

# Forensic Historiography: Narratives and Science

Albert M. Drukteinis, MD, JD

Psychiatrists function, in part, as historians who rely on patient narratives to help them understand presenting mental disorders and explain their causes. Forensic psychiatrists have been skeptical of using narratives, raising concerns about their lack of objectivity and potential for bias. They also have criticized narratives as being more performative than scientific. Recent authors, however, have pointed out that narratives may be helpful in forming forensic opinions and supporting oral testimony, while stressing that their use must be consistent with the ethics espoused by forensic psychiatry. This article reviews the role of narratives in understanding human events and the ubiquitous presence of narratives in the judicial process. It delves into the inescapability of using explicit or implicit narratives in the course of forensic practice, as well as how they may be meaningfully incorporated into evaluations and find expression alongside scientific principles.

**J Am Acad Psychiatry Law 42:427–36, 2014**

Life is not what one lived, but what one remembers and how one remembers it to recount it.

—Gabriel Garcia Marquez<sup>1</sup>

Historiography is the “writing of history based on the critical examination of sources, the selection of particulars from the authentic materials, and the synthesis of particulars into a narrative that will stand the test of critical methods.”<sup>2</sup> In essence, it is the accumulation of records with historical information and storytelling, detailed with explanations and causes. In the past 30 years and despite the increasing use of social science models of historical analysis, there has been greater emphasis on narrative and recognition that narrative may have been the primary rhetorical vehicle used by historians all along.<sup>3–5</sup> Interest in narrative as a research tool has grown in virtually all intellectual disciplines, possibly owing to disillusionment with science and abstraction as the only means of arriving at objective truth.<sup>6</sup> Narrative has also been embraced partly because of its resemblance to literary theory of meaning as an alternative process in the social construction of reality (Ref. 6, p 13). Like historians, psychiatrists rely substantially on their sci-

ence, but may be unable to dismiss narrative, whether their work is clinical or forensic.

Narrative is a critical part of intelligence, if intelligence refers to the capacity to solve the complex problems of life. Through narrative, human beings learn to understand what has occurred in their lives, to use what they have learned to predict when similar experiences might occur again in the future, and to comprehend and deal with them when they do.<sup>7</sup> Finding a relevant past experience that would help make sense of a new experience is at the core of intelligent behavior. In fact, much of everyday mental functioning is essentially narrative storytelling.<sup>8</sup> We dream in narrative; daydream in narrative; remember and believe in narrative; and love, hope, and despair in narrative.<sup>9</sup> If we did not have a narrative, or the prior script of a story to follow, then every life situation would be novel, and we would be overwhelmed with new information, information that is otherwise unstructured by habit, social mores, and practical knowledge, all of which are based heavily in narrative (Ref. 7, pp 1–27). Stories comprise much of the foundation of human communication, shared verbally as parables; presented as examples to illustrate important truths; and given as symbols in art, literature, and the humanities.<sup>10</sup> Stories may be literal, metaphorical, or fictional. Telling a hypothetical story to illustrate a principle makes it easier for people to understand the principle and to test, using other examples, whether it is valid. For this reason,

---

Dr. Drukteinis is Adjunct Associate Professor of Psychiatry, Geisel School of Medicine, Dartmouth Medical School, Hanover, NH, and Director, New England Psychodiagnostics, Manchester, NH. Presented as a Keynote Address at the 2012 Conference of the Royal Australian and, New Zealand College of Psychiatrists, Faculty of Forensic Psychiatry, Hong Kong, September 5, 2012. Address correspondence to: Albert M. Drukteinis, MD, JD, 1750 Elm Street, Suite 601, Manchester, NH 03104. E-mail: aldruk@aol.com.

Disclosures of financial or other potential conflicts of interest: None.

case law narrative is the main format for legal studies in America's law schools. Allowing the legal principle to emerge from the narrative either strengthens the principle or reveals where it is deficient.<sup>11,12</sup>

### Narratives in Psychiatric Practice

For several reasons, every psychiatric treatment relationship with a patient requires a historical context for the presenting symptoms. To begin with, it is important to know the sequence of symptom development and if and when similar symptoms have occurred. Such a context likewise helps to assess the course and variation of the presenting symptoms over time. A comprehensive psychiatric evaluation also looks to the wider history of the patient, including environmental, situational, and personal variables that are relevant to the symptoms. This baseline narrative is needed to formulate a proper diagnosis, because some psychiatric conditions are isolated incidents, others are recurrent, and still others are chronic over the life span. If personality disorders are to be considered, the maladaptive patterns of thinking and behavior must be demonstrated throughout adult life by an accurate historical narrative. In traditional psychoanalytical or psychodynamic therapy, the focus was on identifying forces that have influenced the patient's emotional life and that may continue to affect it in the present and the future. Toward this end, the process of *anamnesis* was used to obtain a more detailed historical narrative, which gave both the psychiatrist and patient a better understanding of his life, in particular the evolution of conflicts that were the source of distress.<sup>13,14</sup> Lately, the field of narrative psychology has re-emerged, providing the perspective that it is not their objective environment that influences people, but their constructs of the world (i.e., the kind of stories they tell themselves).<sup>10,15,16</sup> This notion has led to forms of narrative therapy that try to deconstruct a patient's problem-dominated narrative, instead considering alternatives that offer previously unrecognized meaning and hope.<sup>17</sup> This therapeutic approach has not been without its critics, who argue that it is not based on empirical research and may ignore social and cultural truths in favor of biased reality constructs.<sup>18</sup> Even if narrative is not a primary focus of some psychiatrists, such as those who may take a neurobehavioral or pharmacologic approach to treatment, they may not fully understand the life events associated

