

Testimony by Mentally Ill Individuals

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Integration of individuals with mental illness into the community equates their status with that of the general population, and they may be called to give testimony concerning an incident witnessed, or a crime committed that they were not involved in, to admit guilt to a crime, or to testify about a crime in which they were the victim. Four case descriptions are presented: complaints against family, complaints against staff, abuse in treatment, and sexual abuse. The Israeli courts ruled that the testimony of a mentally ill person is admissible; however, the question that arises is the degree of importance that should be attributed to it. In 2005, a law was passed in Israel concerning the investigation and testimonial processes of individuals with intellectual or mental handicaps. Clinicians may sometimes be the link between the patient and the complex legal system; thus, they must be alert and attentive to the patients and advocate for them when necessary.

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Testimony by individuals with mental illness is an important and interesting subject in terms of both the law and psychiatry. Admission and acceptability of testimonies by individuals with mental illness is one more step toward the integration of that population into the community as citizens with equal rights and responsibilities. Normalization is a social process that occurs in the community, the hospital, and the courts. However, the testimonial capacity of individuals with impaired reality testing and/or impaired judgment may be questionable. According to Jewish law, persons who are deaf, “simpletons” (mentally impaired), and minors cannot testify.¹ Until the 20th century, the mentally ill had no rights; their families or the governments were responsible for them and took care of their needs.² Guardians were appointed and thus the mentally ill were deprived of responsibilities and civil rights. Individuals with mental illness who committed criminal offenses were deemed unfit to stand trial, but could expect prolonged psychiatric hospitalizations. With the advent of psychotropic medications in the 1950s, the process of returning such individuals to the community was initiated. After World War II, the international movement for human rights, including the rights of the mentally ill, gained momentum. More medication, treatment, and rehabilitation options have become available in recent years as awareness of

patients’ rights within the framework of citizens’ rights has increased.

Today, basic human rights (including freedom of movement, autonomy concerning personal and financial affairs, and the right to appeal compulsory hospitalizations),³ are protected, alongside allocation of responsibility. Psychiatric patients can no longer wave psychological diplomatic passports and be granted immunity. The days are gone when an individual who commits a crime unrelated to illness is arrested, but after revealing a documented psychiatric history, is admitted for observation and hospitalization, only to have the legal process halted because of a diagnosis of schizophrenia.

This is a positive process, as the path toward achieving civil rights begins with the realization of civil responsibilities. The return of individuals with mental illness to the community equates their status with that of the general population, and they may be called to give testimony concerning an incident they witnessed or experienced as the victim. Even if a person is under compulsory hospitalization, and/or has a guardian, it does not mean that she or he cannot testify in specific situations.⁴ The law relates to individuals with mental illness the same as it does to other persons with disabilities, and therefore it is relevant to what they have to say, including when they give testimony.^{5,6} The testimony can be divided into three situations. The first occurs when the testimony of a mentally ill individual concerns an incident witnessed, or a crime that was committed, in which he or she was not involved. The status of a mentally ill

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individual who witnessed an incident is the same as that of any other witness; however, there is concern that his or her mental state may cause the witness to testify to something that never happened and may thus incriminate an innocent person, or that the supposedly true testimony will include imaginary details.

This is a dilemma that therapists confront daily in the psychiatric ward. During the ward routine, the therapist encounters many complaints from patients. The therapist must evaluate the validity of each of the patients' testimonies and complaints. There is a difference in attitudes toward the complaints of a patient who believes that another patient is threatening him, sending him radioactive rays and disturbing his sleep at night, and the patient who complains that a roommate stole his or her money, coffee, or cigarettes, for example. Both accusations are based on the patients' personal experiences, but one is based on delusion, and the other apparently is not. Clearly, every complaint must be supported by the degree of proof required by the courts if legal action is to be taken. However, based on familiarity with the patients who testify, the suspects, the opinions of the staff, and the consistency of the complaints, conclusions can usually be drawn in each specific case.

