
<td>3. Crime against property</td>
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<tr>
<td>4. Fewer days hospitalized</td>
</tr>
<tr>
<td>5. Not high school graduate</td>
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<tr>
<td>6. Prior psychiatric hospitalization</td>
</tr>
<tr>
<td>7. Single</td>
</tr>
<tr>
<td>8. Sex = male</td>
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<tr>
<td>9. HX of substance abuse</td>
</tr>
<tr>
<td>10. Younger age</td>
</tr>
<tr>
<td>11. More months at risk</td>
</tr>
<tr>
<td>12. Race = black</td>
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<tr>
<td>13. No children</td>
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</table>

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Table 4
Logistic Regression of Diagnosis, Crime, and Demographic Variables on Subsequent Arrests

<table>
<thead>
<tr>
<th>Variable</th>
<th>Improvement</th>
<th>$x^2$</th>
<th>$p$</th>
<th>$b$</th>
<th>se</th>
<th>$b$/se</th>
<th>Odds ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGRIs (n = 39)</td>
<td>Prior arrest</td>
<td>-</td>
<td>-</td>
<td>-0.58</td>
<td>0.25</td>
<td>-2.28</td>
<td>0.56</td>
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<td>Race</td>
<td>10.65</td>
<td>0.001</td>
<td>3.31</td>
<td>1.59</td>
<td>2.07</td>
<td>27.32</td>
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<td>Diagnosis</td>
<td>3.60</td>
<td>0.058</td>
<td>1.64</td>
<td>0.79</td>
<td>2.06</td>
<td>5.17</td>
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<tr>
<td></td>
<td>Marital status</td>
<td>4.97</td>
<td>0.026</td>
<td>1.54</td>
<td>0.86</td>
<td>1.80</td>
<td>4.69</td>
</tr>
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</table>

Table 5
Gender Differences in Length of Hospitalization by Race

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th></th>
<th>Women</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
<td>Range</td>
<td>n</td>
</tr>
<tr>
<td>White</td>
<td>17</td>
<td>723</td>
<td>37-3,012</td>
<td>11</td>
</tr>
<tr>
<td>Nonwhite</td>
<td>3</td>
<td>610</td>
<td>410-817</td>
<td>9</td>
</tr>
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</table>

that for both white men ($\bar{x} = 654$ days, $t = 12.32, p < .001$) and minority women ($\bar{x} = 642, t = 5.92, p < .01$).

Those persons acquitted of homicide who had been released into the community at the time of this study (10 persons total) had low mean days of hospitalization (for men, $\bar{x} = 402$ days; for women, $\bar{x} = 294$ days) compared with persons committing other crimes. (Paradoxically, our data also show that women and men still hospitalized under court commitment for homicide crimes average the longest hospital stays of all NGRI acquittees.)

Ten women and 10 men were found NGRI of homicide in this sample. All 10 women were found NGRI of manslaughter while 8 of the 10 men were acquitted of murder.

The victims of all women who killed were spouses, partners, or other family members. Three of the women (but none of the men) killed their children. Another woman was originally arraigned for manslaughter after her son died of neglect, but the charge at trial was reduced to injury or risk of injury to a minor. Three other women killed individuals for whom they were caring—two killed their mothers-in-law and one killed her boyfriend who was ill with cancer. Of the men, one killed a neighbor, one an acquaintance, and one a good friend. The remaining seven victims in the male perpetrated homicides were “family” or other intimates.

All of the women and men found NGRI of homicide in this study were thought to have been psychotic at the time they committed their crimes. We plan to report on more detailed analyses of this subgroup of insanity acquittees elsewhere.

Discussion

The literature concerning women found NGRI is limited. Only three studies report sex differences based on samples of more than seven females. The results of our research in Connecticut are in general agreement with what little
has been reported concerning women NGRIs in other states.

The major findings in the prior studies with regard to gender-related differences were: (1) women insanity acquittees have fewer prior and subsequent arrests compared with men,\textsuperscript{6,7,12} and (2) women NGRIs are hospitalized for shorter periods of time than men.\textsuperscript{9} Both of these findings were confirmed by our sample. In addition, this study presents detailed data concerning gender-related differences across several demographic, criminal history, hospitalization, and subsequent criminality variables not previously reported in the literature.