with physiologic disturbance without regard to the patient's narrative.

Regardless of which treatment methodology is used, psychiatrists need to accumulate information from which, more often than not, they can build a story, just as all historians do, woven through with explanations and causes.

One of the threshold problems in psychiatric treatment is that the history from which the psychiatrist works is obtained mainly from the patient, who has already created his own narrative, consisting of always incomplete and often inaccurate factual information, along with not infrequent erroneous interpretations of that information. Narratives are so crucial to the understanding of oneself that they are created at all costs, even that of the truth. Social psychology studies, in fact, now point to a greater role than may be appreciated for preconceived narrative in guiding what is remembered and reported to others.<sup>19–22</sup> There is a difference, therefore, between narrative truth and historical truth.<sup>23</sup>

Erroneous narratives are not necessarily deliberate falsification; rather, they are often a form of self-deception.<sup>24,25</sup> One reason to deceive oneself may be to adhere to a narrative that is consistent with the personal identity that one has constructed—for example, exaggerating one's grades so as not to appear unintelligent to one's peers. Another may be to avoid facing painful emotions, such as ignoring telltale signs of infidelity by one's spouse. Self-deception is a means of rationalization, facilitated by the reality that all narratives are necessarily a condensation of factual memories, because not all factual memories can be included in the narrative.

A two-step process occurs in the screening of factual memories to construct a narrative. In the first step, the memory representation is created as a hypothetical, from among all the possible memories at one's disposal; in the second step, it is interpreted, so that it becomes useful for one's own internal narrative or for the narrative that will be articulated. It is important to note that the need for narrative is so strong that it survives brain damage, whereby memories are lost or memory filters become defective (e.g., confabulation, the spinning of wild fables in Korsakoff's syndrome; Ref. 24, pp 1–23). The process of memory selection and interpretation is ubiquitous; moreover, it may be the foundation of a coherent story that human beings must tell about themselves, to themselves, and to others.<sup>26</sup>

## Forensic Psychiatry Perspectives on Narrative

In developing its “Ethical Guidelines for the Practice of Forensic Psychiatry,” the American Academy of Psychiatry and the Law has emphasized the difference between a treating psychiatrist and a forensic expert witness and advises that a treating psychiatrist should generally avoid accepting a forensic role.<sup>27</sup> Addressing the problems raised by this dual role, Strasburger *et al.*<sup>28</sup> indicated that in psychiatric treatment (particularly dynamic psychotherapy), there is a search for meaning, more so than for facts (that is, narrative truth versus historical truth).<sup>28</sup> Consider that the treating psychiatrist typically accepts the patient’s narrative, complete with its biases and misperceptions, withholds judgment, and strives for insight, which may not always be objectively corroborated. In the process, psychic reality may rule over objective reality. At the same time, the forensic expert is expected to adhere to the ethics of objectivity, assessing the patient’s psychic state from the “outside.” An objective/descriptive approach, with emphasis on classification and a reliable diagnosis, is said to be favored by forensic practitioners, presumably because the law is interested in such categorization. This does not mean that the patient’s inner world as represented by his narrative is of no value; and “it may well be that forensic psychiatry is best practiced by those who can immerse themselves in the evaluatee’s inner world and then exit that world with useful observations and testable hypothesis in a search for corroboration or lack of corroboration” (Ref. 28, pp 451).

Forensic psychiatry as a discipline has also established standards to help practitioners maintain this objectivity and promote scientific analysis, including specifications for how to express their findings and opinions. To that end, various formats for written reports have been suggested, their common denominator being topical categories that include introductory statements regarding how the evaluation was conducted (e.g., explanation of the examiner’s role, list of records and documents reviewed, and log of time spent with the evaluatee); historical information and data collected (e.g., developmental, medical, psychiatric, and criminal histories); background of the events at issue; and conclusions (e.g., diagnosis, discussion, and summary of findings).<sup>29–31</sup> Forensic psychiatrists, in contrast to treating psychiatrists, are

urged to seek collateral information from outside sources to supplement the evaluatee’s history (e.g., medical records, police reports, witness statements).<sup>32</sup> With regard to court testimony, the forensic expert witness is urged to remain neutral and is cautioned against using persuasion on the witness stand.<sup>33</sup> Such attempts to delineate forensic practice have not entirely resolved the questions of ethics, nor the scope and format for conducting forensic psychiatry evaluations, particularly with regard to narrative.

