P S Y C H I A T R Y

AND THE

C R I M I N A L C O U R T S

Prepared by the
Office of the District Attorney

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FOREWORD

Psychiatric testimony within the trial court has become much more prevalent in recent times. This is particularly true in the area of criminal law due to the judicially maturing concept of diminished mental capacity as a defense.

The purpose of this manual is to bring together those areas within the criminal law in which the lawyer will be confronted with psychiatric and psychological concepts.

The first seven chapters are devoted mainly to a discussion of the law and procedure which have developed in the area of criminal insanity, diminished capacity, and other areas involving psychiatric considerations. Since it is not feasible to discuss the law and procedure of all jurisdictions, Chapters I through VII are necessarily confined to the California law. The last five chapters are designed to aid the criminal lawyer in trial technique and approach. Also included in the second part is a discussion of psychiatric nomenclature and medico-legal aspects of organic brain damage.

Psychiatry and its related disciplines have made a significant impact on the California justice system. It is my hope that this manual will help the criminal lawyer to achieve a better understanding of how this speciality relates to the criminal law.

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CHAPTER I

HISTORICAL SUMMARY OF CRIMINAL RESPONSIBILITY

It is helpful to have a basic understanding of the historical background of criminal responsibility in order for the trial attorney to effectively cope with psychiatric concepts and testimony within the trial court.

Free will is the basic concept of our legal and social order. The law of criminal responsibility is based upon the premise that mature and rational persons have the ability to exercise control over their own conduct. Having this ability to choose between various possible lines of action, they are subject to criminal sanctions when they fail to achieve the legally accepted minimum of required conduct. However, if there is something extraordinarily wrong with an individual which destroys his ability to exercise free will, then criminal responsibility often becomes an issue of crucial importance.

In the early medieval cases, it was not uncommon for criminal sanctions to be imposed regardless of a man's state of mind. The practice developed, however, that if it was evident that the convicted man's mind was so deranged as to prevent any cognitive functions, the sovereign would issue a pardon.

During the Middle Ages, the common law recognized that if one's deranged mind prevented any use of his reason, he could not be held criminally responsible. In a textbook called the Eirenarcha, published between 1582 and 1610, William Lombard, a barrister, stated the law as follows:

> "If a mad man or a natural fool, or a lunatic in the time of his lunacy, or a child which has no knowledge of good nor evil, kills a man - it is not a felonious act."
> (Emphasis supplied)

The law of criminal responsibility at common law was applied strictly. For one to be insane and, therefore, not criminally responsible, it was necessary to show that the accused had in effect no mind and, therefore, was no more than a wild beast. In Rex v. Arnold, 16 Howard State Trials 695 at 765 (1724), the test was stated:

> "He must be a man that is totally deprived of his understanding and memory and doth not know what he is doing, no more than an infant, or a brute or a wild beast...."

The modern law of criminal responsibility relies heavily on the benchmark case of the Queen v. M'Naughton, 10 Clark and F. 200, 8 Eng. Rep. 718 (1843). As a result of that case, the House of Lords asked certain questions of judges. The answers given by the judges established the so-

called right and wrong test accepted to some extent by many jurisdictions.

The M'Naughton rules merely crystallized what had already been the law for centuries. The essence of the M'Naughton "right and wrong" test for insanity is:

1. It must be clearly proved that at the time of the commission of the charged act, the accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know it was wrong.
2. If the accused acted under an insane delusion and was not otherwise insane, his criminal accountability is the same as if the facts with respect to which the delusion exists, were real.

Prior to the enactment of the Penal Code, California approved the basic M'Naughton test for insanity in People v. Coffman (1864), 24 C. 230. In 1872, the California Legislature enacted the Penal Code which included:

1. Section 21: ".... All persons are of sound mind who are neither idiots nor lunatics, nor affected with insanity."

2. Section 26: "All persons are capable of committing crimes except...Three--Lunatics and insane persons...."

The Legislature presumably had the M'Naughton test for insanity as approved eight years earlier in the Coffman case, supra, in mind when they enacted the above sections relating to insanity.

At present, California retains a modified M'Naughton test for insanity at the time of the offense. The definition and scope of the California M'Naughton rule is set forth in People v. Wolff (1964), 61 C.2d 795; a complete discussion of which follows in Chapter II.

With the growth of psychiatric and psychological knowledge brought about by the "Freudian Revolution," there has been an increasing tendency to take greater notice of less severe deviations from the normal mind in assessing criminal responsibility.

Where the common law was concerned with whether the accused was deprived of all reason, attention is more and more directed toward whether the mind of the accused is impaired to such an extent and in such a way as to result in some particular incapacity.

Because of this trend many courts and jurisdictions have attempted to substitute other tests for insanity. Some of the leading tests not followed in California and which have broken away from M'Naughton are summarized as follows:

I. Irresistible Impulse:

In its purest form this test may be said to

negate criminal responsibility if one acts under such duress of mental disease as to be incapable of choosing between right and wrong, notwithstanding the fact that he knows the difference between the two at a cognitive level.

Many jurisdictions that utilize the irresistible impulse test do so in conjunction with other tests such as the "right and wrong" test.

II. Currens Test:

In United States v. Currens, 290 F.2d 751 (3d Circuit, 1961), the judge instructed the jury that: "If you believe that the defendant was suffering from a disease of the mind, but believe beyond a reasonable doubt that at the time he committed the criminal conduct with which he is charged he possessed substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated, you may find him guilty...." (Emphasis supplied)

III. Product Test:

In Durham v. United States, 214 F.2d 862 (1954), the court held that it is proper to instruct the

jury that a defendant is not criminally responsible if his unlawful act was the product of mental disease or mental defect.

The rule has been criticized in that it gives the jury no real or tangible guidelines.

The Durham case was decided in the District of Columbia Circuit. On June 23, 1972, the United States Court of Appeals for the District of Columbia decided United States v. Brawner. The recently decided Brawner case expressly abandons the Durham rule and adopts the American Law Institute's Model Penal Code tests for the definition of mental responsibility in criminal cases. (See ALI tests, infra).

IV. American Law Institute
Model Penal Code, Sec. 4.01:

1. A person is not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.

2. The terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

The above tests stress impairment of mental capacity. One's mental illness causes him to do a certain prohibited act because the totality of his personality is such that he has lost the capacity to control his acts.

The "right and wrong" test is criticized by many psychiatrists because it diverts the attention of the medical expert along lines of philosophical imponderables (knowledge of right and wrong) when he should be concentrating upon the understanding or lack of understanding of the defendant. Rather than permitting the psychiatrist to merely set forth his clinical findings, the "right and wrong" test requires him to go beyond his expertise and render a moral judgment.

As noted in Chapter IV, the prolific law of diminished capacity has developed in order to "compensate" for the relatively strict insanity test in California.

CHAPTER II

NOT GUILTY BY REASON OF INSANITY IN CALIFORNIA

I. California Test for Insanity:

Insanity as discussed in this chapter refers to legal insanity at the time of the commission of the offense which bears directly upon whether the accused is criminally responsible for his act. A discussion of other "types" of legal insanity are reserved for Chapters III and IV.

California approved the acceptance of the M'Naughton test in People v. Coffman, 24 C 230 (1864). Under the Coffman rule, in order to establish a defense on the ground of insanity it must be clearly proved that:

> "At the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."

Since the early approval of the "right and wrong" test, the rule has been developed, broadened, and liberalized by the courts in response to the evolving understanding of human nature and the increased sophistication

in the fields of psychiatry and psychology.

In People v. Wolff, 61 C 2d 795 (1964), Justice Schauer articulated the shortcomings of the original M'Naughton language as follows:

> "Under [the original right and wrong test] a mentally ill defendant could be found sane even though his 'knowledge' of the nature of wrongfulness of his act was merely a capacity to verbalize the 'right' or socially expected answers to questions put to him relating to that act, without such 'knowledge' having any affective meaning for him as a principle of conduct. Such a narrow, literal reading of the M'Naughton formula has been justly condemned [citations]. Rather, it is urged by many that the word 'know' as used in the formula be given 'a wider definition of know' that is relevant, i.e., realization or appreciation of the wrongfulness of seriously harming a human being."

The present formulation of the M'Naughton test was crystallized in People v. Wolff, supra.

The court stated the California test of sanity:

"First, did the defendant have sufficient mental capacity to know and understand what he was doing, and

Second, did he know and understand that it was wrong and in violation of the rights of another.

To be sane and thus responsible to the law for the act committed, the defendant must be able to know and understand the nature and quality of his act and to distinguish between right and wrong." (Emphasis supplied.)

The present standard jury instruction CALJIC (3rd Ed.) No. 4.00 derives its substance and wording from People v. Wolff.

People v. Hubert, 119 C 216 (1897) defines the test if the accused is suffering from delusions during the commission of the offense. The court stated that if the defendant has certain special delusions which completely possess him, but is lucid on all other subjects, he must be judged as though the facts with respect to which the delusions exist were real. (See also People v. Nash (1959) 52 C 2d 36 at 45). For example, if the defendant in his delusion believes he is killing in self-defense, his crime would be excused under this test.

What California has done in "liberalizing" the M'Naughton rule is to retreat from the strict or literal differentiation of right and wrong. In an article entitled Criminal Responsibility of the Mentally Ill (14 Stanford Law Review 59 at page 61), Dr. Bernard L. Diamond states that, "Just about every defendant, no matter how mentally ill, no matter how far advanced his psychosis, knows the difference between right and wrong in the literal sense of the phrase." California law requires some appreciative understanding on the part of the defendant.