In Connecticut, demographic data reveal a sample of women NGRIs who are older than men, more likely to be married, and less likely to be substance abusers. These demographic characteristics coupled with the lower prior and subsequent arrest rates suggest that women NGRIs tend to have more social stability than men both before and after insanity acquittal.\textsuperscript{‡} Perhaps as a symptom of more chaotic lives, men had a much higher incidence of drug and alcohol use. Ninety percent of men had a history of substance abuse compared with 32 percent of women.

There is a trend in Connecticut for white women to be hospitalized for shorter periods of time than men and minority women. The literature supports the general finding of shorter hospitalizations for women. This has been reported in Oregon,\textsuperscript{9} New York,\textsuperscript{7,10} and Michigan,\textsuperscript{16} as well. Only in Michigan, where blacks were hospitalized fewer days, was race an important factor influencing length of hospitalization. Minority women in our sample had lengths of hospitalization similar to white and minority men.

Rogers \textit{et al.}\textsuperscript{9} hypothesize that women spend less time hospitalized because they are perceived as being less dangerous. Furthermore, they suggest that perception of dangerousness is also related to who is victimized by insanity acquittees. Because women more often victimize relatives, spouses or children, their criminality is viewed as less random and therefore less threatening.

In Connecticut, women as a group victimized family members 81 percent of the time (of all crimes with a victim). Men victimized family in only 37 percent of all incidents; the remaining victims were neighbors, acquaintances, and strangers.

Minority women commit fewer crimes against family members than white women—minority women's victims are family only 63 percent of the time, compared with 92 percent for white women. Therefore, the longer hospitalizations of minority women may be related to the more random nature of their crimes against persons. Of course, the racist perception that minority women are more dangerous because they are minority may also be operative in determining hospital release.

\textsuperscript{‡} Case histories of these women\textsuperscript{22} often revealed that their lives before insanity acquittal were more structured than the lives of the men. In the case of women who had committed homicide, for example, most were married, had children, and were almost successful in running a household. Men who killed appeared to be more disabled by mental illness, often still living with parents, reclusive, unemployed, and without much social contact or responsibility.
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If one compares days hospitalized of minority women who have victimized family members with white women who have done the same, minorities are actually in for less time (mean of 232 days) than whites (mean of 302 days). This suggests several interpretations. One similar to the one alluded to previously for white women implies that minority women may be perceived as less dangerous when their victims are family. Other interpretations related to societal perceptions, values, and prejudices will have to be evaluated in a different forum using larger samples.

Lastly, longer hospitalizations of minority women cannot be explained by greater prevalence of serious mental illness in the population of minority women compared with white women. The incidence of psychosis is similar in the two groups—62 percent of minority women and 83 percent of white women.

In the homicide cases, women were uniformly charged with manslaughter (10/10) at the time of trial whereas the men were much more likely to be charged with murder (8/10). This may reflect, in part, the nature of the crimes but may also illustrate a view of women as more emotional and less criminally aggressive. Unlike the women’s crimes, there is an element of impulsiveness and unpredictability to many of the homicide crimes committed by men. Some of the crimes do not have any understandable “motives” and appear to have taken place during an exacerbation of a severe mental disorder.

Analysis of the criminal records of insanity acquittees has shown that significant sex differences exist with regard to prior arrests. Does this mean that gender is a good predictor of subsequent arrests? In a regression analysis, gender was found to have very little independent effect on recidivism. Race and diagnosis had the strongest independent effects in a model estimated for women NGRIs and men NGRIs—a finding not previously reported in the NGRI literature. Although prior arrest is highly correlated with subsequent arrest, both racial designation and diagnosis improved prediction of subsequent arrest beyond that afforded by knowledge of prior arrest history alone.

Only two other studies done in this country have attempted to determine characteristics of insanity acquittees associated with recidivism. Both showed that prior criminality rather than clinical factors is more often associated with subsequent arrests.

