

Mutism, Malingering, and Competency to Stand Trial

A. E. Daniel, MD; and Phillip J. Resnick, MD

Mutism and mental illness have had a long-standing historical relationship with regard to the issue of competence to stand trial. This article reports a defendant who remained mute for 10 months and describes his use of the symptom of mutism in his malingering. Although mutism is frequently used by defendants for malingering, clinicians must have a high index of suspicion for the possibility. We recommend a comprehensive evaluation including neurologic workup, repeat interviews, observation of the defendant at unsuspected times for communicative speech with other inmates, study of handwriting sample, collateral nursing documentation, and, if necessary, Pentothal interviews to establish authenticity of mutism. The authors review the historical background and legal considerations of the relationship between mutism and malingering.

Historically, the requirement of competency to stand trial served a ritualistic and protective function in criminal proceedings. The purposes of assessing competency are to ensure accuracy of criminal adjudication, guarantee a fair trial, and preserve the integrity and dignity of the legal process.¹

Over the years, through common law doctrine and various landmark cases in the United States, various criteria have been formulated to determine a defendant's competency. According to *Dusky v. United States* (1960),² for example, the "test must be whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree

of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him." This test has now been superseded for all federal defendants. Under the new Federal Insanity Defense Reform Act (1984), a defendant is presumed competent unless it is shown that he is "suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense."³

In short, defendants must comprehend the nature and object of the proceedings against them and be able to advise their counsel rationally in the preparation of their defense. Thus, in addition to having cognitive understanding of the proceedings, defendants should also be able to verbalize their side of the story to their counsel. Defendants' cooperation and ability to talk are criti-

Dr. Daniel is associate professor of psychiatry at the University of Missouri School of Medicine, Columbia, MO, and superintendent of the Mid-Missouri Mental Health Center. Dr. Resnick is associate professor of psychiatry, Case Western Reserve University, Cleveland, OH, and director of forensic psychiatry, University Hospitals of Cleveland. This paper was presented at the Annual Meeting of the American Academy of Psychiatry and the Law, Albuquerque, NM, October 10-13, 1985.

cal to the evaluation of their competency.

Although the determination of a defendant's competency to stand trial is generally fairly easy, it poses difficult problems under certain special circumstances—e.g., amnesia, brain injury, mutism, and malingering. In most of these situations, defendants fall short of the required standard for competence because of their inherent inability to accurately describe the details of the alleged incident. Amnesia per se is no bar to the trial of the otherwise competent defendant.⁴ If, however, amnesia is coupled with the absence of extrinsic information regarding the offense, making it difficult for the defense to reconstruct events, a defendant may be adjudged incompetent.⁵

A review of the literature revealed ample judicial decisions pertaining to amnesia, brain injury, malingering, courtroom decorum issues, and the medicated defendant.⁶ However, the authors could not find any precedent in which malingered mutism was the central issue in the determination of a defendant's competency to stand trial. This article reports a defendant who remained mute for 10 months and describes his use of the symptom of mutism in his malingering. Some guidelines for psychiatric evaluation of a mute defendant are provided, along with a discussion of historical and legal considerations.

Historical Considerations

Historically, mutism and mental illness have been considered as dual reasons for finding defendants incompetent

to stand trial. In fact, the practice of exempting deaf mute persons from trial probably preceded that of exempting the insane in England.⁷ The "Dooms of Alfred," from the last quarter of the ninth century, provided that "if a man be born deaf and dumb so that he cannot acknowledge or confess his offense, his father must make bot [pay] for his misdeeds."⁸ The deaf mute and the mentally ill were treated like children; their fathers had to pay their fines. In pre-Norman England, persons were required to either pay civil compensation for harming another person or property or face the threat of feud. This situation gave rise to the expression, "Buy off the spear or bear it." It was not until approximately 1100 that some crimes were declared "botless"—that is, criminal penalties imposed by the state could not be avoided by paying compensation.⁷