The second situation occurs when the patient testifies that he or she committed a crime and admits guilt; however, there is a danger that the patient will admit to a crime that he or she did not commit, because of motives stemming from the illness. Following critical incidents in Israel, such as suicide attacks, there are patients who claim to be related to the events (e.g., "The Hamas blew up a bus because of me."). In such cases the therapist does not attach much importance to the admission factually, although the comment attests to anxieties, fears, and guilty feelings stemming from psychosis.

In the third situation, the patient testifies that he or she has been the victim of a crime. This is the most difficult and worrisome possibility. In such a case, the threshold of sensitivity must be very low, since the patient, as a mentally ill individual, is sometimes exposed to exploitation and abuse, and the capacity to speak out and protect him- or herself may be limited. The psychotic content may cause valid complaints to be ignored, leaving the individual unprotected. Conversely, care must be taken not to suspect the innocent, in case it becomes clear that the described events are delusional.

Case Descriptions

Complaints Against the Family

Patient A. was a 26-year-old who had schizophrenia with no remissions. Her thought content was psychotic: she claimed to have palaces in Paris and connections to the Queen of England. When the intensity of the psychosis declined, she was discharged from the hospital, but quickly returned. During hospitalization, she told her therapist that her father had come into the room when she was getting dressed and had sometimes come into the shower with her. She did not repeat the accusation in the presence of the staff during an attempt to clarify details. The parents had raised their daughter with devotion and care for many years, despite her severe condition.

We on the staff decided to confront the family with the accusation. Confronting them turned out to be a mistake from a legal point of view, at the level of the investigation. However, we wanted to raise our concerns with the parents, thinking that the very knowledge of our suspicions would put an end to the behavior, if indeed it were true. The parents totally rejected the accusation, were not surprised or angry, and claimed that it was just another one of A.'s many delusions. We took an intermediary step, according to the law and sent a letter to the social services unit of the Welfare Department.⁷

In due course, A., in a rage, began to scream about the same supposed events. This time we called the police, and A. filed a complaint with the assistance of her psychiatrist. However, before she was questioned and before the photographers arrived, a few hours passed, and the story faded to the point that, during the investigation, it was not possible to gain a clear picture. The police, in fact did not go beyond that point. Later on, the patient moved to live with her grandmother, which probably solved the problem. The fact that she had sexual delusions and a paranoid state could have resulted from many years of abuse, until her attitude toward life became pathologically psychotic. It is also possible that the family had a pathological structure with no borders and role confusion to the extreme incident of incest and rape, and that may have been the cause of the outbreak of A.'s mental illness. It is also possible that the complaints were, in fact, delusional.

Complaints Against the Staff

Patient B. complained that the nurses raped him every night in his room. The complaint was repeated daily for a few days, but passed when there was an improvement in the patient's condition. In this case, the staff did not believe the complaint due to the patient's condition, the sexual psychotic content, and the nurses' descriptions of the way he gazed at them, his occasional attempts to touch them, and their acquaintance with him and the other involved parties (i.e., the night nursing staff). For complaints concerning incidents that occur in the hospital department, we have more control of and information about the environment (including observers of the incidents) and generally feel more confident in determining whether the complaints are feasible or undoubtedly delusional.

Complaint of Abuse in Treatment

Young patient C., who was in a psychotic state, described to his attending physician that before his admission he was in psychological care, and the psychologist was nude when treating him. The doctor described this to the department head, suggesting that the patient was psychotic and thus had accused the psychologist of imagined behavior. The department head, however, felt that it may be a true complaint as the factual description never changed, and the patient lacked psychological knowledge or prior treatment. The department head sent a letter to the psychologist requesting that he explain the nature of the nude treatment, but did not receive a reply. The department head ultimately passed the matter on to the Ministry of Health. However, the patient returned a few days following discharge in an agitated state and described that he had gone to the psychologist, and the incident was repeated. This time, the doctor went to the police and filed a complaint, and there was an investigation that proved the credibility of the complaint via a recording. During trial, it was revealed that the psychologist himself was suspected of having a mental illness, and he was ultimately incarcerated.