Using a stepwise discriminant function analysis, Pasewark et al.23 found that younger age, more prior arrests, more serious NGRI crime, more prior days of imprisonment, fewer parole days, and fewer days hospitalized predicted the NGRIs who were rearrested. Morrow and Peterson17 found that a history of felony convictions and a history of crimes against property were predictive of subsequent arrests.

Significantly more women than men in this sample were evaluated after acquittal with a diagnosis of psychosis. Conversely, our figures showed 48 percent (n = 15) of men were given diagnoses other than a psychosis compared with only 26 percent (n = 8) of women.
A comment concerning these diagnostic subgroups seems warranted. The eight women were not diagnosed as being psychotic during their hospitalizations. They account for 75 of 99 (76%) prior arrests accumulated by all women in this sample. They also account for 33 of 38 (87%) rearrests in this sample. In combination, these data identify a subgroup of women NGRIs in Connecticut who are not psychotic and are very criminally active (indeed, four of these eight are the most criminally active women in our sample). These women were more likely to be acquitted of serious (e.g., manslaughter, assault, risk of injury, and arson) than less serious (e.g., escape, larceny, or harassment) crimes.

The 15 men with diagnoses other than schizophrenia, affective disorder, or organic disorder were not diagnosed as psychotic at any time during their hospitalizations either. This subgroup of men accounts for the majority of arrests prior to NGRI finding (81 of 128 arrests, 63%) as well as subsequent arrests following release (28 of 29 arrests, 97%). These men also were more likely to be charged with serious crimes against persons (e.g., murder, attempted murder, assault, sexual assault, and robbery).

These 21 persons are a serious challenge to the criminal justice and mental health systems. They represent those who have mental disorders of nonpsychotic proportions but who are also antisocial. Frustrating both, they frequently bounce back and forth between the criminal justice and mental health systems. Each system blames the other for providing inadequate services. But they still represent a little over half (52.5%) of NGRIs released during our study period. Public concern directed toward this criminally active group in light of the seriousness of the crimes for which they were acquitted might not be inappropriate. On the other hand, does policy with an eye toward safeguarding the public from this subgroup make sense as general policy for all NGRIs, many of whom will be released and make a successful adjustment in the community?

That differences exist in the crimes and diagnoses of women and men acquitted by reason of insanity is potentially useful—both to those involved in the adjudication of insanity acquittees as well as to those involved in their treatment. The fact that more women than men have a post-NGRI diagnosis of schizophrenia, affective disorder, or organic disorder (i.e., a psychotic disorder) is notable. Are different standards being used? Are men better malingerers? Do more men have antisocial personality disorders as well as other mental disorders? Is the higher prevalence of substance abuse in the male sample a factor? Are men with borderline personality disorders more successful with the insanity defense than women? Is the post-NGRI diagnosis more likely to be different than the diagnosis at the time of trial for men than women? These questions are provocative, but this research has only begun to provide answers.

Our data support the existence of distinct subgroups within the broad classification of insanity acquittees. One ave-
Sex Differences in NGRIs

For the present, our data might provide added impetus to question the insanity defense in disorders of nonpsychotic proportions consistent with recent APA recommendations.24 (However, our early findings regarding trial diagnoses in Connecticut showed that most persons were labeled psychotic at the time of trial. There was a great deal more variability in diagnoses across the sample following evaluation. This suggests that the pretrial evaluation process may be biased or not as carefully performed.) Oregon has recently passed a statute25 that excludes personality disorder as a mental disease for purposes of its insanity defense.

Although more women than men appear to have psychotic disorders, the two groups have comparable psychiatric hospitalization histories. All of the women and almost all of the men had at least one prior hospitalization. The actual number of hospitalizations is also similar between men and women. Other studies, with the exception of a prior Connecticut study,11 do not report this high rate of prior treatment. It is possible that Connecticut NGRIs are more chronically mentally ill, or that regional differences exist in the accessibility of mental health care, or that regional differences exist in factors that lead to successful NGRI acquittal. With regard to this latter assertion, perhaps the knowledge of prior treatment might be associated with a tendency for a panel of judges or jury to render an NGRI verdict.