Early in the development of forensic psychiatry as a discipline, Stone<sup>34,35</sup> argued that forensic psychiatrists can never be completely objective, by virtue of their therapeutic skills and clinical orientation, which, he claimed, would intrude on any evaluation. This, of course, would inevitably include entering into a patient’s/evaluatee’s narrative. In response, Appelbaum<sup>36</sup> offered what has been described as a strict principlist approach as a theory of forensic ethics, according to which the primary value of forensic psychiatry is different from clinical treatment and is said to advance the interests of justice, resting mainly on truth-telling and respect for individuals. Truth-telling, however, assumes that there is accessibility to objective truth in the course of forensic work and may lose sight of the fact that social construction of reality is its own truth. Griffith,<sup>37,38</sup> for one, asserted in response to Appelbaum that any ethics framework must also feature a cultural context (for example, the narrative of historically disadvantaged cultures within society). Candilis *et al.*,<sup>39,40</sup> in turn proposed a reconciling view, contending that the principlist approach works at the level of theory, where objectivity and disengagement dominate; whereas a narrative approach is at the level of application. More specifically, they added: “Narrative offers an approach by which medical knowledge is seen as storytelling knowledge. The individual’s predicament is the telling of a story with empathy and compassion elevated using humanistic language . . . that actively permits reflection on the intricacies of morality.” (Ref. 39, p 171) Furthermore, they indicated:

This kind of forensic practice, informed by narrative ethics while respecting fundamental principles, can be an essential part of what we aspire to as a profession. . . . [A] robust professionalism for forensic psychiatry cannot ignore our physician backgrounds or our diverse personal histories [Ref. 40, p 385].

More recently, Griffith *et al.*<sup>33,41</sup> re-explored the role of narrative in written reports and oral testimony and, in the process, raised legitimate concerns about

the performative aspects of both. Among their concerns was that condensing complex and multilayered human events into a story can lead to oversimplification, the injection of personal values, and the skewing of personal information by that which is included or excluded. Referencing Hudgins,<sup>42</sup> they pointed out how using narrative arouses potential biases, among them the *lie of narrative cogency*, omitting information that may seem inconsequential; the *lie of texture*, inventing details to make stories more believable or more relevant; and the *lie of emotional evasion*, omitting emotionally charged information that could be inconsistent with the theme of the narrative; and other narrative misrepresentations.<sup>41</sup> These biases contribute to the formation of a distorted or incomplete narrative, which may be facilitated either by the forensic evaluator who composes, transcribes, and gives voice to the narrative, or by the evaluatee who fails to provide relevant history. At the same time, Griffith *et al.* noted that:

[F]orensic professionals do not stand outside of the narratives they create. They are participants in the process, bearing witness themselves, and doing their best to persuade readers that the principal story they are in the process of recounting makes good sense and reflects sound training and acquired professional experience [Ref. 41, p 42].

Subsequently, they argued that oral testimony in court may appropriately include performative narrative:

While emphasizing our thesis that oral performance is a significant element in our conceptual schema, we have linked it to a foundation strengthened by the factors of professional identity and representation. . . . Oral performance must be contemplated in the context of a vibrant respect for the ethics we judge applicable to our work [Ref. 33, p 362].

Significant concerns persist about the use of narratives in formulating opinions and supporting oral testimony, because of the potential loss of objectivity that is needed in forensic psychiatry, particularly where a scientific approach is advocated. That said, if forensic psychiatrists are providing opinions based on the science of mental disorders, on clinical questions that the law might otherwise not understand, they should also be aware that those opinions will be applied by the law to competing narratives. Thus, addressing narratives and their use may, in one way or another, be unavoidable.

## Narratives and the Law

The role of narratives in law has been debated extensively in the legal literature, particularly whether the scientific aims of the law can be undermined by them.<sup>43–45</sup> Science applies to the law just as it does to medicine, since, in its broadest meaning, it is concerned with establishing and systematizing facts, principles, and methods for consistent application. The core concern in the law is how best to reach truth, at least legal truth, in the resolution of criminal and civil disputes. At the trial level, rules of evidence serve to screen the admissibility of both factual and forensic expert evidence based on established principles for the value of such evidence (e.g., direct observation of a witness rather than hearsay). Once admitted, how the trier of fact (jury or judge) regards that evidence that reaches legal truth is relevant to the reliability of the outcome in the dispute. While the evidence may be regarded according to its independent weight, credibility, and probability compared with other evidence, research shows that juries more often than not use a “story model” (that is, a narrative) in their findings.<sup>46</sup> As a consequence, trial attorneys typically frame their case in the form of a narrative, from opening statements to introduction of evidence to closing arguments; and jurors, regardless of limiting instructions they are given, are prone to make decisions by evaluating which narrative is more compelling. In this way, jurors can “organize and reorganize large amounts of constantly changing information” to decide what it means; construct a story, or alternative stories; and, finally, decide which fits best in the deliberation (Ref. 45, p 293). Narratives influence not only how jurors respond to arguments, but also how appellate attorneys shape their cases to higher courts. This is not to say that the narrative process is superior to other methods of decision-making, such as probability analysis, but that it will typically play a part in every adjudication.

