Forensic Psychological Evaluations: Considerations for Criminal and Civil Attorneys

A seminar for AccessMCLE.com

Daniel Agatino, Ph.D., Esq.
Gruber, Colabella, & Liuzza
Hamburg, NJ

Gianni Pirelli, Ph.D.
Private Practice
Verona & Morristown, NJ
This CLE course is designed to provide the audience with education and information on the use of forensic psychological evaluations in various criminal, civil, and family law matters.

Information presented and discussed does not represent legal or psychological advice. Such should be sought from an attorney and/or mental health professional specifically retained to assist you.
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LEARNING OBJECTIVES

i. Learn the distinction among the roles of psychologists, psychiatrists, and therapists in criminal and civil matters

ii. Gain an understanding of Forensic Mental Health Assessments (FMHAs)
   i. What they are, when to use them, and how they are conducted

iii. Learn about the different types of forensic psychological assessment approaches

iv. Become familiar with the psychiatric disorders typically seen in criminal and civil cases

v. Gain insight into some considerations relevant to the direct and cross-examination of psychological and psychiatric experts
The process mental health professionals engage in when conducting evaluations for the courts or for attorneys who have retained them.

• Forensic psychologists are not simply clinical psychologists practicing in the legal arena…

• Forensic evaluations are not simply psychological evaluations for legal cases…

• Forensic practitioners have specialized training and conduct evaluations in a manner distinct from traditional psychological assessments.
PSYCHOLOGISTS, PSYCHIATRISTS, & THERAPISTS

Therapeutic vs. Forensic Roles
THERAPEUTIC VS. FORENSIC ROLES

1. Who is the client?
2. Relational privilege
3. Cognitive set…evaluative attitude
4. Areas of competency
5. Nature of the hypotheses
6. Scrutiny of information elicited
7. Amount of control & structure
8. Nature & degree of “adversarialness”
9. The goal of the professional
10. The impact of critical judgment by the expert

Greenberg & Shuman (1997; 2007)
## WORK and WORK PRODUCT

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EXAMPLE: PI Case

Treatment Summary

I have seen Ms. Smith weekly over the past six months for individual therapy to treat her depression, resulting from a motor vehicle accident in which she was involved. She was very depressed upon intake and she continues to struggle with depressive symptoms as well as symptoms of anxiety related to the accident. For example, she experiences nightmares at least once weekly and cold sweats each time she enters a vehicle. Dr. Miller is continuing to work with Ms. Smith in managing her medication to alleviate her symptoms. Furthermore, continued psychotherapy is recommended.
Forensic Evaluation Report Summary

The following conclusions are based on data generated from two clinical-forensic interviews with Ms. Smith totaling six hours, psychological assessment instruments, collateral interviews with her husband and treatment providers, and available legal, mental health, and medical records...

Data generated across sources indicates that Ms. Smith experienced psychological injuries as a result of the 2013 motor vehicle accident (MVA)…
Ms. Smith had a pre-existing mental health history, but the symptomatology associated with such is different than the symptoms present subsequent to the referral incident...

She has a history of experiencing depressive symptoms; however, symptoms associated with Anxiety and Posttraumatic Stress Disorder (PTSD) were not a part of her clinical presentation in the past. Furthermore, the nature of her depressive symptoms has changed…
Specifically, she has experienced intrusion-related symptoms in the form of intrusive distressing memories; she has engaged in avoidance behaviors, including avoiding distressing memories of the accident as well as external reminders...

The accident represents the proximate cause of most of the aforementioned symptoms Ms. Smith has experienced. She appears to have benefited from engaging in cognitive therapy and receiving psychiatric care, such that her symptoms have notably decreased per reports. Nevertheless, she continues to experience certain symptoms and she is likely to continue to for some time…
In addition, it is likely that Ms. Smith will encounter difficulties in the future as a result of the medical, physical, and psychological injuries she sustained as a result of the accident. Such difficulties may lead to an exacerbation of existing symptoms or the development of new symptoms.