The "Assizes of Jerusalem" contains one of the earliest reported examples of court-ordered medical examinations to determine the authenticity of alleged illness which could preclude standing trial.⁹ This code of laws was framed for the Kingdom of Jerusalem in 1100, at the request of the Crusader Godfrey de Bouillon. Because vassals were likely to be subjected to trial by battle, it is understandable that some persons would feign illness in order to avoid trial. A physician, an apothecary, and a surgeon were sent to conduct a personal examination in the home of the allegedly sick person. "If the physician says an oath, by which he is bound, that he is ill, he can no longer be brought, just as if he (the physician) or the surgeon finds nothing wrong with him nor reason why

he must refrain from appearing in court, he must go and appear."¹⁰

It was probably not until the fourteenth century that the insane in England became exempted from standing trial. Deferring trials for the insane is recorded as early as 1353. Because reverence for the ritual of law made it unthinkable to proceed with the trial unless the defendant pleaded guilty or not guilty, mutism was a critical issue. Failure to plead either guilty or not guilty precluded conviction and the subsequent forfeiture of the defendant's property to the king. Consequently, it became common for men of property to avoid conviction and forfeitures by refusing to plead.⁷

The court's first question regarding a person who would not enter a plea was whether the person was truly a madman or a deaf-mute, or whether he was faking. It was phrased then, "Is he mute of malice or by the visitation of God." *Peine forte et dure*, a procedure during which a person was slowly pressed to death under an increasing weight of stones, was used to encourage a defendant to enter a plea. In the absence of very strong evidence, e.g., that the accused had been deaf and dumb from birth, the court was unlikely to decide in favor of "the visitation of God." The *Peine forte et dure* was not abolished in England until 1722, and is the origin of the phrase "to press someone for an answer."

Hale¹¹ suggested that a mentally ill person should not be found incompetent to stand trial unless he or she were "absolutely mad." It was not until the middle of the eighteenth century, however,

that the insane prisoner had any real chance of being found unfit for trial. The phenomenon coincided with the legal requirement that jail physicians perform regular medical examinations on all prisoners.¹²

Isaac Ray's *Treatise on the Medical Jurisprudence of Insanity*¹³ included a few cases in which criminals facing trial used mutism in malingering mental illness. For instance, one defendant who was arrested for murdering a woman stopped talking altogether and "laid motionless on his bed." Physicians who examined him felt that "it appeared to be a paralysis of the nerves of the tongue and ear." His simulation was exposed by repeated application of cautery to his feet and neck. Isaac Ray described the difficulty of differential diagnosis in such simulated cases, and provided a detailed outline for a medical examination.

Case History

A 53-year-old, white, divorced man was charged with a rape and first-degree murder that occurred on July 29, 1982. He allegedly killed an 11-year-old girl by asphyxiation in the perpetration of a rape.

The suspect was apprehended by the police at 10:00 p.m. on the day of the crime, but was released after giving two or three different stories about the offense. On the morning of July 30, 1982, he voluntarily admitted himself to a state hospital, with a complaint of hearing voices that said, "Don't let the devil get me. Stop the voices; don't let them hurt me." He gave only his name and social security number, and stopped talking completely upon being told that he had been formally charged with murder. Subsequent observations by the hospital psychiatrist revealed that he was mute and would tense up and be resistive when examined. He would make exaggerated chewing motions with his mouth and would also tightly close his eyes. Such conduct was not apparent when the patient did not know he was being observed.

After one week's observation, he was transferred to jail, where he continued to be uncommunicative. Although he initially refused to eat, his personal hygiene, bowel functions, and sleep were reported to be normal. His behavior remained unchanged until his admission to a maximum security unit for a pretrial examination on October 26, 1982. For the first couple of days on the unit, he refused to eat; when he was firmly told that he would be tube-fed, however, he returned to normal food intake. Daily observations confirmed the persistence of mutism. Although he made no attempt to answer any questions, he was not observed to be hostile.

On December 13, 1982, he made a suicide attempt by ingesting a bottle of disinfectant he had taken from the cleaning cart on the ward. He did not speak a word during the resulting two-day hospitalization. On January 14, 1983, he was observed mumbling to himself for the first time. He walked around the ward with his head down, and occasionally attempted to kick other patients. He became increasingly aggressive and had to be placed in leather restraints. Because he continually banged his head against the wall, he was asked to wear a helmet for his own protection.

Mental Status Examination The defendant's clothing was relatively clean and his face was unshaven. When requested to take a seat, he came forward and sat down slowly and cautiously. He usually sat with his hands supporting his face and looking far away; he avoided eye contact with the examiner. When examined in his room, he would lie curled up and would not respond to any questions. As soon as the examiner left the room, he would straighten up and stare into space. On several occasions, he got up from the bed, paced the floor, and appeared to be mumbling to himself. When he thought he was not being observed, he made a number of attempts to talk to fellow inmates. He never seemed to be listening to outside stimuli or responding to hallucinatory commands. With the exception of the first two days of his admission, his personal hygiene and eating habits remained within normal limits. He did not lose weight and was noted to be sleeping soundly. Repeated examinations failed to reveal the presence of catatonic signs such as waxy flexibility, automatic obedience, or peculiar postures. There were no signs or symptoms suggestive of severe depression or stupor.