II. Statutory Provisions:

A. Section 21 Penal Code:

"....All persons are of sound mind who are neither idiots nor lunatics, nor affected with insanity." (Emphasis supplied)

B. Section 26 Penal Code:

"All persons are capable of committing crimes except those belonging to the following classes:...Two: Idiots. Three: Lunatics and insane persons....".

The use of the terms "idiot" and "lunatic" is apparently legislative recognition that one with "no mind" cannot be criminally responsible. There is little or no case law on the legal meaning of the terms; however, in the Binet system of psychological measurement, the term

"idiot" refers to the lowest class (0-24) of intelligence.

Both of the above sections were passed in 1872 after the Coffman case and, therefore, the Legislature presumably had the M'Naughton test of insanity in mind in using the term "insane".

Since the M'Naughton test has been reformulated by court decisions, the term "insane" as used in the statute refers to the test for insanity as defined by the case law.

III. The Bifurcated Trial:

The Legislature in 1927 added Section 1026 to the Penal Code which provides for a specific plea and separate trial on the issue of not guilty by reason of insanity. This procedure, referred to as a bifurcated trial, procedurally separates the specific issue of the defendant's sanity as defined by the "liberalized" M'Naughton test (see CALJIC 4.00).

If the accused enters two pleas - namely, not guilty and not guilty by reason of insanity, he is first tried by court or jury on the general issue of guilt or innocence. At this first phase, testimony or evidence relating to the accused's legal sanity at the time of the commission of the offense is immaterial. At the guilt phase the defendant is conclusively presumed to be sane. However, if a particular mental state is relevant to the charge, then medical, psychiatric and other evidence relating to the accused's state

of mind is admissible on the general issue. As stated in People v. Wells, 33 C 2d 330, at page 351:

> "Evidence which tends to show legal insanity (likewise, sanity) is not admissible at the first stage of the trial because it is not pertinent to any issue then being litigated; but competent evidence, other than proof of sanity or insanity, which tends to show that a (then presumed) legally sane defendant either did or did not in fact possess the required specific intent or motive [or other mental state] is admissible." (See Chapter V on Diminished Capacity).

If the defendant is found guilty at the guilt phase then the defendant's legal sanity is tried to the same jury or a new jury at the discretion of the court. There seems no legal need nor practical necessity for impaneling a new jury to decide the defendant's sanity. The jury's verdict at the "sanity phase" must be unanimous.

If, at the second phase, the defendant is found sane, then the matter is set down for sentence and/or probation. If he is found legally insane at the time of the commission of the offense, Section 1026 provides that the defendant shall be confined to a hospital for the

criminally insane unless it appears that the defendant has recovered his sanity. If it appears to the court that the defendant has recovered his sanity he is remanded to determine that issue. (See Chapter V: Judicial Commitment of the Mentally Ill.)

The bifurcated trial, although procedurally separate, is legally one trial; therefore, the court and attorneys must voir dire on both phases before the first phase begins. Since a plea of not guilty by reason of insanity is in the nature of confession and avoidance, the prosecution is tactically favored.

The defendant may enter or withdraw a not guilty by reason of insanity plea at any time before trial at the discretion of the court. However, it is incumbent upon the court to protect the defendant's rights so as not to preclude a valid defense. In People v. Merkouris (1956) 46 C 2d 540, the defendant personally insisted that his plea of not guilty by reason of insanity (which had previously been entered by his attorney over the defendant's objection) be withdrawn. The court in Merkouris stated:

> "It is settled [law] that the attorney of record has the exclusive right to appear in court for his client and to control the court proceedings, so that neither the party [defendant] himself, nor another attorney, can be recognized by the court

> in the conduct or disposition of the case. Considering the fact that defense counsel desired to proceed with the trial on the plea of N.G.I. and the further fact that a doubt existed as to defendant's sanity, it appears that the trial court clearly abused its discretion in permitting defendant personally to withdraw his plea of not guilty by reason of insanity."

A defendant may enter only <u>one</u> plea of "not guilty by reason of insanity". Penal Code Section 1016 states that:

> "....A defendant who pleads not guilty by reason of insanity, without also pleading not guilty, thereby admits the commission of the offense charged."

There is, then, only the issue of the defendant's legal sanity to be determined by the trier of fact. If the defendant enters only the one plea the prosecutor and/or court must be certain that the defendant understands the effect of such plea and knowingly and intelligently waives his "Tahl rights." (See <u>In re Tahl</u> (1969) 1 C 3d 122).

The foregoing procedures that have been set forth for proceedings under a plea of not guilty by reason of insanity have assumed that the defendant was charged with a felony. In such a case, the guilt phase <u>and</u> the insanity

phase are tried in the same department of the Superior Court.

However, where a defendant is charged with a misdemeanor and enters a plea of not guilty and not guilty by reason of insanity, the first phase, or the guilt phase, is tried in the Inferior or Municipal Court. If he is found guilty of some charge the defendant is then certified to the Superior Court for a trial to determine the question of whether the defendant was sane or insane at the time of the offense as provided for by California Penal Code Section 1429.5. In Los Angeles County, a special department of the Superior Court, Department 95, has been set aside for such purposes. The Superior Court proceeds to determine the defendant's sanity pursuant to Sections 1026 and 1027 of the Penal Code. If the defendant is found sane he is then remanded to the Municipal Court for probation and/or sentence. If he is found insane at the time of the offense, the Superior Court proceeds pursuant to Section 1026 of the Penal Code.

IV. Burden of Proof:

On the issue of defendant's sanity, the defense has the burden of proof by preponderance of the evidence.

Evidence Code Section 522:

> "The party claiming that any person, including himself, is or was insane has the burden of proof on that issue."

Although, traditionally, the prosecution could open the case in chief at the sanity phase if they so choose, the better and more logical practice is to allow the defense to initially open his case in chief thereby adhering to the logic in People v. Flanagan (1969) 275 CA 2d 966. In the Flanagan case, the District Court of Appeals held that since the defendant has the burden of proof at the sanity phase, he should be given the right to open and close argument.

The treatment of presumptions at the sanity phase has troubled the courts. It is clear that at the first phase or guilt phase, the defendant is conclusively presumed sane. Prior to People v. Wolff (1964) 61 C 2d 795, the law presumed that the defendant was sane, and the jury was so instructed, at the sanity phase. It was treated as a rebuttable presumption that was controlling until overcome by a preponderance of the evidence. However, the prior law recognized that if there were a prior adjudication of insanity the rebuttable presumption of sanity was dispelled and a rebuttable presumption of continued insanity arose. In such a case the defendant was entitled to an instruction on the presumption of "settled insanity". (People v. Baker (1954) 42 C 2d 550.)

In People v. Wolff, supra, the court criticized the

practice of instructing the jury on presumptions at the sanity phase since the court had earlier held that the presumption had no evidentiary effect. Cf. In re Dennis (1959) 51 C 2d 666. The California Evidence Code in Section 600 specifically states that a presumption is not evidence. California Jury Instructions - Criminal (CALJIC) Third Edition has eliminated the general instruction on the rebuttable presumption of sanity at the sanity phase as well as eliminating the instruction on the presumption of insanity where there has been a prior adjudication of insanity. Existing law concerns itself merely with placing the burden of proof on the defense without involving itself with the confusing overlay of presumptions.

V. Appointment of Psychiatrists:

Penal Code Section 1027 provides that when a defendant pleads not guilty by reason of insanity the court must select and appoint two, and may select and appoint three, psychiatrists to examine the defendant and investigate his sanity.

Section 1027 states that the appointment of psychiatrists does not preclude any other expert evidence relating to sanity of the defendant. For example, the defense may wish to obtain psychological testing and/or neurological testing. If the defense requests these

additional expert services under Section 730 of the Evidence Code, the usual practice is for the court to forego the appointments unless they are requested by one or more of the psychiatrists.

Should the prosecution wish to hire outside psychiatrists to examine the defendant, the permission of defense counsel must first be sought.

In re Spencer (1965) 63 C 2d 400, pages 412-413, the court held that the presence of counsel at the psychiatric examination is not constitutionally required so long as certain safeguards are afforded the defendant; before submitting to an examination by court appointed psychiatrists, a defendant must be represented by counsel or intelligently and knowingly have waived that right; defendant's counsel must be informed as to the appointment of such psychiatrists; if, after submitting to an examination, a defendant does not specifically place his mental condition into issue at the guilt trial, then the psychiatrist should not be permitted to testify at the guilt phase; if the defendant does place his mental condition into issue at the guilt trial, then the court appointed psychiatrist should be permitted to testify at the first phase, but the court should instruct the jury that the psychiatrist's testimony as to any incriminating statements made to him should not be regarded as

proof of the truth of the facts disclosed by such statements and may be considered only for the limited purpose of showing the information upon which the psychiatrist based his opinion.

Section 1017 of the California Evidence Code states the general rule that there is no psychotherapist-patient privilege when a psychotherapist is appointed by the court.

However, Section 1017 permits defense counsel to request the court to appoint a psychotherapist (under Section 730 of the Evidence Code) to examine a defendant and to render a confidential report to the defense to aid counsel in determining the advisability of tendering defendant's mental state as an issue at trial.

The opinions and reports submitted to aid defense counsel (under 730 and 1017 of the Evidence Code) are not accessible to the prosecution until such a time as the defense chooses to place the defendant's mental state into issue.

It is advisable for the prosecution to make a demand to discover all reports and documents as early as possible as well as placing the court appointed psychiatrists under subpoena to assure their availability.

The procedures and law involved in processing an individual who is found not guilty by reason of insanity

is reserved for a separate discussion in Chapter V: Judicial Commitment of the Mentally Ill.