Sexual Abuse in the Immediate Surroundings

Two female patients complained that the hospital cafeteria owner indecently assaulted them. A complaint was filed with the police, but the matter was closed in the attorney's office, citing lack of proof, since the patients had severe mental illness, were in-

coherent, and their testimonies were inconsistent. After a time, they complained again. This time the security officer installed cameras that documented the events, and with the recordings the police were called again. The police then also installed cameras, and the assault was documented again. Ultimately, the cafeteria owner was tried and imprisoned. The intent of the filming was to support the patients' testimony. The matter of the necessity for additional testimony to support a patient's testimony is problematic. Contrary to a healthy complainant, who might voluntarily take a tape recorder and return to the scene of the crime to tape the criminal, these mentally ill patients were exposed to a repeated serious incident, having been taped again without their consent. However, this may have been the only way to prove guilt and convict the criminal. Thus, there is a regression to the era of paternalism expressed by decision-making for the patients. To the department staff it was clear that the patients were telling the truth, despite the fact that they were psychotic and had persistent mental illness. The staff's trust in the patients was based on long-term acquaintance with them and familiarity with their psychoses, which did not have a sexual quality. The nursing staff has a wealth of experience and special intuition acquired through many years of working in a psychiatric hospital. The documentation of daily nurses' reports, three shifts per day, may also help in obtaining a reliable picture of the patient's status in these situations.⁸

Admissibility of Testimony

The Supreme Court of Israel has ruled that the admission of guilt by a mentally ill person is admissible as evidence. The question that arises regarding this type of confession is the degree of importance that should be attributed to it.^{9,10} Even if the witness's perception is inadequate, it does not mean that admissibility of his or her testimony should be rejected, as the law concerning the witnesses' capacity to provide relevant answers to others is dependent on the nature of the impairment and the degree of influence it has on the credibility of the testimony.¹¹ Here, the question of the impairment that may develop in mental illness and that may harm the patient's capacity to give testimony should be emphasized. The Court determined that hospitalization alone does not determine that testimony is inadmissible. It noted that a mental patient may not testify regarding his or her illness, but may testify on other matters.

The U.S. Supreme Court quoted a British case in which an ill person thought that there were thousands of spirits inside him. In response to the question in court about when an event he witnessed had occurred, he stated: "These creatures insist upon it, it was Tuesday night, and I think it was Monday" (Ref. 12, p 620).

There is a basic difficulty regarding how to relate to the two different answers that the witness provides. When relating to a person with mental illness, we don't assume that he is entirely ill, rather that he has both sick and healthy components. The sick components are treated, and the treatment alliance is created via the healthy components. There may be an absolute division between the healthy and sick components, and the patients live quite well with this division.

For example, a mentally ill patient with delusions of grandeur, may leave the hospital, walk to the bus stop, stand in line, and pay the driver. That ability would not conflict with his belief that he is the Messiah. When two worlds become involved, the sick and the healthy, it is difficult to know which represents reality. When the witness quoted earlier says that the creatures insist that the events took place on a different day, we must remember that the creatures are part of him, and it is not clear when he says "me" what he means. The borders between illness and health become blurred. The extent of his understanding of the meaning of truth is not clear.

The Supreme Court of Israel refers to the capacity of the witness to understand his obligation to tell the truth and examines his or her capacity to give testimony on the topic under deliberation.¹³ In our daily lives, we uphold the basic principles determined by the courts concerning testimony^{14,15}: direct impression from the witness and the manner in which he or she testifies; internal testing of the testimony for logic, organization, and signs of common sense; and signs of external testimony. (For example, when a patient complains that a specific patient is stealing his coffee, and the coffee is indeed found in that specific patient's cupboard, there are strong external testimonial signs to support the allegation.)

In a case in the village of Lifta, where an unusual gang planned to blow up the Temple Mount, the issue of testimony was deliberated in great detail, since two members of the gang were mentally ill with schizophrenia and were in court-ordered hospitalization following the trial, one for lack of criminal responsibility and the second for inability to stand trial.