The dichotomy between narrative and science is a part of a broader distinction in how conceptual knowledge is formed. Narrative (intuitive, experiential) knowledge is distinguished from scientific (theoretical, discursive, paradigmatic) knowledge, in that it represents understanding gained from personal experiences and facts, viewed along a chronological time line.<sup>47,48</sup> Scientific knowledge, in contrast, is analytical and gained through empirically derived principles, in concert with logical reasoning and

probability assessment (Ref. 45 pp 298–301). Together, narrative and scientific knowledge are the primary means of cognitive processing. Narrative knowledge includes interpretations implicit in the life course of an individual (e.g., the effects of a violent household on his violent behavior), whereas scientific knowledge would focus on empirical facts about human behavior (e.g., neurochemical substrates of violence).<sup>49</sup> Human beings may best be understood through natural sciences, but the “self” is best understood as a story. The adoption of a scientific mindset should not stand opposed to the observation that people tell stories and that their stories may provide relevant insight into them.<sup>50</sup>

That distinction is made in trials as well. Legal scientific knowledge includes rules of evidence, jury instructions, and applications of statutory law and generalized principles emerging from case law. It may also represent a method by which the trier of fact weighs evidence from logical reasoning and probability. However, if the trier of fact uses a story model to weigh evidence, then it is based on narrative knowledge.

Narrative knowledge and scientific knowledge also differ fundamentally in the type of memories that underlie each. *Episodic memories* are the building blocks of all narratives and represent personal autobiographical experiences.<sup>51,52</sup> The process of creating a narrative involves building a memory structure for episodic memories, which becomes a template from which the same narrative is retold in the future and from which similar future experiences are interpreted and remembered. With retelling, a narrative frequently changes, by a complex process in which interpretation during each stage of recording and retrieving memories can alter the information contained in them. Furthermore, episodic memories that form narratives are vulnerable to physiological and psychological alteration and to a variety of potential distortions, which also give rise to criticisms of narrative knowledge. Not the least of these distortions is the inevitable memory selection that occurs because not everything experienced can be remembered, and not everything that can be remembered is worth remembering for the individual.<sup>22,53</sup>

*Semantic memories*, on the other hand, lay the foundation of scientific knowledge; they are not gained from personal experiences, but are taught or learned as abstract points of reference.<sup>51,52</sup> They include an understanding of both social and physical properties of the environment, empirical facts, and

predicted outcomes from derived probabilities, which, arguably, are detached from personal bias and therefore are more scientific. Semantic memories of an accepted scientific theory can be reassuring when attempting to understand a complex situation, but may fall short of explaining the full range of human events, which they often are purported to do. At the same time, scientism and abstraction are criticized as being too far removed from real life and, therefore, often appear irrelevant (Ref. 5, p 13).

Griffin (Ref. 45, pp 281, 334–5) critically evaluated the relationship between constructing subjective narratives and achieving factual accuracy in trials. He contended that coherent narratives allow juries to construct accounts consistent with their experience and common sense and to counter the false assumption that any piece of evidence can exist in isolation. At the same time, he cautioned that judicial outcomes that are not based on reliable fact finding and sound scientific and theoretical principles may undermine legitimacy and confidence in the judicial system (Ref. 45, pp 315–19). Psychiatric historiography in the context of forensic practice, if it is to be relevant in the judicial process, may need to include narrative as well as scientific knowledge, but with an understanding of the limitations of each.

## Narratives in Forensic Practice

The science of mental disorders (their symptoms, causes, and behavioral manifestations) is important in forensic analysis; unfortunately, it is often not sufficient to address the ultimate questions posed in litigation, even when principles of evidence-based medicine are applied. It may, in sum, be only a tool to help determine which is the most reliable narrative. To begin with, other than in determining competency to stand trial, various civil competencies, and involuntary commitments, plaintiffs in civil cases and defendants in criminal cases typically raise the question of their mental state and assert mental impairment. They may allege, for example, that the impairment is a result of someone else’s behavior or that it affected their own behavior. The question of mental state, with or without a formal psychiatric diagnosis, is not raised in a vacuum or as a condition whose features should be implicitly applied to the matter at hand. Instead, mental state is offered as part of the story of what happened and why. These stories, or narratives, require analysis of their internal coherence and consistency and determination of

whether they are compatible with scientific understanding of mental disorders, including their causes, known features, and natural course.