CHAPTER III

LAW OF DIMINISHED CAPACITY

I. HISTORY

The concept of diminished capacity as a legal defense arose out of dissatisfaction with the alleged harshness of the M'Naughton rule. A large number of psychiatrists and attorneys felt that the "right and wrong" test of the rule considered the mental state of only the most severely disturbed individuals in assessing culpability. Repeated efforts to have the courts change the test met with rejection by the California Supreme Court. The court would not undertake the adoption of a new and different standard on the reasoning that long-standing legislative acquiescence in the M'Naughton rule was tantamount to a legislative act adopting it as the law of the land. Any change, therefore, must come from the legislature itself. [People v. Sloper, 198 Cal. 238 (1926)] [People v. Nash, 52 Cal. 2d 36 (1959)].

The opponents of M'Naughton's rule decided that the best attack would be to attempt to negate the mental elements of a crime at the guilt phase of the trial. If a person is rendered incapable of forming some specific intent by mental

disease or defect, then he would not be guilty of any crime requiring that intent as an element thereof. A convenient analogy was already in existence in the form of Penal Code Section 22, enacted in 1872.[1] This section is based on the reasoning of People v. Harris, 29 Cal. 678 (1866). The Harris case asserts that if intoxication prevents a person from forming a necessary specific mental element of a crime then the crime is not in fact committed and the defendant cannot be found guilty thereof. Accordingly, the effect of Section 22 is to negate intoxication as a defense to a crime unless some particular purpose, motive or intent is a necessary element of that crime.

California is not original in applying the theory of Penal Code Section 22 to mental illness. In cases other than those involving pure intoxication, the doctrine of diminished capacity can be traced to the beginning of the 20th century. In State v. Anselmo, 148 Pacific 1071 Utah 137 (1915), the Supreme Court of Utah reduced a conviction for first degree murder

[1]Penal Code Section 22. Voluntary intoxication; no excuse for crime; consideration on questions of purpose, motive or intent

DRUNKENNESS NO EXCUSE FOR CRIME. WHEN IT MAY BE CONSIDERED. No act committed by a person while in a state of voluntary intoxication is less criminal by reason of his having been in such condition. But whenever the actual existence of any particular purpose, motive, or intent is a necessary element to constitute any particular species or degree of crime, the jury may take into consideration the fact that the accused was intoxicated at the time, in determining the purpose, motive, or intent with which he committed the act. (Enacted 1872)

to second degree on the basis that there was no evidence to support premeditation. The defense doctors testified that the defendant, because of epilepsy, had an abnormal sensitivity to alcohol and that under the facts of the case he was incapable of premeditating and deliberating upon his intent to kill. This case went beyond the doctrine as it relates to voluntary intoxication and considered the defendant's mental disease and defect which, when combined with the effects of the small amount of alcohol he had consumed, deprived him of the capacity to harbor that mental state which is a requisite of first degree murder. In this context the defense was known as "partial insanity".

In California, the principles of diminished capacity were first clearly expounded in the case of People v. Wells, 33 Cal. 2d 330 (1949). In 1959 the case of the People v. Gorshen, 51 Cal. 2d 716 restated the principles of the Wells case. In consequence of these two cases the defense has become known as the Wells-Gorshen rule.

II. EFFECT OF DOCTRINE

There are certain procedural differences between insanity and diminished capacity in California which should be borne in mind in evaluating a case where psychiatric testimony is expected.

1. In the defense of insanity the defendant is presumed sane and has the burden of proof

on the issue. He must prove insanity by a preponderance of the evidence; whereas in diminished capacity, the burden of proving the defendant guilty beyond a reasonable doubt remains with the People as to all issues. The defendant merely has the burden of raising a reasonable doubt as to whether he could entertain the necessary specific mental element.

2. Section 1026 Penal Code provides for a separate trial on the issue of sanity whereas in diminished capacity the psychiatric witnesses would testify at the guilt phase of the case.

3. If a defendant is found not guilty by reason of insanity certain prodecural steps are gone through in order to protect society from the defendant. There are no such provisions with the defense of diminished capacity. It is often stated that diminished capacity is a partial defense and that raising it will not result in a total acquittal of the defendant. This statement is true only when there is a lesser necessarily included offense that the jury can find. If there is no such lesser offense, the defendant would be acquitted with the same force and effect as if he had not committed the act in question.

4. In most cases the test to be met by the defense is not as demanding in diminished capacity as it is with the M'Naughton rule. If a defendant is insane when he commits a specific intent crime, the chances are that he will never face a trial on sanity unless he is found guilty of a lesser included offense. It is rather obvious, particularly in murder cases, that a person who is incapable of understanding the nature and quality of his act or understanding that it was wrong would ipso facto also not be able to form the specific mental elements required for the crime.

5. While evidence of insanity is not admissible at the guilt phase of a criminal trial when couched in terms of the "right and wrong" test, [People v. Nicolaus, 65 Cal. 2d 866 (1967) @ p. 881] at the sanity phase, the jury will, in most cases, have heard the psychiatric opinions as to diminished capacity by the time that stage of the proceedings is reached. It therefore can be argued that the jury has, in finding the defendant guilty, already rejected that part of the M'Naughton defense that raises the issue as to whether the defendant understood the nature and quality of his act, by their very finding that the defendant had the capacity to form the specific

intent required in the crime in question. This is particularly true in view of the lesser "burden" borne by the defendant at the guilt phase of California's bifurcated trial procedure. That this difference of burden has practical effects, at least at the appellate stage, can be seen in the discussion of the Wolff case in the Section entitled "Quantum of Evidence" (infra.). Any reasonable juror who has rejected diminished capacity would be wont to wonder why he is being called upon again to do something which he has done before, under conditions of greater difficulty. It is as if a mountain climber who has just ascended Mount Everest is called upon to prove it by climbing the steps of the Hall of Justice.

It is paradoxical that, the same jury can hear the same evidence at two different times on essentially the same issues, yet be forced to apply different standards in evaluating it. If the paradox is not one of pure logic it is certainly a contradiction in a practical sense. It is this sort of logomachy that often causes juries to wonder at the equine pedigree of the law.[2]

[2] equus asinus - The wild Ethiopian donkey, ancestor of the ass of Europe.

III. PREMEDITATION AND MALICE

The diminished capacity defense has been almost wholly developed with respect to the crime of murder. The complexity of the mental elements required in criminal homicide has provided a fertile field for both psychiatric speculation and for judicial interpretation. Murder is defined in Penal Code Section 187 as "...an unlawful killing of one human being by another with malice aforethought." Thus, unless a defendant acts with malice, an unlawful killing cannot be murder. Malice aforethought is defined by Penal Code Section 188 as being of two kinds, express and implied.

> "Such malice may be express or implied. It is express when there is manifested a deliberate intention unlawfully to take away the life of a fellow creature. It is implied, when no considerable provocation appears, or, when the circumstances attending the killing show an abandoned and malignant heart."

The phrase "abandoned and malignant heart" has been interpreted to mean "acting in wanton wilful disregard for human life". [CALJIC No. 8.11] Although malice is an element of both degrees of murder, Penal Code Section 189 sets forth an additional mental element for the crime of murder in the first degree. Unless the felony-murder rule is applicable, first degree murder must be by "destructive device or explosive, poison, lying in wait, torture, or by any other kind of wilful, deliberate, and premeditated

killing...". The Supreme Court of California has uniformly held that both the elements of premeditation and deliberation and that of malice aforethought are specific states of mind that can be negated by either voluntary intoxication under Penal Code Section 22 or by the application of the Wells-Gorshen rule with respect to mental disease or defect. [People v. Conley, 64 Cal. 2d 310 (1966)] On the other hand all forms of manslaughter are viewed, for the purpose of the diminished capacity defense, as general intent crimes so that in the case of murder a defendant cannot be completely acquitted by this defense so long as the jury follows the instructions of the court.

It has long been clear that the phrase "premeditation and deliberation" calls for substantially more sophisticated mental activity than the mere formation of the intent to kill. In the case of People v. Holt, 25 Cal. 2d 59 (1944), Justice Schauer stated that in the use of "wilful, deliberate and premeditated" as an element of first degree murder the legislature emphasized its intention to require "considerably more reflection than the mere amount of thought necessary to form the intention to kill". Two cases, one defining premeditation and deliberation [People v. Wolff, 61 Cal. 2d 795 (1964)], and the other defining malice aforethought [People v. Conley, supra.] have further refined the mental elements of murder for the purpose of the rules on diminished capacity. The Wolff case involved a fifteen year old boy

who killed his mother pursuant to a plan that he made. Wolff was a schizophrenic and all four psychiatrists testified to that effect. Furthermore, they said that although he had the capacity to formulate a plan, he did so in a "vague and detached manner." The Supreme Court stated that when a defendant is so afflicted with mental disease or defect as to be unable to "maturely and meaningfully reflect" on the consequences of his act, he cannot premeditate under the meaning of Penal Code Section 189. The choice of the word "maturely" was an unfortunate one. The difficulty with it is that in psychiatry the term has a meaning quite different than that apparently intended by the Supreme Court. Henry P. Laughlin, M. D., in his authoritative book entitled The Neuroses (Butterworth, 1967) defines maturity on page 6 as "...implying the achievement of successful personal and social adjustment." Obviously a person who has achieved that degree of stability would not kill in order to resolve his problems. In point of fact a number of psychiatrists in California have given the term maturity precisely this psychiatric connotation. Some prominent California psychiatrists have concluded that the Wolff case eliminates premeditated and deliberate murder in California. It is indisputable that this result was not intended since many first degree murder cases have been subsequently affirmed by the very court that coined the phrase [e.g. Peo. v. Sirhan, 7 Cal.3d 369 (1972)].

It is therefore felt by the writer that the Wolff case, and those cases following it which use the term, mean it in a

normative rather than an optimal sense.