Objective examination of orientation, mem-

ory, intelligence, insight, and judgment could not be performed because the patient was uncooperative and uncommunicative. He was very fidgety. He became angry on one occasion when he was confronted about the alleged crime and his past history of child molestations. All attempts to encourage him to verbalize his feelings were to no avail. It was the general impression of the staff, however, that he seemed to be aware of his immediate environment, and his ability to understand spoken language was inferred from his non-verbal responses.

Laboratory Examinations Routine laboratory workup, electroencephalogram, x-rays of skull and chest, electrocardiogram, and neurology consultations revealed no physical or neurologic disorder. After obtaining written permission from him and his attorney, diagnostic Pentothal interviews were conducted on August 4, 1982, and December 2, 1982. After slow intravenous infusion of 800 mg of Pentothal, the defendant began describing the alleged offense and the circumstances surrounding it. Although his responses were occasionally disjointed, he was able to tell a logical story. The defendant continued to talk for about 90 minutes at each Pentothal session but did not utter a word afterward.

Past History The defendant had been arrested at least 30 times on varied charges and had used at least six different names. From 1947 until 1967, his arrests were related primarily to stealing and burglary. There were reports of numerous thefts, burglaries, breaking and entering, possession of burglary tools, forgery, and escape. For reasons not readily apparent, almost all of his arrests subsequent to 1969 were for child molesting and sex offenses. Throughout the course of his lengthy criminal career, he had been incarcerated in various state, county, and city correctional facilities in Missouri, Oklahoma, California, Nebraska, and Iowa. He had also been both an inpatient and an outpatient at multiple psychiatric hospitals.

Coincident with his change from property to sexual offenses, a new behavioral pattern emerged. After committing a sexual offense, he would voluntarily admit himself to a nearby psychiatric facility for "treatment." After convincing the mental health professionals that he was suffering from a mental illness, the charges would be dismissed due to commitment to mental health facilities. He would then "work his way

out of" the hospital commitment, leave the area, and repeat the same behavior in another community.

When he was arrested in 1980 on a charge of third-degree sexual assault of a mentally retarded young adult, he acted in a "bizarre manner," banged his head, talked incoherently, and said that he was seeing the devil. The charge was dropped when he was committed to a psychiatric facility. He was charged with child stealing in 1981, but "collapsed before he could be fingerprinted." He was admitted to a psychiatric facility where he began to bang his head and roll his eyes as though he were experiencing hallucinations. He remained uncommunicative until he was found to be incompetent to stand trial, with a diagnosis of chronic schizophrenia in acute exacerbation. Although a psychiatric examination on January 25, 1982, did not specify a psychotic diagnosis, the psychiatrist stated that "there remained indications of psychotic process because of flat affect and distant slowness to respond." There was no clearcut thought disorder, but he evidenced "idiosyncratic thinking." He complained of voices saying, "They are going to burn me up; they are going to let me smell the gas they are going to use." When asked about any peculiar or olfactory experiences, he stated, "I used to have them before." The report showed "almost immediate response to antipsychotic medications."

Hospital Course During his four-month stay, he was examined by four board-certified psychiatrists. Although all the psychiatrists individually came to the conclusion that the defendant was not suffering from any mental disorder or deficit, they were uncertain about his competence to stand trial. Nonetheless, on February 19, 1983, he was informed that the court would be advised that he was competent to proceed. After this announcement, he showed some aggressiveness, refused to eat, and began headbanging.

The defendant remained on the unit for two additional months, until his competency hearing on April 18, 1983. Three psychiatrists, including the primary author of this article, testified that the defendant did not suffer from any mental illness and was malingering. The testimony emphasized that the mutism was elective, i.e., that he was unwilling, rather than unable, to talk. Moreover, the defendant's symptoms, including mutism, had a sudden onset after legal difficulties

were encountered. There was no evidence of catatonia, depressive stupor, or organic disorder. The defendant was found to be competent to stand trial.

Diagnostic Considerations

In a comprehensive paper on the detection of malingered mental illness, Resnick¹⁴ classified five purposes of malingering and outlined some strategies for evaluating a criminal defendant suspected of malingering. One reason a criminal defendant may pretend to be mentally ill is to be found incompetent to stand trial and thus avoid punishment.