Making an accurate diagnosis of a mental disorder is challenging, because in doing so, forensic psychiatrists often must rely on subjective symptoms and few objective signs. More recently, this reality has led to a flurry of antipsychiatric rhetoric in popular and scientific publications.<sup>55-57</sup> The ever changing Diagnostic and Statistical Manual of Mental Disorders (DSM) has become an easy target for criticism, as have studies reporting a growing prevalence of many mental disorders. The criticism is not without merit, but is not completely justified either, since psychiatric research has made marked advances in understanding the neurobehavioral substrates of many disorders: notably, schizophrenia, bipolar disorders, and autism spectrum disorders. Other disorders, however, especially those forensic psychiatrists face regularly, too often include variants of normal emotions; and the symptoms that define those disorders (e.g., depressive disorder, anxiety disorder, posttraumatic stress disorder, brief psychotic reaction, and dissociative state) can be intuitively constructed or easily suggested in a review of symptoms or in psychological questionnaires.<sup>58</sup> As a result, forensic psychiatrists may find that a consistent, or inconsistent, narrative from the evaluatee, or from collateral sources, is at times more valuable than meeting DSM criteria for the disorder. Consider, for example, an evaluatee who complains of anhedonia and loss of interest in hobbies and pastimes, yet is engaged in an active social life. Such inconsistencies may be better elicited through a careful narrative inquiry into life activities, rather than a checklist of symptoms.

Narrative is also relevant for forensic psychiatrists in understanding ancillary matters in litigation, such as lack-of-memory claims, important omissions of historical information, distorted attributions of illness, conflicting behavioral accounts, and exaggerated mental impairment. Keeping in mind that all narratives are incomplete and at least partially distorted, enables forensic psychiatrists to take a less critical stance toward an evaluatee with memory inconsistencies, but a stance that ensures that no narrative is taken for granted.

### **Dissecting Narratives**

When litigants raise their mental state before the court, they will have already “written” their own nar-

rative and may firmly believe in it. Acceptance of their narrative by the court is important for them, as it may support disability status, a damage award, exculpation of criminal responsibility, and other desired outcomes. Forensic psychiatrists will, of course, be focusing on mental state, to determine whether there is a symptomatic basis for diagnosing a mental disorder and then its relevance to the legal issue. A thorough history is an essential component in this assessment, but must also address the explicit or implicit narrative of the evaluatee. To gather this information, most forensic psychiatrists initially employ an open-ended format, to allow evaluatees to tell their stories unimpeded; eventually, they will conduct a much more detailed inquiry. They should also, however, delineate a chronology of relevant events, from beginning to end. Simply put, it is very difficult to conduct a comprehensive and relevant forensic psychiatric evaluation without first establishing a time line. Still, what often emerges from the evaluatee is an unreliable time line or one drawn only in broad strokes, marked by such statements as, “I was fine before the accident, but look at me now.” When asked to provide more details of the time line, evaluatees are often resistant, feeling perhaps that their assertions are being challenged.

Moreover, in the same way that psychoanalysts traditionally confronted resistance to raising unacceptable memories and emotions in their patients’ narratives, forensic psychiatrists also face resistance from evaluatees who feel the need to frame memories that mainly support their narratives. The inquiry must therefore include follow-up questions that seek to corroborate facts that are vague and to trace mental and emotional processes as they intertwine with the time line of the story. This method of eliciting what are, in essence, the factual episodic memories that comprise the story, is necessary to expose the memories that are cloudy, contradictory, or, often, inexplicably missing.

Although all memories are reconstructed, shaped, or distorted to fit the desired narrative, it does not necessarily mean that the story is of no value; it is not automatically unreliable. That said, the more that memories have been distorted or omitted, the less confidence the forensic psychiatrist can have in the narrative. Only by conducting a careful inquiry, challenging generalizations, insisting on a complete chronology, and testing the evaluatee’s memories against collateral information can the forensic psy-

chiatrist correctly assess the relevance of a mental disorder to the legal question being raised. Every historical assessment by forensic psychiatrists must also consider whether the facts behind the story asserted are accurate and supported by other known facts. Ensuring accuracy includes addressing both physical evidence and witness accounts. Obtaining collateral information is vital to establishing consistency with the facts asserted, but is most valuable when it becomes part of the time line. This type of analysis for a forensic psychiatrist is not based on scientific principles but on a survey of historical facts that ultimately must be proven and become a historical narrative that does or does not demonstrate the relevance of a mental disorder.

It would be easy to conclude, when faced with inconsistencies in the presenting narrative, that the evaluatee misrepresented his history or conveniently forgot some of the relevant information. Notwithstanding the reasons for inconsistencies, narratives told by evaluatees and narratives constructed by forensic psychiatrists can easily result in markedly different accounts, simply due to alternative memory selection and perspective. With an understanding of how narratives are formed, a more detached and less pejorative position can be taken, one that merely identifies the inconsistencies in the evaluatee's narrative and, if substantial, how they do not support the claim.