There are too few studies that consider female NGRIs separately from male acquittes. Our analyses began an exploration of ethnic differences within these groups as well. Rather than advocate another series of studies exploring these gender/ethnic differences for one specific locale, perhaps now is the time to begin regional or national explorations using longitudinal databases similar to our registry (a position also advocated by Steadman4). This would allow one to identify factors related to crimes, diagnoses, dispositions, recidivism, etc. that might be similar across various NGRI samples versus those factors that might be unique to a particular jurisdiction. Longitudinal assessments of changes within these factors related to modifications within the insanity defense systems might provide a basis for theory generation and the institution of more thoughtful public policy.

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"False Confessions" and Identification with the Aggressor: Another Forensic Misuse of a Psychiatric Concept

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Some psychiatrists misuse theoretical concepts beyond their generally accepted dimensions in an attempt to support a conclusion favorable to a litigant or defendant. In the case presented, the concept of identification with the aggressor was used in an attempt to eliminate or minimize the effect of a confession and to buttress the claim that the confession itself was false. Quotations from the actual reports and testimony are used to reflect both this tactic and the context in which these issues were pursued, including a rather startling admission by the psychiatrist dealing with the thoroughness of his professional effort. A brief history of "identification with the aggressor" is presented, a history which contrasts with its application to rather routine police questioning. Similarly, skepticism is clearly merited when a psychiatrist testifies as to truthfulness or falsity of a statement.

Often in criminal cases a suspect is confronted with evidence that he has been involved in an illegal act. The evidence may be an allegation by a victim or be circumstantial in the sense that the reported events implicate the accused. However, with many crimes, there may be no direct physical evidence to support the allegations, and the victim may not be the most persuasive of witnesses particularly if there is no substantiation from other sources. Nonetheless, commonly a suspect when apprehended confesses to the crime. Sometimes this occurs because of a sense of guilt, the anxiety after confrontation with the fact of having been "caught" or implicated, or circumstances in which the suspect reacts with a sense of futility and can no longer deny his involvement. This is particularly the case with naive, noncareer criminals; the career criminal is more likely to have learned the merits of noncommunication.

Once the confession is made, the defense attorney is then confronted with a written statement, an audio tape, or even a videotape—in which a statement has been given voluntarily with or without a Miranda warning. Defense under these circumstances is often hopeless unless the confession can be eliminated by demonstration of a failure in the administration of the Miranda warning or by a claim of intimidation and coercion.
The need to confess was described by Theodor Reik in his classic, "The Compulsion to Confess." Very rarely, of course, a person may go to the police and volunteer a confession for a crime that he obviously did not do. In recent years, claims of false confessions due to intrapsychic needs have been rare. Individuals involved are usually easily excluded as suspects because of their lack of knowledge of events, but investigators are not unfamiliar with volunteers who seek out the authorities to proclaim their guilt. Many are grossly mentally ill or at least demonstrate significant psychopathology.

Another special circumstance occurs when multiple defendants, charged with a crime, have confessed in the heat of apprehension by authorities. Later, each may attempt to deny his own confession claiming threat or coercion, not by the authorities, but by the codefendant, another aspect that will not be discussed in this paper.

The attorney confronted with a situation, where his client confessed to the crime, is a legitimate suspect, knows the details and circumstances, and provides a statement that on the face of it seems appropriate, must then attempt to deal with the confession. The first line of defense is to have the confession excluded. In many cases, with no confession to overcome, the defense attorney may be able to use the doctrine of reasonable doubt to obtain an acquittal. Thus the defense attorney's prime consideration is the hearing before a judge and outside the presence of the jury to exclude the confession.

The second line of defense, not nearly as effective, is to attack the credibility of the confession at the trial. Here any avenue of concern will be used—the defendant was brain-damaged or retarded, the defendant was trying to please, the defendant was extremely dependent, the defendant was trying to impress, the defendant was threatened by a codefendant or police authorities. A major problem confronting a defendant under these circumstances is the fact that the confession itself is admitted, and the jury has to decide its weight. When the jury hears the statement, the content itself may speak louder than any argument made to diminish its utility, and the trial becomes more ritualistic than real.

**The Case of Howie the Postman**

This article reports a case in which a unique defense was attempted using purported psychiatric expert information in support of the defense.