Unfortunately, there has been no Supreme Court decision explaining exactly what was meant by "maturely and meaningfully reflect". The Court of Appeals has spoken on the issue, however. The case of People v. Juarez, 258 Cal. App. 2d 349 (1968) indicates that the word maturity should not be interpreted in a psychiatric sense. Justice Pierce in writing a unanimous opinion says, "nor is emotional immaturity the equivalent of immaturity of judgment. ...Our surmise is that a very large portion of the adult population of the world suffers emotional immaturity in some respects, in some degree; and that practically all who commit murder and other serious crimes of violence would have to be classified as persons, even though they be un-psychotic, are nevertheless emotionally unstable in a very marked degree. The judgments that they make when they decide to kill or assault or rape are not necessarily committed with a lack of realization of the gravity of their offense." The Court goes on further to state that the defendant in the case in question was unquestionably immature emotionally and markedly so. "The trial court nevertheless reasonably held that the defendant killed possessing and exercising a maturity of judgment and realization of the gravity of his act negating an application of the doctrine of diminished capacity." (@ p. 360)

Prior to the Conley case, Section 192 of the Penal Code was

supposed to contain exclusively the permissible methods of reducing a crime which would otherwise be murder to manslaughter. Aside from the special case of homicide resulting from the operation of a motor vehicle, manslaughter was said to be of two kinds, voluntary and involuntary. Voluntary manslaughter occurs upon a sudden quarrel or heat of passion. The law, out of a realization of human infirmity, is said to excuse the intent to kill in these circumstances. Involuntary manslaughter arises out of either the commission of a misdemeanor or in the commission of a lawful act which might produce death with gross negligence [People v. Penny, 44 Cal. 2d 861 (1955)]. Mental disease or defect could not reduce an intentional killing to manslaughter prior to the Wells case since the heat of passion required by Section 192 had to be judged by an objective rather than a subjective test. Unless the circumstances facing the defendant would drive a reasonable man into a "heat of passion", and cause him to act rashly, it had no legal effect that the defendant was himself so driven. A person suffering from a mental disease or defect is not reasonable by definition, and if his infirmity drove him to kill under circumstances that a reasonable man would not be put in a heat of passion, his crime was murder.

The case of the People v. Conley modified this rule of law by interjecting a new element in defining malice for the purpose of deciding issues of diminished capacity. On

page 322 of the opinion it is stated that "an awareness of the obligation to act within the general body of laws regulating society, however, is included in the statutory definition of implied malice...and in the definition of express malice as the deliberate intention unlawfully to take life."

The court further states "if a defendant is unable to COMPREHEND his duty to govern his actions in accord with the duty imposed by law he does not act with malice aforethought." The latter quotation bears a striking resemblance to the second part of the definition of insanity in the Model Penal Code published by the American Law Institute. In that code a person is insane if he lacks the substantial capacity to CONFORM his conduct to the requirements of law.

The distinction between the two tests is easily seen if the rules are closely examined. The rule of the Conley case in setting forth this requirement of malice is a cognitive test, that is, it relates to the defendant's capacity to understand a duty. It has no reference to his capacity to control his conduct. The ALI rule, however, seems to be an expanded version of the irresistible impulse test. Therefore, the Model Penal Code sets forth a conative test, that is one which relates to a defendant's capacity to will his actions. That a conative test is not meant by Conley is expressly set out in the case of People v. Morse, 70 Cal. 2d 711 at

pp. 735 and 736. The court says..."defendant's personality disorder and the effects of his environment rendered him disinclined to or incapable of conforming his conduct accordingly. Such a state of mind cannot amount to absence of malice aforethought as we have defined that term in Conley. (Emphasis ours) Though defendant's conduct may in fact have been in some sense psychologically predictable, under the present law of the State of California this fact does not itself affect his criminal liability."

It is not clear, however, whether a mental disease that interferes with the defendant's capacity to control his conduct would serve to negate premeditation and deliberation. It is arguable that a person who cannot control his conduct also cannot meaningfully and maturely reflect on the consequences of his act. However, a kleptomaniac who is driven by a severe neurotic urge to steal, for whatever gratification it may bring him, may be able to reflect fully on the consequences without being able to control himself. A similar situation might occur with respect to a person who commits a murder, although a specific disease whose prime outward manifestation is a compulsion to kill is unknown. It would all depend, of course, on whether a person can be mature with regard to reflecting on his actions when he has lost the capacity to control them, and whether such reflection would in any sense be meaningful. If the defendant's lack of

volitional control is due to a mental disease characterized by delusions it would be extremely unlikely that it could reasonably be said that he could meaningfully reflect [for possible inferences to the contrary, see People v. Cantrell, 8 Cal.3d 672 at pp. 685, 686 (1973)].

IV. FELONY-MURDER

In cases of felony-murder, the defendant need neither have the capacity to premeditate and deliberate nor to form that state of mind known as malice aforethought. It suffices that the defendant have the capacity to harbor the specific intent to commit the felony which forms the basis for the application of the felony-murder rule [People v. Ford, 65 Cal.2d 41 (1966) at p. 54] [People v. Ireland, 70 Cal.2d 522 (1969) at p. 538] A large number of cases decided by the California Supreme Court assume that the first degree felony-murder rule set out in Section 189 of the Penal Code[3] is an exception to the general rule that premeditation and deliberation is required for a finding of first degree murder. According to this theory, the specific intent to commit the felony posits the element of malice aforethought and operates, by statutory classification, so as to raise the murder to first degree. [People v. Ireland (Supra. @ p. 538)]

[3] §189. Murder; degrees
All murder which is perpetrated by means of a bomb, poison, lying in wait, torture, or by any other kind of wilful, deliberate, and premeditated killing, or which is committed in the perpetration of, or attempt to perpetrate, arson, rape, robbery, burglary, mayhem, or any act punishable under Section 288, is murder of the first degree; all other kinds of murders are of the second degree.

The requirement that the defendant have the specific intent to commit the underlying felony applies even to those enumerated felonies which are usually considered to be general intent crimes. Depending on one's definition of the distinction between general and specific intent crimes, arson, mayhem and rape could be construed as general intent crimes in California. Their exact characterization depends on what view of the definition of specific intent crimes one adopts. Under Perkins' definition, a crime is said to require a specific intent when some mental state is necessary other than the intent to commit the act prohibited. [Criminal Law by R. M. Perkins, Foundation Press, (1969) @ p. 762] Under this test all the aforementioned crimes would be general intent crimes. Despite this analysis, whether they would be treated as such with respect to the diminished capacity defense is not clear in this state.

In the crime of mayhem it appears that even the intent to commit the prohibited acts is not necessary. [People v. Sears, 62 Cal. 2d 737 (1965) @ p. 744.] This leads to the paradoxical situation that a state of mind which suffices for a conviction of the underlying felony when the victim survives, does not bring the felony-murder rule into operation if the victim succumbs to his injuries. The same could be said with respect to rape. Arson, however, is in quite a different category. Even though analysis would classify it as a general intent crime with respect to felony-murder, the distinction is of little

consequence. The term wilfully and maliciously appearing in Section 447a has been interpreted to mean merely that the fire must be set intentionally. [People v. Nichols, 3 Cal.3d 150 @ p. 164 (1970)] Thus a wilful disregard for consequences would suffice for neither a conviction of arson nor of first degree murder under the felony-murder rule. Repeatedly, the cases have stated that a wanton disregard for consequences is not tantamount to a specific intent. [People v. Nichols, supra pp. 164, 165] Of course, wanton disregard for human life is a state of mind that amounts to implied malice and the defendant could always be convicted of second degree murder unless premeditation is independently shown. With respect to the applicability of the diminished capacity defense to an arson not resulting in death, the Court of Appeal has spoken. In People v. Nance, 25 Cal.App.3d 925 (1972) the first district held that for purposes of diminished capacity, arson should be treated as a crime requiring only a general mens rea.

The distinction between general intent and specific intent crimes often depends on the purpose for which the court wishes to make the differentiation. [People v. Hood, 1 Cal. 3d 444 (1966) at p. 458; People v. Rocha, 3 Cal.3d 893 at p. 897 (1971)]. Nevertheless with regard to the felony-murder rule it is clear that the defendant, to be convicted under that rule, must harbor the intent to commit the particular crime which is enumerated in Section 189 of the Penal Code or some other felony which is inherently dangerous to human life. In the case of People v. Sears.

(supra) the Supreme Court stated that a killing resulting from an indiscriminate attack which incidently causes those species of harm enumerated in the statute on mayhem (Penal Code Section 203) would not be first degree murder by the operation of the felony-murder rule. There must be an actual intent to commit mayhem even though mayhem is a general intent crime. The intent to commit the underlying felony, however, is not as sophisticated a mental state as that required for premeditation and deliberation, or even malice aforethought. There need be no mature and meaningful reflection, nor capacity to comprehend the duty to conform one's conduct to legal requisites.

The previously stated rule that in a felony-murder case there need not be a capacity to form malice aforethought must be qualified by the holdings in recent Supreme Court cases limiting the felony-murder rule's usually automatic operation. Under the case People v. Washington, 62 Cal. 2d 777 (1965) a killing of a co-conspirator by the victim of a robbery is not first degree murder attributable to a surviving robber. The effect of this rule was clarified, however, in the cases of People v. Gilbert, 63 Cal. 2d 690 (1965) and Taylor v. Superior Court, 3 Cal. 3d 578 (1970).