### **Reporting Narratives**

The starting point for forensic psychiatrists in forming opinions and reporting them is whether there is a diagnosable mental disorder from which conclusions can be drawn about the mental state of the evaluatee. As discussed above, even the symptoms that constitute the disorder may need to be validated within a narrative. Of course, those symptoms may be so unusual that their description alone, with or without validation by more formal test instruments, appears to be an exaggeration, or even represents malingering. More helpful, however, may be questioning the evaluatee about these symptoms in reference to a time line, along with his activities within that time line. What emerges from such an inquiry is a narrative that may either confirm or refute the presence of a mental disorder or at least its severity. From there, the forensic psychiatrist can address its role, if any, in the legal issue.

In cases where criminal responsibility, for example, is the legal issue, a forensic psychiatrist arguably

might stop at the point of concluding that the defendant did or did not have a mental disorder at the time of the crime. However, and consistent with the Practice Guidelines of the American Academy of Psychiatry and the Law, the psychiatrist might also offer an opinion on "the relationship between the mental disease or defect, if any, and the criminal behavior . . . [and] whether the defendant's mental state at the time of the crime satisfies the jurisdictional requirements for an insanity defense" (Ref. 30, p S26). If the forensic psychiatrist is to engage in forming an opinion on this ultimate question, the scope of inquiry into factual evidence necessarily becomes wider, to include addressing potentially incriminating facts such as the defendant's history of criminal behavior or other evidence that points to motives independent of a mental disorder. Factoring in such evidence is not fundamentally scientific, but could be presented alone as informational data to support criminal responsibility. However, the forensic psychiatrist could also present an opinion as an alternative narrative of what the data might show, different from the defendant's expressed or implied narrative. Although ascertaining the credibility of all evidence is the task of the trier of fact, evaluating that evidence is also necessary for the forensic psychiatrist who is providing an opinion on the ultimate question. To the extent that the evidence is in dispute, then the psychiatrist's opinion needs to be couched as contingent on how the disputed facts are resolved. In any case, the incriminating evidence may point to an alternative narrative to explain the defendant's actions. Regardless of how those facts are reported, the jurors are likely to compare them to the competing narratives.

In both civil and criminal litigation, it is not unusual to be presented with extensive evidentiary material and numerous disputed facts, so forensic psychiatrists must take care not to conclude that one or another piece of evidence has been established, when it may not have been. During trial, that evidence will be assembled by opposing parties as competing narratives and imposed on the psychiatrist. If forensic psychiatrists attempt to distance their conclusion from these disputed narratives, they will, under direct or cross-examination, be drawn into hypotheticals. They will be asked to respond to one version or another of a narrative and whether under those other circumstances their opinions would be the same. Psychiatrists can maintain their relative neutrality by acknowledging facts that

are in dispute or those that are beyond their psychiatric role to determine. They can also opine on the weight of facts that are not in dispute and whether the story based on those established facts provides a scientifically reliable explanation of how a mental disorder manifests, its natural course, and its functional impairment. Conversely, they may opine that an alternative story is equally, if not more scientifically, reliable.

When performed comprehensively, forensic psychiatric evaluations will typically result in an accumulation of large amounts of data, conflicting reports, contradictory witness statements, and too much information about some parts of the history and not enough about other parts. It falls on the shoulders of forensic psychiatrists to coalesce what often becomes an unwieldy mass of information. Not everything an evaluatee reports can be included; otherwise, a verbatim transcript must be produced. Nor can all information reviewed from records be incorporated, or the report would be as lengthy as the records. Forensic psychiatrists thus should compare recorded information with the subject's own account and at least exclude superfluous and irrelevant data. In doing so, they may be pulled into creating a narrative of their own, with its inevitable factual memory selection. The result then is no longer purely scientific; it may, nevertheless, be difficult to avoid. The most common pitfall for the forensic psychiatrist is assuming facts that have not been established or making a credibility determination before any rules of evidence screen those facts for admission and before they have been subject to impeachment in trial, unlike jurors, who benefit from both before their determination. Assuming facts or attempting to determine factual credibility prematurely may not be unethical, but it is presumptuous, and will weaken the psychiatrist's credibility. Eliminating a narrative does not necessarily protect against this pitfall, since even isolated evidentiary facts may be given undue weight by the psychiatrist before the screening and impeachment that follow.

If forensic psychiatrists use topical categories in their reports, they will not necessarily eliminate the narrative either, since an implied narrative may still exist, for the simple reason that a narrative analysis is likely to be what the forensic psychiatrist used to reach an understanding of how the mental disorder fits, or does not fit, with his ultimate conclusions. Similarly, testimony may not be as helpful to a jury if

it simply articulates the science of mental disorders, without reference to a narrative. Every testimony addresses memories that the evaluatee chooses to include, because they can be confirmed, or chooses to omit, because they are contradictory to the narrative. Narratives and alternative narratives are presented to the jury, not only to persuade but to give jurors an opportunity to play out their understanding of all the evidence in the form of potential narratives and thereby determine whether the person raising the question of his mental state has satisfied the burden of showing that the question and its associated narrative are credible.