The most commonly faked diagnostic categories are psychosis, Ganser syndrome, and posttraumatic stress disorder; the most frequently feigned symptoms are auditory hallucinations, amnesia, conversion symptoms, and delusions. The detection of malingered auditory hallucinations requires a careful analysis of the ways in which the alleged voices compare with the known characteristics of genuine auditory hallucinations. Similarly, considerable diagnostic skill is required to determine whether amnesia is functional or organic, temporary or permanent, and genuine or feigned.¹⁵

Malingered mutism may either occur as a solitary symptom or as part of malingered psychosis (as seen in our defendant). Giving up speech for a prolonged time is not an easy sacrifice and is not usually attempted unless a defendant is facing a very severe penalty. Davidson¹⁶ states:

This monolithic silence is almost unbearable to the sane man. To maintain it would require

that the defendant sit in his cell or walk in the yard day after day, hearing himself discussed, hearing statements made that ought to be contradicted, charges that can be denied, hearing all this and saying nothing. It would require him to deny himself the solace of companionship in his most trying period, to spurn all offers of friendliness, to eat only what is put in front of him, to do without tobacco or any other little luxury to which he may have been accustomed, and in which he can indulge by uttering only a brief request. Few sane persons are cast in so heroic a mold that they can do this sixty minutes an hour, twenty-four hours a day.

Genuine mutism may occur in a variety of organic and functional clinical conditions. Lesions of the third ventricle, midbrain, and thalamus may produce a condition called akinetic mutism in which the patient, while remaining unconscious, keeps his eyes open and shows a reflex response to painful stimuli. Other neurologic conditions such as Pick's disease and Huntington's chorea, will occasionally cause mutism.

Mutism occurring as a part of catatonic stupor will be recognized by the presence of generalized catatonia, posturing, negativism, automatic obedience, waxy flexibility, and other typical schizophrenic features. Patients with extreme psychomotor retardation, as seen in depressive stupor, are likely to show universal motor inhibition in addition to mutism. Malingered mutism after recovery from a genuine schizophrenic episode or psychotic depression must also be considered.

The most difficult differential diagnosis of mutism is between a conversion disorder and malingering. The critical distinction is whether or not mutism is under the defendant's voluntary control. In difficult determinations, a detailed

history and the collection of all past psychiatric records are required. An inpatient assessment may be necessary, along with Pentothal interviews and/or a written polygraph examination. The exact details of when the defendant stopped speaking are critical. The onset may have been after a crime that involved "unspeakable horror" or upon arrest, which may also have been traumatic. The defendant with mutism due to a conversion disorder is likely to have a history of past conversion symptoms, to display evidence of repression and dissociative phenomena, to have mutism as a solitary symptom, and to be suggestible and easily hypnotized. When hysterical mutism occurs in children, it is usually sudden in onset and transient. The malingeringer is more likely to have a history of prior antisocial conduct, lying, and past malingering and an extensive criminal record. The malingeringer is less likely to submit to written psychological tests, Pentothal examinations, hypnosis, or polygraph examinations.

Establishing the presence of mutism in a person is accomplished with relative ease. A proper physical and neurologic examination will eliminate any contributory neurologic disorders. Malingered mutism must always be suspected, but there is great reluctance to accuse somebody of faking. For example, not one of 11 medical reports mentioned the possibility of fraud in a man who was mute for several months after a head injury. Nonetheless, a defendant insurance company detective discovered that the man spoke normally during a train trip.¹⁷

Repeat interviews, observation of the

defendant at unexpected times for communicative speech with other inmates, study of a handwriting sample, and collateral nursing documentation will aid in establishing the authenticity of mutism. Narcoanalysis may be a useful procedure in clinching a diagnosis of malingered mutism.¹⁴ Pascoe, in an unpublished case, effectively utilized repeat Pentothal interviews to uncover the true nature of mutism in a defendant charged with robbery (H. Pascoe, personal communication, October 1983).

Legal Considerations

Defendants are presumed competent to stand trial unless a preponderance of the evidence indicates otherwise. The differential diagnosis of mutism in a criminal defendant is critical for the competency evaluation. In most cases in which mutism is clearly due to a mental disease, such as catatonic schizophrenia or psychotic depression, it is relatively easy to conclude that such defendants are incompetent. If mutism is the sole symptom, the differential diagnosis between conversion reaction and malingering must be considered. If, after a complete evaluation, including inpatient observation and a Pentothal interview, the examiner concludes that a defendant is probably malingering, the court should be encouraged to proceed with the trial.