Of interest, the court determined that even though one individual was not criminally responsible due to his illness, his testimony was valid and in fact contributed to the conviction of an additional member of the gang.¹⁶ A person with mental illness, as any other person, can confess to a crime that he or she has committed and be judged for it. The main danger is that the mentally ill person may confess to a crime that he or she did not commit, or take responsibility for performing a deed that he or she did not do, potentially leading to suicide by confession.¹⁴

Strashnov¹⁴ described the case of a man in Israel who confessed to something that he did; however, his motives for making the confession were psychotic. The patient entered the police station, following a psychiatric hospitalization during which he was found to be in a paranoid psychotic state, and expressed his desire to volunteer for the civil guard, but he first wanted to cleanse his conscience and confess to a series of crimes that he had committed, among them burglary and theft.

There were no doubts that he had committed the crime; rather, there was a discussion regarding his confession and whether it was given of his free will. According to his physicians, his reasoning was not logical. The regional court annulled the confession because the accused had a mental disorder while giving the confession at the police station and was subject to severe psychotic episodes. However, the Supreme Court ruled that inner pressure (e.g., remorse, conscience, or even psychosis) does not nullify testimony. This case is quite similar to the U.S. Supreme Court case of *Colorado v. Connelly*.¹⁷

There is sometimes no connection between the psychotic motive and the facts, such as in the difficult days following the murder of Prime Minister Yitzchak Rabin, when there was a need to cope with patients who believed that they were related to the murder. It can be understood that the sense of psychotic guilt was so great in some patients that they related to the most critical event of the time and felt guilty.¹⁸ In this case the feelings of the patients were more important than their thought content.

Legislation in Israel

In 2005, a law was passed concerning the investigation and testimonial processes of individuals with intellectual or mental handicaps that attempts to deal with these problems.¹⁹ The law relates to persons with "mental handicap" and "intellectual handicap";

the latter refers to mental retardation, cognitive impairment, and pervasive developmental disorder (PDD). An individual with mental illness may belong to one of these categories in either an exacerbated or residual state of his or her illness.

A person with a mental handicap is entitled to be accompanied during the investigation by a relative, a representative, or a therapist. The investigation should be documented by filming and recording, and the taped testimony may be admissible. It is desirable that the investigator have knowledge in the field of mental health. The assistance of video recording is important in cases in which the individual changes the version or the nature of the story.

There is an additional difficulty in the "once only" testimony in court. It takes time for individuals with disabilities to acclimate themselves to people and situations and to trust them. It may be preferable for them to appear in court several times.²⁰ According to the new law, the court may also decide that testimony should take place in court, not in the patient's presence, but only in the presence of the defense attorney. Witnesses may also testify behind a screen, in the judge's chambers, or elsewhere.

Role of Therapists

A victim with a history of mental illness faces barriers that all victims confront when filing a complaint. The first is the barrier of feeling shame about the incident that has transpired and sometimes even a sense of guilt or shame for what occurred. Family members may question the credibility of the accusation, and the therapist may tend to relate the complaint to the patient's psychotic state. In order for the police to file a complaint, it has to be coherent and meaningful. The attorney's office must be convinced that there is enough evidence to submit an indictment. And finally, the victim with mental illness must be able to come to court for interrogation and cross-interrogation (something that many healthy people have difficulty doing). The therapist may need to provide additional support and monitoring under these circumstances.

The criminal justice system has recognized the necessity for attention to the needs of such vulnerable witnesses.²¹ The approach that relates more realistically to the mentally ill individual and his or her limitations is preferable. Recognition of the limitations is a step toward realizing equality in rights and responsibilities. When treatment staff become involved in their patients'

legal system interactions, they must be mindful that they are not an interrogation unit of the police force. But sometimes they are the main link between the patient and the complex legal system. Thus, they must be alert and attentive to patients and their needs and advocate for them when necessary.

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