In the early 1980s, two young boys at about eight or nine apparently were sexually assaulted under unusual circumstances. At the time they were living with a mother later determined to be psychotic. She purportedly was promiscuous; the father in turn was charged with sexual abuse and with sodomy (anal intercourse) with one of the boys. Also claimed was picture taking, physical abuse, and insertion of a dildo in the anus of the younger boy by a number of men in the neighborhood. The boys were later put into foster homes, and the mother was hospitalized as mentally ill. The boys a few years later finally told the foster mother of their experiences;
she in turn reported these statements to the police authorities.

The younger boy reported that one of those mentioned, known in the neighborhood as Howie the Postman (and so readily identifiable), paid to have sex with his mother and had put a “long white thing” into the boy’s anus. The older boy described sexual contact with his mother since age seven; at eight, she attempted to have sexual intercourse. The mother acknowledged the truth of the events charged by the boys; she saw Howie the Postman put a dildo in the younger boy’s anus and took pictures that she no longer had when interviewed. The husband also acknowledged anal intercourse with his younger son.

Howie the Postman gave a statement that three or four years earlier he had had attended three or four parties, that the other men had had sex with the mother and had inserted a dildo into the younger boy (he called it a dido—pronounced “deedo”). He admitted to having done this on three occasions.

The younger boy was about 12 when he made his allegations about the events of three to four years earlier. The father and three of the neighborhood men were charged with sexual penetration of a minor under 13.

In his statement the defendant acknowledged that he had been read the Miranda warnings, understood them, and was willing to talk voluntarily. He acknowledged knowing the family involved three or four years earlier, that he had been invited over about three times by the mother, that he had been out of uniform (postal uniform), and that sexual activity occurred. He denied doing any drinking. “(T)he other guys started fooling around and the kid came out and they started fooling with the lady . . . , and they wanted to experiment with the child, the young boy, so he used a dido (sic!) on him, it was about five inches long, and a little less than a half inch, maybe a little less, so it was inserted in his rectum.” Howie stated that five adults were present and identified them. The boy was about eight years old at the time. Howie acknowledged that others had sex relations with the mother, but he denied doing so and denied seeing any of the others having anal intercourse with the boy. He acknowledged inserting the dildo on one occasion and later on three occasions. “I just pushed it back and forth a little bit, easy.” He stated that the boy was bent over and that he, the boy, “felt good.” The others watched, and the mother took pictures of the various men inserting the dildo.

**The Defense Psychiatric Evaluation**

Howie, a 58-year-old single man, was evaluated by a psychiatrist for the defense a number of months later. This psychiatrist in his later testimony indicated that about one-half of his practice consisted of Workers Compensation evaluations but little criminal work. In his report, Howie stated that he was picked up at the post office by the police, that he was put on a polygraph, that he got “nervouser and nervouser.” He stated that he had three polygraphs. He was confronted with pictures of himself dressed in woman’s clothes, as a result
of which he was “embarrassed” and stated that “they had it all against me.” His history revealed little of note. He admitted to having sex relations with two women in his life, that sex should not be a pushy thing, that sex should be like the workings of a rifle—it should not be forced. He denied homosexual activity. The MMPI purported to show repression, denial, and need to make a favorable impression (elevated K). The highest scale was Hs, then D and Hy; this was interpreted as showing low self-esteem and a tendency to react with somatic symptoms. His Mf scale was normal. No specific psychiatric diagnosis was made. The psychiatrist concluded,

“It is likely that this man did indeed make a false confession. Under stress, given feelings of shame and guilt for his transvestite behavior, given his need for approval and identity from others, given his all-pervading low self-esteem, given his sexual inhibitions and perception (compared sex relations to using a rifle, something therefore dangerous), given his tendency to confusion and anxiety under stress, he felt intimidated, if not terrorized by, and then identified with, the "aggressors" (the authorities).

From the academic forensic psychiatric standpoint, questions raised were these:

1. Even assuming that the defendant was anxious and gave his confession because of intrapsychic factors, how could a psychiatrist state to a degree of medical certainty, that such a statement was false?

2. The psychiatrist used the concept of identification with the aggressor as the rationale upon which to explain the defendant’s behavior in giving a confession. He did not allege threat, duress, or coercion—acknowledging only that his identification with the aggressors who “intimidated, if not terrorized” him. How reasonable was the use of this concept?