## Conclusions

The science of mental disorders, although important, may not be sufficient to address ultimate questions in litigation put to forensic psychiatrists. In most cases, the forensic psychiatrist confronts an evaluatee who is asserting an explicit or implicit narrative for legal relief. Included in the narrative is the claim of a mental disorder, which alone may need a narrative confirmation through questioning and collateral information about alleged symptoms in the person's daily life. In turn, the relationship of the disorder to the ultimate legal question will become part of competing narratives that the forensic psychiatrist must address, to help determine which are or are not consistent with the science of mental disorders. One of the most valuable methods in this effort is to create a detailed chronological time line that can lead to important information and more clearly demonstrate which narrative is reliable. Of course, many facts along the time line may be in dispute and are not for a psychiatrist to determine, but contingent opinions can be offered as alternatives for consideration by the trier of fact. Presenting fairly constructive narratives is more helpful than just reporting on the elements of a mental disorder or evaluating isolated facts for their consistency. Ethics should govern this process, as should an understanding of how memory selection influences any narrative presented or reported. However, narratives should not be dismissed as irrelevant because of their subjectivity, but should be used to test the science that forensic psychiatrists bring to their evaluations and to expert opinions.

## References

1. Marquez GG: *Living to Tell the Tale*. Translated by Grossman E. New York: Alfred A. Knopf, 2003, p v
2. Merriam Webster Dictionary (online). Available at <http://www.merriamwebster.com/dictionary/h>. Accessed April 6, 2013
3. Phelan J, Rabinowitz PJ: *A Companion to Narrative Theory*. Malden, MA: Wiley-Blackwell Publishing, 2005
4. Wengraf T: *Qualitative Research Interviewing: Biographic Narrative and Semi-structured Methods*. London: Sage, 2001
5. Crossley M: *Introducing Narrative Psychology: Self, Trauma, and the Construction of Meaning*. Buckingham, UK: Open University Press, 2000
6. Gewirtz P: Narrative and rhetoric in the law, in *Law's Stories: Narrative and Rhetoric in the Law*. Edited by Brooks P, Gewirtz P. New Haven CT: Yale University Press, 1996, pp 2–13
7. Schank RC: *Tell Me a Story: Narrative and Intelligence*. Evanston IL: Northwestern University Press, 1990
8. Kouser JM: The revivalism of narrative: a response to recent criticism of quantitative history. *Soc Sci Hist* 8:133–49, 1984
9. Hardy B: An approach through narrative, in *Towards a Poetics of Fiction: Essays from Novel, A Forum on Fiction, 1967–1976*. Edited by Spilka M. Bloomington, IN: Indiana University Press, 1977, pp 31–40
10. *Narrative Psychology: Internet and Resource Guide*. Available at <http://web.lemoyne.edu/~hevern/narpsych/narpsych.html>. Accessed October 18, 2014
11. Case Method. West's Encyclopedia of American Law. 2005. Available at <http://www.encyclopedia.com/doc/1G2-3437700738.html>. Accessed October 10, 2012
12. Marks TC: Understanding the process of judicial policy making through case analysis. *Stetson L Rev* 29:1155–80, 2000
13. Scott D: *Recollection and Experience*. Cambridge, UK: Cambridge University Press, 1995
14. Wolitsky DL: Contemporary Freudian psychoanalytic psychotherapy, in *Essential Psychotherapies: Theory and Practice* (ed 3). Edited by Gurman AS, Messer SB. New York: Guilford Press, 2011, pp 33–72
15. Bruner J: *Acts of Meaning*. Boston, MA: Harvard University Press, 1990
16. Wilson TD: *Strangers to Ourselves: Discovering the Adaptive Unconscious*. Cambridge, MA: Harvard University Press, 2002
17. White M: *Maps of Narrative Practice*. New York: WW Norton, 2007
18. Etchison M, Kleist DM: Review or narrative therapy: research and review. *Fam J* 8:61–7, 2000
19. Gottschall J: *The Storytelling Animal: How Stories Make Us Human*. New York: Houghton Mifflin Harcourt, 2012
20. Beach, LR: *The Psychology of Narrative Thought: How the Stories We Tell Ourselves Shape Our Lives*. Lexington, KY: Xlibris, 2010
21. Wilson TD: *Redirect: The Surprising New Science of Psychological Change*. New York: Little, Brown and Co, 2011
22. Shermer M: *The Believing Brain: From Ghosts and Gods to Politics and Conspiracies—How We Construct Beliefs and Reinforce Them as Truths*. New York: Times Books, 2011
23. Spence DP: *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis*. New York: WW Norton, 1982