These two cases set forth the proposition, when read together, that if one robber causes death, directly or indirectly, by an act that goes beyond those normally done

in committing a robbery and that act amounts to malice aforethought, then the felony-murder doctrine of Section 189 would operate to raise the murder to first degree. In the Gilbert case the act was initiating a gun battle and in the Taylor case the robbers acted so as to give innocent persons a reasonable apprehension that their lives were threatened. The effect of these two cases is to require some act on the part of the conspirators which in itself amounts to malice aforethought. Thus it is as if there were two felony-murder rules in the State of California, each rule relating to a separate mental element of murder. One would be the common law felony-murder rule which implies malice aforethought from the commission of any inherently dangerous felony. [People v. Phillips, 64 Cal. 2d 574 (1966).] The other would be the first degree felony-murder rule contained in Penal Code Section 189 which applies to the enumerated felonies, and whose operation supplies both malice and premeditation.

The first degree felony-murder rule would only be applicable so as to supply the element of malice aforethought in those cases where a non-accomplice is killed. If an accomplice is killed there is no murder under the doctrines of Gilbert and Taylor unless there is some act by an accomplice which amounts to malice aforethought. An act amounting to malice aforethought can be either the initiation of a gun battle by a felon or some other type of

act which is inherently dangerous to human life which goes beyond those acts that are necessarily committed in the course of the particular felony enumerated. It can readily be seen, then, that even in those cases that potentially apply the felony-murder rule it may be necessary for the defendant to have the capacity to appreciate his duty to conform his conduct to the requirements of law.

V. MANSLAUGHTER

The case of People v. Conley (supra.) stands additionally for the proposition that a person who kills intentionally can be found guilty of voluntary manslaughter even if the killing did not arise out of a sudden quarrel or heat of passion as set forth in Penal Code Section 192 subdivision 1. In strictly applying Section 22 of the Penal Code the court stated that if the defendant by voluntary intoxication renders himself incapable of appreciating his duty to form his conduct to the requisites of law he cannot be found guilty of a crime of a higher degree than voluntary manslaughter. It remained for the Mosher case, 1 Cal. 3d 379 (1969) to clarify how this result was achieved. After numerous references to a concept previously designated as non-statutory voluntary manslaughter the court stated that the statutory grounds for reducing an intentional killing to voluntary manslaughter were not exclusive. Anything that effectively interferes with the defendant's capacity to form malice aforethought as defined in the Conley case would

result in such a reduction. This is necessary to give effect to the statutory definition of murder which sets forth malice aforethought as an element thereof. It is also presently undisputed under California law that a person who is rendered unconscious by voluntary intoxication would be guilty of involuntary manslaughter under the Conley case. Although Penal Code Section 26, subdivision 5[4] totally exempts an unconscious person from any criminal liability, this section is governed by Section 22 (supra.), with the result that if unconsciousness results from voluntary intoxication the defendant is not completely acquitted. If voluntary intoxication is the cause of the unconsciousness the defendant can therefore be found guilty of some lesser crime requiring only a general intent.

VI. QUANTUM OF EVIDENCE

After the defense of diminished capacity is raised by competent and substantial evidence, it is particularly important that the prosecutor present, on rebuttal, some psychiatric evidence on the issue of whether or not the defendant could meaningfully and maturely reflect and whether he could appreciate his duty to conform his conduct to the requirements of law. In the second of the Ford cases

[4] §26. [Who are capable of commiting crimes.] All persons are capable of committing crimes except those belonging to the following classes:

.....Five. Persons who committed the act charged without being conscious thereof.

[65 Cal. 2d 41 (1966)] a conviction of first degree murder was reduced to second degree murder because of the uncontradicted testimony of three psychiatrists who testified that the defendant could not premeditate and deliberate. A similar result was had in People v. Bassett, 69 Cal. 2d 122 (1968) where four psychiatrists testified that the defendant could not premeditate and two testified that he could do so. The two who appeared for the People addressed themselves expressly to the question as to whether or not he could maturely and meaningfully reflect and replied in the affirmative. The People's psychiatrists had not actually examined the defendant since he refused to speak to them after being advised of his constitutional rights. The court in modifying the verdict to second degree stated that since observation of the patient so as to see the nuances of his behavior is a crucial part of psychiatric examination, their opinions based on viewing the naked record would not be substantial evidence to rebut the four psychiatrists who testified to lack of capacity. The reasoning of these two cases is similar to that in the Wolff case [61 Cal. 2d 795 (1964)].

The Wolff case points out what practical effect the differences in the standards between the defense of diminished capacity and that of insanity can produce. Despite the fact that all four psychiatrists testified that the defendant was insane as well as incapable of premeditation, the result was affirmed on appeal as to insanity and the crime was

reduced to second degree murder on the issue of diminished capacity. This seemingly contradictory result came about because of the fact that the defendant has the burden of proof to a higher degree of persuasion in the sanity phase. In other words it takes less evidence to raise a reasonable doubt as to one's mental capacity than it does to prove by a preponderance of the evidence that one is insane.

Two extremely difficult cases to resolve are People v. Goedecke, 65 Cal. 2d 850 (1967) and People v. Nicolaus, 65 Cal. 2d 866 (1967). In both these cases there was testimony for the People that the defendants could premeditate and deliberate. In each case the Supreme Court held that there was not substantial evidence to the effect that the defendants could premeditate and came very close to interfering with the trier of fact. In the Nicolaus case the Supreme Court said that neither psychiatrist testifying on behalf of the People expressed an opinion as to the extent of the defendant's ability to meaningfully and maturely reflect upon the gravity of his contemplated act. The court stated that indisputedly, based on the record, the defendant was not a fully normal or mature, mentally well person. This result was reached despite the fact that Doctor Rappaport testified for the People that the defendant was not mentally ill and that Doctor Peschau stated that he had the "ability to meaningfully reflect on everything he did".

These cases point out the necessity of having the psychiatric witnesses for the People utter certain "magical phrases" to avoid their opinions being discounted on appeal. Apparently, neither People's psychiatrist testified as to the "maturity" of the defendant. In the Goedecke case the defendant killed his father, his mother, a brother and a sister. The jury found him guilty of the first degree murder of his father and the second degree murder of the other persons killed. He was found to be sane at the time he killed his father and insane at the time he killed the rest of the family. The father was the first one killed in point of time. Apparently, the jury adopted the testimony of Doctor Alfred Larson who stated that any dissociative reaction suffered by the defendant was a result of killing the father and not a cause thereof. Despite this testimony the Supreme Court reduced the degree of the crime because the extent of the defendant's understanding, his reflection on the crime and its consequences, and his realization of its evil was materially vague and deta ched. The Court seemed to be particularly impressed by the defendant's being plummeted into insanity during the course of the killings and stated that this fact indicated he was never very far from such a state to begin with. Of course, the mere utterance of such phrases would be insufficient if not soundly founded in fact and in reason. The California Supreme Court has shown no hesitancy in evaluating the reasonableness of a psychiatrist's conclusions and in judging the psychiatric testimony as a whole.

When a psychiatrist states that a defendant was capable of mature and meaningful reflection at the time of his act, the prosecutor should not be satisfied with the mere utterance of this naked conclusion. The premises relied on by the psychiatrist together with his reasoning in obtaining this result should be thoroughly exposed.

Thus, the foregoing cases should not be taken as asserting the proposition that psychiatric testimony on the part of the People is a sine qua non of a first degree murder conviction when the defense is one of diminished capacity. In the case of People v. Coogler, 71 Cal. 2d 153 (1969) there was one psychiatrist who testified that the defendant was suffering from diminished capacity. His testimony was supported by the findings of a neurologist and a clinical psychologist. However, these latter two witnesses did not express an opinion as to the ultimate issue. In this case, however, the prosecutor was able to show that the psychiatrist did not speak to any of the witnesses in the case, did not read the transcript of the preliminary hearing and did not read the police reports. He admitted that he relied entirely upon the statements of the defendant and his wife. Furthermore, the testimony of the witnesses to the crime indicated that the defendant acted rationally at all times. The psychiatrist acknowledged that the defendant could have killed to avoid detection. The jury

returned a verdict of first degree murder and recommended the death penalty. The Supreme Court affirmed. The apparent discrepancy between this case and those cases where there was psychiatric testimony on the part of the People's witnesses can be explained by the Supreme Court's statement that psychiatric testimony must have an adequate basis in fact. This results in the court applying the standard of the Bassett case, relating to the substantiality of the evidence, to the defense as well as to the prosecution.

VII. REBUTTAL

A particularly perplexing case in the area of diminished capacity is People v. Mosher, (supra.) In that case, the District Attorney hired a psychiatrist to examine the defendant shortly after the commission of the crime. On page 399 of the Opinion, the Supreme Court criticized the People for not calling that physician as part of their case in chief. The court stated that the People had notice of the defendant's diminished capacity defense and therefore the doctor's testimony should have been presented as part of the People's case. These statements are dicta since there was no objection made at the trial to the order of proof which was in fact adopted. Supreme Court dicta, of course, is enormously persuasive to the lower courts. In evaluating a decision as to whether to put prosecution psychiatrists on the stand in the People's case in chief, the Mosher case should be distinguished from the ordinary case. In the Mosher case the psychiatrist was an agent of

the District Attorney and was practically a percipient witness to the defendant's mental state at the time of the crime. The short period of time between the crime and his interview would not usually allow of an appreciable change in mental state. The danger in following this dicta literally is that in this writer's opinion the defendant should retain the option as to whether or not to present a defense based on diminished capacity until the People have rested their case. This is so he can evaluate the evidence which has been presented. It is well known that the defense of diminished capacity is looked upon by most juries as one of confession and avoidance. When there is some doubt of the defendant's guilt, it may be very prejudicial to his case to put on a psychiatrist who may have gotten incriminatory statements from the defendant regarding crimes other than the one in question. It is felt that a limiting instruction by the court under these circumstances would not cure the defect. Such premature introduction of psychiatric testimony would seem to deprive the defendant of the option to change his mind as to whether or not to call such witnesses to the stand and reveal his entire life history which may or may not be beneficial to him.