The Evaluation by the Psychiatrist for the Prosecution

Howie stated that he was picked up between 11 a.m. and noon, volunteered for a polygraph, which he was told, he failed. He gave permission for a search of his house; pictures of him in women’s clothes were found. Howie stated that because of this, he confessed.

He apparently would dress in such clothes—underwear, nightgowns, and dresses and would take pictures using a timer—a practice that he followed for three years before his arrest, giving little information as to frequency or the nature of the outfits themselves. He now claimed that he confessed to something that he did not do, that he had never been in the home of the boys adding that he never went inside because it was dirty; asked how he knew it was dirty, he indicated that he could see the inside when he delivered mail. He denied knowing the parents, though he described the mother as a filthy thing who did not know what she was doing, and he denied any participation in the events alleged.

Little relevant information was obtained in review of his background. He was a marginal student, graduated at 19, having repeated one grade, and was in the military for two years during the Korean War. After a number of factory
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jobs, he became a postman, a job that he held for about 27 years until arrested, and he lived with his retired stepfather. He was vague in discussing past social and sexual interactions.

Mental status was not striking. He was of modest height (5'7''), weighing 160 lbs. He spoke well and openly about areas of his life not involved in the charges but was cautious, evasive, and resistant. About neutral subjects he was quite affable. No major deviation in thought processes was noted. Based on five of six verbal subtests on the WAIS, he had a prorated IQ of 92. He was tense during the interview and in general was not very sophisticated. The Rorschach (nine responses) reflected caution with some underlying hostility but no gross abnormality. The thematic apperception test responses again reflected caution and evasion; responses were brief and unspontaneous. He was not considered to be a reliable informant. Problems of sexual identity were suggested in his drawings of persons in which no sexual differentiation was noted. He seemed to be a constricted, immature person with problems in sexual identification and low self-esteem.

The cross-dressing practices suggested transvestite fetishism (though the full details were not known), and the current charges raised a question of pedophilia. Situational anxiety related to the charges, loss of job, financial problems, and possibility of incarceration was also present, though not marked.

The report concluded:

If “false confession” means a statement that the content is untrue or inaccurate, I can find no professional basis for labeling a statement as true or untrue. The statement itself is straight-forward, is one in which [Howie] acknowledges certain behaviors and not others, and indicates an attempt to reflect a limited participation rather than a denial. Not only do I not see a basis for a likelihood or probability that the statement is false, I question the applicability of a professional judgment in this regard.

I do not find the further statements concerning intimidation, terrorization, and identification with the aggressor as having any factual or professional basis or relevance to a current legal issue.

If the inference is that coercion was involved, then that is a matter to be determined by the fact-finders. In any event, there is no mental disorder that would impair his capacity to give a statement.

The practices in New Jersey require a sharing of reports from experts so that both sides are quite aware, well in advance of legal proceedings, of the contents and the issues raised.

The Concept of Identification with the Aggressor

The use of the concept of “identification with the aggressor” to negate a confession was rather novel. Review of several major texts on psychiatry resulted in little or no commentary on this issue. Several references were found in the International Encyclopedia of Psychiatry, Psychology, Psychoanalysis, and Neurology.

The earliest was the use of the term by Alfred Adler who, after the collapse of the monarchy and dismemberment of the Austrian-Hungarian empire, attacked the ruling class who had caused the war, misled the people, and driven them to slaughter. He criticized writers...
and scientists for supporting the establishment and defended the people, who he felt were ignorant. He explained the attitude of the people as "being due to their identifying with the aggressors in order to escape their unbearable feeling of being humiliated and incompetent." This mechanism was later used by Anna Freud as will be noted below.

Another reference under Mechanisms in discussing the subject, stated that in identification with the aggressor, the subject assumes the role of an object who has, or who he fears, will hurt him.