24. Hirstein W: *Brain Fiction: Self-Deception and the Riddle of Confabulation*. Cambridge, MA: MIT Press, 2005
25. Hirstein W: Self-deception and confabulation. *Phil Sci Proc* 67: 418–29, 2000
26. Gilovich T: *How We Know What Isn't So*. New York: Macmillan, 1991
27. American Academy of Psychiatry and the Law: *Ethics Guidelines for the Practice of Forensic Psychiatry*. Adopted May, 2005. Available at <http://aapl.org/ethics.htm>. Accessed October 18, 2014
28. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. *Am J Psychiatry* 154:448–56, 1997
29. Hoffman BF: How to write a psychiatric report for litigation following a personal injury. *Am J Psychiatry* 143:164–9, 1986
30. Giorgi-Guarnieri D, Janofsky J, Keram E, *et al*: Practice Guideline: Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense. *J Am Acad Psychiatry Law* 32(Suppl 2):S1–40, 2002
31. Noffsinger SG, Resnick PJ: Insanity defense evaluations. *Direct Psychiatry* 19:325–38, 1999
32. Wettsetin RM: The forensic psychiatric examination and report, in *Textbook of Forensic Psychiatry* (ed 2). Edited by Simon RI, Gold LH. Arlington VA: American Psychiatric Publishing, 2010, pp 180–3
33. Griffith EEH, Baranoski M: Oral performance, identity, and representation in forensic psychiatry. *J Am Acad Psychiatry Law* 39: 352–63, 2011
34. Stone AA: The ethical boundaries of forensic psychiatry: a view from the ivory tower. *Bull Am Acad Psychiatry Law* 12:209–19, 1984
35. Stone AA: Revisiting the parable: truth without consequences. *Int'l J L & Psychiatry* 17:79–97, 1994
36. Appelbaum PS: A theory of ethics for forensic psychiatry. *J Am Acad Psychiatry Law* 25:233–47, 1997
37. Griffith EEH: Ethics in forensic psychiatry: a cultural response to Stone and Appelbaum. *J Am Acad Psychiatry Law* 26:171–84, 1998
38. Griffith EEH: Personal narrative and an African-American perspective on medical ethics. *J Am Acad Psychiatry Law* 33:371–81, 2005
39. Candilis PJ, Martinez R, Dording C: Principles and narrative in forensic psychiatry: toward a robust view of a professional role. *J Am Acad Psychiatry Law* 29:167–73, 2001
40. Martinez R, Candilis PJ: Commentary: toward a unified theory of personal and professional ethics. *J Am Acad Psychiatry Law* 33: 382–5, 2005
41. Griffith EEH, Stankovic A, Baranoski M: Conceptualizing the forensic psychiatry report as performative narrative. *J Am Acad Psychiatry Law* 38:32–42, 2010
42. Hudgins A: An autobiographer's lies. *Am Schol* 65:541–53, 1996
43. Weisberg R: Proclaiming trials as narratives: premise and pretenses, in *Law's Stories: Narrative and Rhetoric in the Law*. Edited by Brooks P, Gewirtz P. New Haven, CT: Yale University Press, 1996, pp 64–83
44. Simon D: The limited diagnosticity of criminal trials. *Vand L Rev* 64: 143:186, 2011
45. Griffin LK: Narrative, truth, and trial. *Geo L J* 101:281–335, 2013
46. Pennington N, Hastie R: A cognitive theory of juror decision making: the story model. *Cardozo L Rev* 13: 519–42, 1991
47. Worth SE: Narrative Understanding and Understanding Narrative. *Contemporary Aesthetics* 4, 2004. Available at <http://www.contempaesthetics.org/newvolume/pages/article.php?articleID=>. Accessed October 18, 2014
48. Avdi E, Georgaca E: Narrative and discursive approaches to the analysis of subjectivity in psychotherapy. *Soc Pers Psychol Compass* 3:654–70, 2009
49. Quackenbush SW: Remythologizing culture: narrativity, justification, and the politics of personalization. *J Clin Psychol* 61:67–80, 2005
50. Wilson EO: *Consilience: The Unity of Knowledge*. New York, Alfred A. Knopf, 1998
51. Tulving E: Episodic and semantic memory, in *Organization of Memory*. Edited by Tulving E, Donaldson W. New York: Academic Press, 1972, pp 381–403

## Forensic Historiography

52. Baddeley A, Eysenck MW, Anderson MC: *Memory*. London: Psychology Press, 2008
53. Engel S: *Context is Everything: The Nature of Memory*. New York: WH Freeman, 1999
54. Schacter DL: *Memory Distortion: How Minds, Brains and Societies Reconstruct the Past*. Cambridge, MA: Harvard University Press, 1995
55. Whitaker R: *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Crown Publishing Group, 2010
56. Carlot D: *Unhinged: The Trouble with Psychiatry: A Doctor's Revelations About a Profession in Crisis*. New York: Free Press, 2010
57. Frances A. Good grief. *New York Times*. August 14, 2010. Available at <http://www.nytimes.com/2010/08/15/opinion/15frances.html>? Accessed April 5, 2013
58. Zapf PA, Grisso T: Use and misuse of forensic assessment instruments, in *Coping with Psychiatric and Psychological Testimony* (ed 6). Edited by Faust D. New York: Oxford University Press, 2012, pp 488–508