VIII. INSTRUCTIONS

In any presentation on this subject, a word must be said about instructions to the jury. The California Supreme Court

has repeatedly reversed cases because the jury was not told precisely how diminished capacity could operate to reduce a crime to voluntary or involuntary manslaughter. It is insufficient merely to instruct that malice aforethought is an element of murder and that diminished capacity can refute the presence of any specific mental state. They must also be told that if the defendant could not harbor malice due to mental disease or intoxication, he may still be convicted of voluntary or involuntary manslaughter depending on whether he was unconscious or merely unable to appreciate his duty to conform his conduct to the requirements of law. [People v. Graham, 71 Cal. 2d 303 (1969)]

Whether a voluntarily intoxicated defendant need be unconscious to be entitled to involuntary manslaughter instructions has never been clearly set forth in the cases. Despite possible contra-indications in People v. Tidwell, 3 Cal. 2d 62; 82 (1970), language in People v. Mosher, 1 Cal. 3d 379 (1969), when read together with the Conley case, allows of a theory of involuntary manslaughter without actual unconsciousness. The Mosher case states, "...If, due to diminished capacity the defendant had neither malice nor the intent to kill, the offense would be no greater than involuntary manslaughter" (p. 391). Thus if a defendant is conscious but cannot form the intent to kill or harbor implied

malice due to voluntary intoxication, he would be guilty of involuntary manslaughter. This concept would have particular applicability in cases of the voluntary taking of psychedelic drugs, if this resulted in delusions or hallucinations related to the defendant's act.

In the area of unconsciousness, not only is such a state not a complete defense, when it is due to voluntary intoxication, but paradoxically it is error to instruct a jury that it is. Although this instruction would seem to be of benefit to the defendant, in that it allows him a defense to which he is not entitled, such effect is illusory. Juries do not wish to acquit a person who kills while intoxicated. If they are instructed that the effect of this defense is to totally exonerate a person, they would be prone to ignore it. This concept was given complete judicial effect in the Graham case (supra.) on pages 316 and 317.

IX. OTHER CRIMES

It is often stated that the defense of diminished capacity applies only to specific intent crimes. In actual fact the doctrine is much broader than that and encompasses those crimes in which any specific MENTAL STATE is an element, whether it can be characterized as an intent or not. Thus, if a crime must be committed with knowledge, malice aforethought, premeditation or with any other state

of mind than the mere intent to commit the prohibited act, the defense would be applicable.

Diminished capacity can be raised to negate the intent to defraud in forgery, the intent to permanently deprive in theft, or malice in criminal libel. Ingenious defense counsel have sometimes urged that a defendant must be capable of understanding a duty to conform his conduct to the requirements of the laws regulating society or he cannot form the specific intent necessary for a certain crime. It is reasoned that if such a capacity is necessary to the intent to kill in express malice, it should also apply to any specific intent.

This theory can easily be refuted by considering the effect of the felony-murder rule on express malice. As previously stated, the felony murder rule operates so as to make malice easier to find by the trier of fact [People v. Ireland, Supra.]. If as sophisticated a state of mind as the Conley case requires for malice is a necessary part of any specific intent, then in an intentional killing the felony-murder rule would not so operate. It would be just as difficult to prove the intent to commit the underlying felony in a felony-murder case as it would be to prove malice itself. This is clearly not the result intended.

X. INTENTIONAL REDUCTION OF CAPACITY

Occasionally, when the defense relies on intoxication by alcohol or drugs to prove diminished capacity, the evidence reveals that the defendant drank or took drugs during his deliberation on the crime. Thus, at the time of commission he may be far more intoxicated than he was when he formed the necessary specific intent. His subsequent intoxication, even if it amounts to unconsciousness is no legal defense to the crime if he took the alcohol or drugs to gain courage for his endeavor. This is particularly true if while still able to form the specific intent he actually embarks upon the illegal venture and becomes unconscious during its commission [People v. Norwood 39 Cal. App. 2d 503 (1940)]

CHAPTER IV

PRESENT SANITY

In Chapter II the sanity or insanity which bears directly upon criminal responsibility was discussed: legal sanity at the time of the commission of the offense under the liberalized M'Naughton test.

California recognizes another meaning or "type" of legal sanity, namely, legal sanity or insanity of an accused at the time of trial, allocution, or punishment. It is based upon the fundamental common law philosophy that one who is presently insane cannot be convicted or punished for a crime. To convict or punish one who is not mentally present is analogous to the trial of an accused in absentia, which violates the basic principles of Anglo-Saxon jurisprudence. As stated by the court in Saunders v. Allen (1939) 100 F. 2d 717:

> "The trial and conviction of a person mentally and physically incapable of making a defense violates certain immutable principles of justice which inhere in the very idea of free government."

The conviction of an accused while he is legally incompetent violates the due process clause of the Fourteenth Amendment. (Pate v. Robinson (1966) 383 U.S. 375.) To try, pass

judgment, or punish an individual while presently insane is jurisdictional error in the sense that the trial court has no power to do so. (People v. Laudermilk (1967) 67 C 2d 272 at 282.)

Present sanity, then, has no direct bearing on the defendant's criminal responsibility for the act charged. Rather than being concerned with the defendant's mental state at the time he committed a prior act, it is concerned with whether the defendant is sufficiently "sane" or "mentally present" to understand the nature of the proceedings, his status in reference to the proceedings, and the ability to aid in his defense.

I. Statutory and Case Law in California

A. Penal Code Section 1367 states:

> "A person cannot be tried, adjudged to punishment, or punished for a public offense, while he is insane."

In People v. Merkouris (1963) 52 C 2d 672, the test for "present sanity" under 1367 of the Penal Code is stated:

> "Whether the defendant understands the nature and purpose of the proceedings and whether he has the ability to assist his attorney in his defense."

The present standard criminal jury instruction (CALJIC) No. 4.10 sets forth the test for present sanity as follows:

> "If a person charged with a crime is capable of understanding the nature and

purpose of the proceedings against him; if he comprehends his own status and condition in reference to such proceedings, and is able to assist his attorney..., he is to be deemed sane for [this] purpose..., although on some subjects his mind may be deranged or unsound."

There is nothing necessarily inconsistent from a psychiatric or legal point of view with a finding that the defendant is presently sane under 1367 et seq. of the Penal Code, but legally insane at the time he committed the act charged (and vice-versa). The tests or criteria for the two "types" of sanity are different and distinct.

It should be noted that one is presently sane if he has the ability to aid in his defense. The fact that a defendant refuses to cooperate with defense counsel for some reason, such as dislike or obstinance is immaterial so long as he possesses the ability.

B. Penal Code Section 1368 states:

"If at any time during the pendency of the action and prior to judgment a doubt arises as to the sanity of the defendant, the court must order the question as to his sanity to be determined by a trial by the court without a jury or with a jury if

a jury is demanded. From the time of such order, all proceedings in the criminal prosecution shall be suspended...".

The "doubt" referred to in Section 1368 is doubt in the mind of the trial judge rather than in the mind of counsel for defendant or any third person. (People v. Merkouris (1963) 52 C 2d 672 at 678.) The judge may base his doubt upon the conduct of the defendant or upon information provided to him by counsel or a third person. However, if the defense presents "substantial evidence" of present insanity, he is entitled to a hearing as a matter of right under the due process requirements. (Pate v. Robinson, supra.)

In People v. Pennington (1967) 66 C 2d 508, the court states:

> "An accused has a constitutional right to a hearing on present sanity if he comes forward with substantial evidence that he is incapable, because of mental illness, of understanding the nature of the proceedings against him or of assisting in his defense. Once such substantial evidence appears, a doubt as to the sanity of the accused exists, no matter how persuasive other evidence - i.e., prosecution witnesses or the court's own observations - may be to the contrary."

When the evidence casting doubt on an accused's present sanity is less than substantial, the rule in People v. Merkouris, supra, controls, namely, that the matter of declaring a doubt is in the sole discretion of the trial judge.

Courts have declared "substantial evidence" to be something more than the verbal opinion of defense counsel. In People v. Laudermilk, 67 C 2d 272 at 285, the court states:

> "...under the substantial evidence test of Pate and Pennington more is required to raise a doubt [as a matter of law] than mere bizarre actions or bizarre statements or statements of defense counsel that defendant is incapable of cooperating in his defense or psychiatric testimony that defendant is immature, dangerous, psychotic, or homicidal or such diagnosis with little reference to defendant's ability to assist in his own defense."

If counsel for defendant represents to the court that he believes that his client is presently insane, under 1367 et seq., the judge should order a psychiatric examination of the defendant under Section 730 and 1017 of the Evidence Code (see Chapter II, page 20.) The judge should not, however, declare a doubt at this point. If the "1017 report" comes back with a psychiatric opinion that the defendant is presently insane, the

judge then must declare a doubt, suspend criminal proceedings, advise the defendant of the pending sanity hearing under Section 1369 of the Penal Code, and appoint two psychiatrists under 730 of the Evidence Code to examine the defendant and file written reports.

Since in many cases there may already have been one initial psychiatric examination under 1017, the defense and prosecution may decide to stipulate to that report and opinion, necessitating the appointment of only one additional alienist instead of two.