In another reference dealing with Anna Freud, the example is given of the little boy, afraid of ghosts, who acts the role of the ghost. Another discussion noted Lewy's application of such internalization of values in discussing Frederick II, who identified with his father after being tormented by him for his effeminate musical and literary interests; his father even compelled him to watch the beheading of his adolescent friend. Frederick II himself ultimately became an aggressive and expert militarist, the son incorporating the external threatening object into his own personality. "This, of course, takes place to some degree between all parents and children, and between student and teachers." Bettelheim later used the concept of identification with the aggressor to describe events in Nazi concentration camps wherein prisoners came to accept SS values, tried to emulate SS games, language, and uniforms. In a discussion of treatment of schizophrenia, the term was used to show how the patient imitates the therapist by identification with the aggressor (the therapist), thus learning new techniques in facing painful issues.

In Kaplan and Sadock, identification with the aggressor is described as a process in which a person incorporates a mental image of a person who represents a source of frustration. It operates in the interest of the developing ego. The classic example is that of the end of the Oedipal stage where the male child identifies with the father who is a source of frustration, being the rival of the mother. The child cannot master or run away from his father, so that he is obliged to identify with him. Another example is that of counterphobic play where a child, playing doctor, gives the doll a shot, like the one received earlier in the day by the child. Similarly introjection of a feared object serves to avoid anxiety through internalizing the aggressive characteristics of the object, and thereby putting the aggression under one's own control. The aggression is no longer felt as coming from outside, but is taken within and utilized defensively, thus turning the subject's weak, passive position into an active, strong one.

In the American Handbook of Psychiatry (ed 2), the example is given of an individual who takes into himself some or many aspects of the threatening situation or person, the example being given of a child who in the face of a significant threat (castration) from the father becomes cruel to a younger sibling.

The great popularizer of the expression was Anna Freud with her chapter, "Identification with the Aggressor," in the classic text, The Ego and the Mechanisms of Defence. In her commentary she focused on childhood development.
and noted that identification with the aggressor was "a by no means uncommon stage in the normal development of the super-ego." She noted that such a mechanism may be supplemented by another defensive measure, namely, the projection of guilt. It may also be a stage in the development of paranoia.

**Legal Management of the Concept**

The evolution of the term was discussed in detail with the prosecutor, opinion being offered that identification with the aggressor was a somewhat amorphous concept with different nuances but that none of them appeared applicable to the case at issue where a suspect was interrogated by the police and confessed after a number of events, including discovery of his aberrant sexual practices (wearing woman's clothes). The interrogations took place over a few-hour period, and no claim of coercion or abuse was made.

It is not clear which definition of identification with the aggressor was used by the defense psychiatrist. Certainly his use of the word, "terrorized," implied that perhaps the Bettelheim usage was involved. In any event, identification involves a mimicking or incorporation so that the person incorporates the behaviors or values of the aggressor. How this would be applicable to a confession and adoption of a perpetrator role is not clear. Certainly the questioning of a suspect as exemplified in this case is not to be compared to the horrendous circumstances of concentration camps or the examples given in past reports of confessions in totalitarian societies where the will of the person is gradually broken down through other techniques—starvation, physical hardship and abuse, torture, isolation, sleep and sensory deprivation, and so forth.

**Denouement**

A hearing was scheduled before the judge to determine the admissibility of the confession. Both psychiatrists were present and ready to testify when the defense attorney indicated that he would not contest the admissibility of the confession but would raise the issue of its credibility at the trial.

The rationale for this was not clear. Perhaps the defense attorney recognized that the argument that the confession was tainted because of identification with the aggressor was not likely to be persuasive to a judge. Or perhaps he felt that the pretrial publicity about the confession might affect his ability to use the issue at trial should the confession be declared admissible. In any event, he was in a difficult position because of the nature of the charges and the content of the confession that fitted in readily with the charges.

Finally the trial was held. Howie the Postman testified before the defense psychiatrist. At the trial he communicated readily, showed no evidence of overt mental difficulty, and was evasive—even to the extent of indicating that he was unclear what words meant even though his use of the terms was quite appropriate. He described his apprehension by the police, subsequent questioning, and his denials of involvement fol-
allowed by his "breaking down" after being confronted with the pictures and because he was nervous. On cross-examination Howie acknowledged his voluntary going with the police. He testified that the police told him the words to use in the confession and that the police had rehearsed the confession with him but acknowledged that many of his remarks were his own and not rehearsed. He continued to deny ever having been in the apartment, reiterating that he said everything under stress. The pictures of Howie in woman's clothes were not introduced at the trial.