Therefore, it is recommended that Ms. Smith continue to engage in individual psychotherapy to maintain her functionality as well as to address symptomatology that may increase or arise.
ROLES OF MH PROFESSIONALS

Comparison of Psychologists and Psychiatrists
TYPES OF FORENSIC EVALUATIONS

- Criminal
  - Criminal Competencies
  - Criminal Responsibility (e.g., Diminished Capacity, Insanity)
  - Sentencing Mitigation

- Civil and Family
  - Civil Commitment
  - Civil Competencies
  - Personal Injury
  - Workers’ Compensation and Employment Discrimination
  - Fitness for Duty
  - Firearm Evaluations
  - Immigration
  - Domestic and Family Matters
CRIMINAL FORENSIC EVALUATIONS

- Criminal Competencies

- Criminal Responsibility
  - (e.g., Diminished Capacity, Insanity)

- Sentencing Mitigation
CIVIL & FAMILY FORENSIC EVALUATIONS

- Civil Commitment
- Civil Competencies
- Personal Injury
- Workers’ Compensation and Employment Discrimination
- Fitness for Duty
- Firearm Evaluations
- Immigration

- Domestic and Family Matters
FORENSIC EVALUATION APPROACHES

Structure of the Evaluation

- Unstructured
- Semi-Structured/Structured Professional Judgment
- Structured

Perspective on Examinee

- Idiographic
- Nomethetic
Areas of Relevance:

Referral Incident(s)

Psychological Functioning

- Family
- Financial
- Trauma
- Mental Health
- Substance Use
- Behavior
- Employment
- Education
- Medical
- Leisure
- Goals/Plans
- Relationships
- Attitudes
Data Considered

- Interview(s) with Examinee
- Psychological Testing of Examinee
- Behavioral Observations of Examinee
- Interviews with Collaterals
- Review of Records
COMMON PSYCH. DISORDERS

- Mood Disorders (<1% BPD; ~7% MDD)
- Trauma-Related Disorders (~3-9% PTSD)
- Psychotic Disorders (<1%)
- Personality Disorders (~2-6%)
- Substance Use Disorders (variable)

*DSM-5*
MAJOR DEPRESSIVE DISORDER

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
MDD cont.

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.
BIPOLAR DISORDER

A. Criteria have been met for at least one manic episode (Criteria A–D under “Manic Episode” above).

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
MANIC EPISODE

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
POSTTRAUMATIC STRESS DISORDER

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence.

B. Presence of one (or more) intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred.

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred.

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred.

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred.

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Abnormalities in 1 or more of 5 domains:

- Delusions
- Hallucinations
- Disorganized thinking (speech)
- Grossly disorganized or abnormal motor behavior (including catatonia)
- Negative symptoms
An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.
"CLUSTER A"

**Paranoid personality disorder** is a pattern of distrust and suspiciousness such that others’ motives are interpreted as malevolent.  
**Schizoid personality disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.  
**Schizotypal personality disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.
“CLUSTER B”

**Antisocial personality disorder** is a pattern of disregard for, and violation of, the rights of others.

**Borderline personality disorder** is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

**Histrionic personality disorder** is a pattern of excessive emotionality and attention seeking.

**Narcissistic personality disorder** is a pattern of grandiosity, need for admiration, and lack of empathy.
“CLUSTER C”

Avoidant personality disorder is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent personality disorder is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.

Obsessive-compulsive personality disorder is a pattern of preoccupation with orderliness, perfectionism, and control.
The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.

Criterion A criteria can be considered to fit within overall groupings of impaired control, social impairment, risky use, and pharmacological criteria. Impaired control over substance use is the first criteria grouping

(Criteria 1-4). The individual may take the substance in larger amounts or over a longer period than was originally intended (Criterion 1). The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use (Criterion 2). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 3). In some instances of more severe substance use disorders, virtually all of the individual's daily activities revolve around the substance. Craving (Criterion 4) is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used.
Social impairment is the second grouping of criteria (Criteria 5-7). Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home (Criterion 5). The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (Criterion 6). Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 7). The individual may withdraw from family activities and hobbies in order to use the substance.

Risky use of the substance is the third grouping of criteria (Criteria 8-9). This may take the form of recurrent substance use in situations in which it is physically hazardous (Criterion 8). The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (Criterion 9). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite the difficulty it is causing.

Pharmacological criteria are the final grouping (Criteria 10 and 11). Tolerance (Criterion 10) is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed. Withdrawal (Criterion 11) is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance.
WORKING WITH MH PROFESSIONALS

- Direct/Cross-Examination of Experts
  - Credentials
  - Approach/model
    - How data collected, weighed, & interpreted
    - *Admissibility ≠ Utility
  - Transparency
  - Link between mh issues and psycholegal questions
  - Subjectivity, Error, & Limitations

[note: Trial Consultation is also an option…]
Thank You!

DANIEL P. AGATINO, PH.D., ESQ.  
GRUBER, COLABELLA & LIUZZA  
WWW.GRUBERLAW-NJ.COM  
(973) 827-0057

Gianni Pirelli, Ph.D.  
Licensed Psychologist  
NJ #4975   NY #019418  
WWW.GPIRELLI.COM  
Gianni.pirelli@gmail.com  
(973) 944-0810