The order and procedure to be followed at the "present sanity" or "1368" hearing is set forth by statute in Section 1369 of the Penal Code as follows:

> "The trial of the question of insanity must proceed in the following order:
>
> 1. The counsel for the defendant must open the case and offer evidence in support of the allegation of insanity;
>
> 2. The counsel for the people may then open their case and offer evidence in support thereof;
>
> 3. The parties may then respectively offer rebutting testimony only, unless the court, for good reason in furtherance of justice, permit them to offer evidence upon their original cause;

4. When the evidence is concluded, unless the case is submitted to the jury on either or both sides without argument, the counsel for the people must commence, and the defendant or his counsel may conclude the argument to the jury;

5. If the indictment be for an offense punishable with death, two counsel on each side may argue the cause to the jury, in which case they must do so alternately. In other cases the argument may be restricted to one counsel on each side;

6. The court must then charge the jury, stating to them all matters of law necessary for their information in giving their verdict."

[See CALJIC No. 4.10.]

The defense is only entitled to a jury trial under 1368 and 1369 if one is demanded. The court in People v. Hill (1967) 67 C 2d 105 states the law that applies:

"...a 1368 hearing is not within the scope of Article I, Section 7, of the California Constitution, precluding a waiver "in criminal cases" unless the defendant and his attorney concur. A 1368 hearing is a special proceeding. The only right to a jury trial in a special proceeding collateral to the criminal

trial is that provided by statute. Section 1368 imposes no duty on the judge to advise the defendant of a jury trial."

If a jury trial is demanded, a 9 to 3 verdict will resolve the issue. Since the special proceeding under 1368 and 1369 is in the nature of a civil proceeding the defense is only put to proof by a preponderance of the evidence.

People v. Hill, supra, further states that the accused be afforded "all of the elements of due process" at a 1368 hearing. This requirement is met by providing an indigent defendant with counsel, two psychiatric examinations, the processes of the court, and the opportunity to present evidence. Should the prosecutor and defense counsel wish to stipulate to the psychiatric reports and opinions, it is suggested that a personal waiver of confrontation be elicited from the defendant himself. (People v. Townsend (1972) 20 CA 3d 919.) However, a "waiver" from a defendant who is presently insane is susceptible to attack on appeal; therefore, it is better practice to elicit in-court testimony in such cases.

If the court declares a doubt during a jury trial, the judge, at his discretion, may discharge the jury, or retain it until the defendant's present sanity has been resolved. In either case, the criminal proceedings remain suspended until the issue of present sanity is resolved.

The Superior Court (Department 95 in Los Angeles County) handles all 1368-1369 hearings from Justice and Municipal Courts.

II. Commitment and Return

The procedure for handling an individual who is found to be presently insane is set forth in Penal Code Sections 1370, 1371, and 1372.

If the accused is found presently sane, the trial must proceed or judgment pronounced. If he is found presently insane, he is committed to a state hospital for the criminally insane (Atascadero). The criminal proceedings remain suspended until such a time as he becomes able to understand the nature of the proceedings against him and assist in his defense. If and when the state hospital determines that the patient is sufficiently sane to meet the test for present sanity, the patient is returned to the Superior Court with the hospital's certification of his present sanity. Upon return, criminal proceedings are resumed. In many cases the judge may wish to hold a new 1368 or sanity hearing upon return. Such is good practice when the defendant is exhibiting bizarre behavior or if regression between the time of release and his court appearance is suspected.

III. The Mentally Retarded

Until recently the mentally retarded have been given no special or unique consideration by the law in the area of present sanity or criminal responsibility. The terms "idiot" and "lunatic" as used in the Penal Code are ill-defined, and carry archaic and medieval connotations.

However, the Legislature in 1971 enacted Assembly Bill No.

2647 which adds Section 1370.1 to the Penal Code. The new legislation expresses the intent of the legislature to treat those who are "presently insane", because of mental retardation, differently from those who are "presently insane" because of mental disease. The new section provides that, (1) pending determination of the degree of mental retardation the accused is not to be placed in a jail and, (2) if the accused is mentally retarded he is not to be sent to the state hospital for the criminally insane but is to be processed under 6500, et seq. of the Welfare and Institutions Code and placed in a state hospital for the mentally retarded.

Section 1370.1 provides in part:

> "Notwithstanding the provisions of Section 1370, if the court has reason to believe that the defendant's inability to understand the nature and purpose of the criminal proceedings taken against him so as to be able to conduct, or assist in, his own defense in a rational manner is a result of mental retardation, the trial or judgment shall be suspended, and the court shall order the regional center for the mentally retarded, which serves the counties in which the court is situated, and which is established under the Lanterman Mental Retardation Services Act of 1969, Division 25 (commencing with Section 38000) of the Health and

Safety Code, to examine the defendant and within 90 days report to the court the results of the examination and its recommendation for the care and treatment of the defendant. The court may make such orders as may be necessary to provide for the examination of such person by the regional center and for the safekeeping, necessary medical treatment, care or restraint of the defendant pending further orders of the court following receipt of the regional center's report, in the county hospital, his own home, in a state hospital, or in such other place, excluding a jail, as will afford access to personnel of the regional center for the purpose of examination and suitable provisions for the safety and comfort of the defendant."

Section 6500 of the Welfare and Institutions Code defines mentally retarded persons as:

"Those persons, <u>not</u> <u>psychotic</u>, who are so mentally retarded from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control, and care, for their own welfare, or for the

welfare of others, or for the welfare of the community."

IV. Competency While Under Medication

Since World War II the field of pharmacology has taken tremendous strides. Doctors have access to a great array of tranquilizers, sedatives and anti-psychotic drugs (psychotropic agents). These drugs have the propensity to alter subjective thought processes as well as modify behavior. In the field of psychiatry, maintenance doses of some of these drugs permit an individual to cope with reality within society where otherwise he would be an institutional psychotic. To use the psychiatric profession's jargon, the individual's overt psychotic symptoms are being held in remission through the use of psychotropic medication.

The legal issue involved is whether the accused is mentally competent to stand trial while he is receiving a maintenance dosage of that very medication which is producing remission of his symptoms that cause him to be mentally incompetent to stand trial.

There is a danger that the compelled medication may alter the defendant's demeanor in court causing him to appear relaxed and casual while testifying. The jury may, under such circumstances, interpret this adversely to the defendant by deciding that the defendant shows a callous disregard for his crime. In such cases, the defense may be prejudiced by the prescribed medication.

In People v. Rogers (1957) 150 CA 2d 403, the defendant, an experienced diabetic, took large doeses of insulin on the fourth day of the trial and wilfully abstained from eating breakfast, thus inducing insulin shock. The court determined that the defendant, by his own action, induced the mental state whereby he could not assist at the time of trial and this amounted to a waiver of the right to be mentally present. By adhering to the same logic, a patient-defendant may be placed in the position of choosing between receiving medication, which might produce remission of the symptoms, causing him to be held mentally competent to stand trial, or facing the risk of waiving his right to be mentally present at the time of trial.

CHAPTER V

JUDICIAL COMMITMENT OF THE MENTALLY ILL

Another significant area in which the criminal law and psychiatry meet is the judicial processes involved in committing those individuals that have severe mental illnesses. The criminal law encounters this problem in two situations, both of which directly involve the District Attorney's Office:

1. The mentally ill <u>criminal</u> offender who has been found not guilty by reason of insanity.
2. The mentally ill person who has not been processed through the criminal system but, because of the severity of his mental disease, poses an obvious threat to the health and safety of himself and/or others.

This chapter deals with the two situations separately since the latter problem involves the complexities involved in the recently enacted Lanterman-Petris-Short Act (Sections 5000-5401 of the California Welfare and Institutions Code).

I. <u>Post Adjudication Insanity</u>:

Chapter II discussed the law and procedure involved in processing the criminal offender through the bifurcated

trial resulting from a plea of not guilty and not guilty by reason of insanity. If the defendant is found guilty and also legally sane he is, of course, subject to probation and/or sentence. However, if he is found or pleads not guilty by reason of insanity the defendant is no longer subject to criminal sanctions since he stands acquitted. Upon a finding of not guilty by reason of insanity California Penal Code Section 1026 provides that:

> "Unless it shall appear to the court that the defendant has fully recovered his sanity, [the court] shall direct that the defendant be confined in the state hospital for the criminally insane ... If, however, it shall appear to the court that the defendant has fully recovered his sanity, such defendant shall be remanded to the custody of the sheriff until his sanity shall have been finally determined in the manner prescribed by law."

Section 1026 gives no guidelines for the court to apply in determining what is meant by a defendant having "fully recovered from his insanity". As discussed in the prior two chapters, California courts have applied separate and distinct tests in determining "sanity" as it bears on criminal responsibility (liberalized M'Naughton test), and "sanity" as it relates to the ability of an accused to stand trial. In People v. Mallory (1967) 254

CA 2d 151, the court rejected the M'Naughton "right and wrong" test as being the one appropriate when the question of restoration to sanity is an issue under 1026 or 1026(a) of the Penal Code. The court stated that one committed to a state institution under the provisions of Section 1026 is held for the primary purpose of protection of the public in the course of administration of laws prohibiting crime (cf. People v. Mallory, supra, at page 156.)

In In re Jones (1968) 260 CA 2d 906, the court set forth a "third test" for sanity when dealing with mental restoration or recovery of the mentally ill criminal offender under 1026 and 1026(a) of the Penal Code. Jones, supra, held that the appropriate test is whether the individual has improved to such an extent that he is no longer a menace to the health and safety of others.

If it should appear to the court, after a finding of not guilty by reason of insanity, that the defendant has fully recovered his sanity, the statute provides that he is to be remanded until his sanity shall have been finally determined "in a manner prescribed by law." Here again, the statute does not define what is the prescribed manner of law. There are basically three ways the court may properly proceed:

1. In many cases the court will have initially requested the psychiatrists appointed under 1027 of the Penal Code to render an opinion

as to whether the defendant is presently a danger and menace to the health and safety of others along with their opinions of his mental state at the commission of the offense. If such a report exists the court may rely on it in making a finding on restoration of sanity. This finding may be made immediately following the verdict of not guilty by reason of insanity.