If the examiner concludes that the mutism is probably due to a conversion reaction, he may opine that the defendant is not currently competent to stand trial, but has a substantial probability of becoming competent within a reasonable period of time. If treatment is unsuc-

cessful in restoring speech within that time, the defendant must either be declared nonrestorable or brought to trial.

In cases of permanent amnesia, defendants ordinarily do proceed to trial. If a mute defendant can communicate with his attorney through writing, his mutism is not a bar to competence. If the court concludes that a defendant has an involuntary inability to communicate with his attorney by speech or writing, the defendant would not be restorable. Today, such defendants would be eligible for civil commitment only if they were considered dangerous due to their mental illness.¹⁸ Should such defendants begin to speak in the future, they could be brought back for trial.

Historically, there has always been concern about the issue of adequately protecting the public from persons who are found not restorable to competence. Following Hadfield's insanity acquittal in England, the "Criminal Lunatics Act of 1800" required that persons found incompetent to stand trial should be kept in strict custody until His Majesty's pleasure was known. Some deaf and dumb persons who unfortunately appeared retarded were found incompetent to stand trial under these provisions and were held indefinitely.¹⁹ The Federal Insanity Defense Reform Act³ provides maximal protection for the public consistent with the constitutional mandate of *Jackson v. Indiana*.¹⁸

The use of a Pentothal (or Amytal) interview in nonconsenting defendants to help determine whether mutism is malingered raises some thorny legal issues. Intravenous injection of Pentothal is clearly an invasion of both the body

and the mind. Although the risks associated with the procedure are small, serious complications, such as laryngospasm, can occur. Defendants' Fifth Amendment rights not to incriminate themselves preclude using information learned in the interview to prove guilt. Narcoanalysis cannot be considered highly reliable in ascertaining whether defendants had been consciously or unconsciously choosing not to speak. One half of the subjects in one study were able to maintain a lie under the influence of Amytal Sodium.²⁰

Conclusion

Mutism and mental illness have had a long-standing historical relationship with regard to the issue of competence to stand trial. Although mutism is infrequently used by malingering defendants, clinicians must have a high index of suspicion for the possibility. A careful evaluation must be done so that no mute impostor escapes punishment and no genuinely mute defendant silently suffers an unjust conviction.

References

1. Smith SM: Competency. *Psychiatr Clin North Am* 6:635-50, 1983
2. *Dusky v. United States*, 362, U.S. 402 (1960)
3. 18 USCS 424(a), June 1985
4. *State v. Garrett*, 595 SW 2d 422, Mo. App. 1980
5. *Wilson v. United States*, F 2d 460, 1980
6. Halpern AL: Use and misuse of psychiatry in competency examination of criminal defendants. *Psychiatr Ann* 5:8-73, 1975
7. Walker N: *Crime and Insanity in England*, Vol 1. Edinburgh University Press, 1968
8. Robertson AJ: *The Laws of the Kings of England from Edmund to Henry I*. Cambridge, England, Cambridge University Press, 1925
9. Brittain RP: The History of Legal Medicine: The Assizes of Jerusalem. *Medicolegal J* 34:72-3, 1966
10. Cousin A: *Essai sur les Origines de la Médecine légale*. Paris, Jouve, 1905, 24-25 (Thesis)
11. *Historia Placitorum Coronae*, I, Ch. IV
12. 28 and 29, Vict., c. 126
13. Ray I: *Treatise on the Medical Jurisprudence of Insanity*. Boston, Little, Brown, 1871
14. Resnick PJ: Detection of malingering mental illness. *Behav Sci Law* 2:21-38, 1984
15. Koson D, Robey A: Amnesia and competency to stand trial. *Am J Psychiatry* 130:588-91, 1973
16. Davidson HA: *Forensic Psychiatry*, 2nd Ed. New York: Ronald Press, 1965, pp. 217-9
17. Pollack S: Elements of legal proof of malingering. Paper presented at the annual meeting of the American Academy of Psychiatry and the Law, San Francisco, California, 1971
18. *Jackson v. Indiana*, 406 U.S. 715, 92 S Ct 1845, 1972
19. *R. v. Dyson*, 7 Carrington & Payne, 305: I Lewin 64, 1831
20. Redlich RC, Ravitz LJ, Dession GH: Narcoanalysis and the truth. *Am J Psychiatry* 107:586-93, 1951