The defense psychiatrist was then called as a witness and in essence read much of the body of his report. He described the MMPI as indicating neurotic tendencies. He stated that transvestite behavior resulted when a person reassured himself against castration and said because of Howie's sexual inhibitions, his tendency to react with confusion and anxiety under stress, and a need to be liked, Howie gave a false confession under stress since he wanted to give "people what they wanted to hear just to be approved of." He further stated that the confession was false, a statement that he could make with "reasonable medical probability."

On cross-examination the psychiatrist indicated the Mf scale on the MMPI was normal, reliable, and valid despite Howie's admitted transvestism. He acknowledged that there was no mental illness and that the defendant did not indicate that he was terrorized, intimidated, or harshly handled and that anxiety and fear would not be abnormal under the circumstances. The psychiatrist was then questioned at some length as to why he felt that the confession was probably false; his responses were rather vague and unclear. He did acknowledge that an argument could be made that the confession was true. He was also asked how the defendant was able to give the details in the confession that comported with the known facts and allegations—if he had not been involved and if the confession was false. The psychiatrist responded, "Now, I don't know what happened. If he spontaneously without any coaching came up with the version that coincided with what he was accused of without any coaching . . . then I want to go home now." The psychiatrist also acknowledged that he never in fact had read the confession that he had testified was false. He also indicated that he did not think that, after having denied involvement, Howie could be coached in 25 minutes as to all the details given in the 17-minute confession (apparently that was the only time period that such coaching could have occurred).

The rather amazing testimony obtained on cross-examination that the expert never read the confession that he testified was false is shown in these actual words:

Q: Did you—by the way, did this confession that he told you he gave that was false, did you ever read it?
A: No.

Q: No? Did you ever ask anybody what it said?
A: No.

Q: You curious about any details maybe?
A: I was curious recently and I asked—
Q: How recently?
A: It occurred myself. I asked myself the same
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questions you’re asking me.Q: Just yesterday you got curious?
A: It occurred to me, yes.

The prosecutor felt so comfortable with the results of the cross-examination that he did not call a psychiatrist in rebuttal. He was quite familiar with all the details of the initial report and relevant literature concerning identification with the aggressor. At the trial the defense lawyer stayed away from a discussion of this concept. The prosecutor did not explore this area, probably because the concept would only confuse the jury and because he felt that the defense psychiatrist had been reduced to a stance of noncredibility.

Howie the Postman was found guilty.

Conclusion

My analysis of recent professional reports and testimony used in legal proceedings indicates that professional input has become more and more inappropriate as courts have become quite tolerant in allowing the expression of all kinds of opinions within the leeway given to experts and the practices of the adversarial environment.

In this case, a psychiatrist claimed that a confession was false, initially basing this opinion on personality characteristics and invocation of the concept of “identification with the aggressor.” Forensic psychiatrists generally avoid the use of psychodynamic concepts in court where traditionally juries are quite skeptical particularly of sweeping generalizations based on relatively brief examination contact and ill-defined theoretical postulates.

Some psychiatrists in the past have stated that a given person could not have committed a crime because his personality was incompatible with the alleged behavior; this has occurred despite overwhelming evidence that the person did do the acts claimed. Obviously psychiatrists would be well advised to avoid such testimony as demeaning to the mental health professions when the facts turn out to be clearly to the contrary.

In this case a similar event has occurred in that a confession was declared to be false by a psychiatrist witness. Such a statement or conclusion at a level of medical probability or certainty is of dubious credibility. This article also provides a good example of psychiatric concepts being misused or distorted far beyond their usual professional dimensions in support of an adversarial position.

In this case, it is probable that “justice” resulted. However, it cannot be said that the cause of the reasonable application of professional knowledge for legal purposes was similarly served.

References

3. Ibid. Vol I, p 238
4. Ibid. Vol IV, p 28
5. Ibid. Vol V, p 91
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7. Ibid. Vol X, p 32
9. Ibid. p 902
10. Ibid. p 389