2. If no opinion exists in the form of a pre-existing psychiatric report, the court may make its finding on restoration to sanity if psychiatric testimony has been elicited during the sanity trial to support the view that the defendant is improved to the extent that he is not presently a danger and menace to the health and safety of others.

If it does not appear to the court that the defendant has fully recovered his sanity following a verdict of not guilty by reason of insanity, the defendant is committed to the state hospital for the criminally insane (Atascadera). This commitment brings the provisions of Section 1026(a) into play. Institutional commitment for 90 days under Section 1026(a) has been held to be reasonable, meeting the requirements of due process and equal protection. In re Franklin (1972) 7 C 3d 126. The

petitioner in the Franklin case argued that he was entitled to a judicial determination regarding his present sanity or restoration to sanity immediately after the sanity phase. The court in Franklin reasoned that a 90-day observation period as provided by the statute was reasonable particularly in light of the psychiatric necessity for observation before making a valid diagnosis. After 90 days the superintendent of the hospital or the patient himself may make application to the Superior Court for release alleging that the patient's sanity has been restored. If a defendant, having been sent to the state hospital under Section 1026, is returned to the Superior Court under Section 1026(a) of the code, the Superior Court holds a hearing ("1026(a) hearing") to determine whether the applicant is restored to sanity. The test set down in In re Jones, supra, namely, whether the individual has improved to such an extent that he is no longer a menace to the health and safety of others, is the appropriate criterion in a 1026(a) hearing. The petitioner, at a 1026(a) hearing, is constitutionally entitled to a jury trial upon the question of his release; he has the burden of proof by a preponderance of the evidence upon his restoration to sanity; he is given the advantage of a 3/4ths verdict so that he may obtain release upon establishing to the satisfaction of at least 3/4ths of the jurors that he no longer constitutes a danger to the health and safety of himself or others. In re Franklin, supra.

As can be seen, Sections 1026 and 1026(a) envision an outright release once an individual has been found "restored to sanity". This presents a potential danger to society since the "cured" individual may regress to psychotic behavior once released. An individual may manifest no psychotic symptoms after being committed to a psychiatric hospital and appear cured; however, this lack of psychotic behavior may simply be due to the structured environment of the institution and/or anti-psychotic medication. The legislature had this problem in mind when they enacted Section 7375 of the Welfare and Institutions Code. Section 7375 provides for release on parole from the state hospital once the patient appears to have improved to the extent that he is no longer a danger to himself or others. Since remission in psychotic behavior can now be rapidly achieved in many cases due to the effectiveness of anti-psychotic medication, the prosecution should generally take the position that society would best be protected by a Section 7375 "parole release" rather than an outright release, thus assuring psychiatric follow-up and retention of jurisdiction over the patient.

II. Lanterman-Petris-Short Procedures:

The Lanterman-Petris-Short Act (hereinafter referred to as the "LPS" Act) provides for the processing of those persons that are mentally ill to such an extent that they pose a danger to themselves or society but have not committed a criminal offense. Since there is no underlying criminal offense, the state

is functioning in the role of parens patriae. The LPS Act attempted to set forth procedures to protect the suicidal and gravely disabled from injuring himself or others while according him due process. The Act, which became effective July 1, 1969, terminated the indeterminate involuntary judicial commitment of the mentally disordered and provides for the involuntary detention and treatment of the mentally disordered by way of medical certifications for periods of 72 hours, 14 days, 90 days, and for conservatorship when appropriate. There is vested in the alleged mentally disordered a right to judicial review should he be certified beyond the initial 72-hour period.

Section 5007 of the LPS Act states that the provisions of the Act do not apply retroactively to terminate court commitments of the mentally ill persons processed under pre-existing law. However, in In re Gonzales (1972) 6 C 3d 346, the California Supreme Court held that a person committed under the former provisions of the Welfare and Institutions Code should neither be automatically released under the new LPS Act nor be deprived of the medication he needs to control his violence; but should, instead, be accorded the benefits of a conservatorship proceedings under the Act. (W&I Code, Sections 5350 et seq.)

The District Attorney's Office becomes involved in certifications and commitments under the LPS Act as a result of the provisions for judicial review. The District Attorney represents the interest of the state when a patient or his representative challenges the certification procedure.

The statutory procedures for certification are set forth in the Welfare and Institutions Code beginning with Section 5000 through Section 5400. The following outline sets forth the more important procedures regarding certification and commitment:

A. Any peace officer, member of an attending staff of an evaluation facility designated by the county, or other professional person, designated by the county, may with reasonable cause, take a person who is a danger to himself or others, or gravely disabled, to a facility for 72 hours of evaluation and treatment. (Section 5150, W&I Code.)

   1. The term "gravely disabled" means that an individual cannot provide for his basic personal needs of food, clothing, and shelter because of mental disorder.

   2. "Designated facility" means those facilities which have been set up by the local county health department as regional mental health centers under the Short-Doyle Act.

B. The facility may detain the person for a period not to exceed 72 hours excluding Saturday, Sun-

day and holidays. (Section 5151, W&I Code). The individual must be released after 72 hours unless recertified.

C. If a person detained for the 72-hour evaluation period is mentally disordered and will not accept voluntary treatment, he may be certified for not more than 14 days of involuntary intensive treatment. (Section 5250, W&I Code). He may only be certified for this additional 14 days if as a result of mental disorder, he presents a danger to others, or to himself, or is gravely disabled, and refuses voluntary treatment.

1. Upon the 14-day certification, a copy of the certification and notice of the person's right to judicial review are given to him.

2. Copies of the 14-day certification are filed with the Superior Court. A copy is also sent to the individual's attorney, the District Attorney, the defendant, and to the State Department of Mental Hygiene.

   There is no mandatory provision for judicial review at this stage. However,

the patient has a right to request review by way of filing a writ of habeas corpus with the Superior Court. If the patient desires judicial review at this stage, a Superior Court mental health counsellor will prepare and file the writ providing for a court hearing within 2 judicial days. If a writ is filed and an evidentiary hearing is held in the Superior Court (Department 95 in Los Angeles County) it is the duty of the deputy district attorney to present evidence as to the patient's immediate status. If the court finds the patient a danger to himself or others or gravely disabled as a result of mental disorder the writ is denied and the patient is remanded for continuation of the 14 days of involuntary treatment. (Section 5276, W&I Code).

D. An individual may be detained an additional 14 days involuntarily if, as a result of mental disorder, the person during a 72-hour or initial 14-day detention attempted to take his own life or who is detained for evaluation and treatment because he

threatened or attempted to take his own life and whose condition presents an imminent threat of taking his own life. The individual again has a right to judicial review as set forth above under paragraph C-3.

E. Section 5300 of the Welfare and Institutions Code provides that a person may be confined for further treatment not to exceed 90 days if he (1) has threatened, attempted or inflicted physical harm upon the person of another after having been taken into custody for evaluation and treatment, and who, as a result of mental disorder, presents an imminent threat of substantial physical harm to others or, (2) attempted or inflicted physical harm upon the person of another, that act having resulted in his being taken into custody and who presents, as a result of mental disorder, an imminent threat of substantial physical harm to others.

1. A petition, supported by affidavit, for the additional 90 days of involuntary treatment must be filed, within the 14-day period in the Superior Court. (Section 5301, W&I Code).

2. The individual is arraigned in Superior Court, counsel is appointed, and the time and place is set for a court or jury trial pursuant to the provisions of Section 5303, W&I Code. The person is advised of a right to a trial by jury.

3. Section 5303 of the W&I Code provides that the court shall conduct proceedings (an evidentiary hearing) on the petition for post-certification treatment within 4 judicial days of the filing of the petition. If at the time of the hearing the person named in the petition requests a jury trial, such trial shall commence within 10 judicial days of the filing of the petition. The decision of the jury, if requested, must be unanimous for continued hospitalization. The deputy district attorney appears for the state at the "5303 hearing" and presents evidence regarding the patient's present mental status. If the court or jury finds that the patient re-

quires 90-day post certification treatment, the patient is returned to the treating facility for the remainder of the 90-day certification treatment.

F. Section 5350 of the Welfare and Institutions Code provides that a conservator of the person and of the estate may be appointed for any person who is gravely disabled as a result of mental disorder or impairment by chronic alcoholism. A conservator appointed pursuant to Section 5330, W&I Code, shall have the right, if expressed in the court order, to place his conservatee in a medical, psychiatric, nursing or other state licensed facility. (Section 5358, W&I Code).

As can be seen, the LPS Act provides that in cases where an individual has received the maximum amount of limited involuntary treatment and still poses a threat or danger to himself or others or is gravely disabled, the matter is to be resolved by the appointment of a conservator rather than continued involuntary detention. The conservator is appointed and functions in the role of a fiduciary under the provisions of the California Probate Code. Under the conservator statutes in the Probate Court, the Superior Court

requires detailed accountings and periodic judicial review regarding the status of the conservatorship.

III. Commitment under Section 4011.6 of the Penal Code:

When a defendant who is in custody demonstrates a mental disorder, the court has a choice of two courses of action. One choice would be to express a doubt as to the defendant's sanity and proceed under Section 1368 of the Penal Code, as discussed in Chapter IV, supra.

The other choice is to proceed under Section 4011.6 of the Penal Code. This section grants authority to the courts as well as to the jailers to cause the person to be taken to a facility for 72-hour treatment and evaluation pursuant to the provisions of the Lanterman-Petris-Short Act by a direct referral without going through Department 95 or without benefit of a court commitment. This releases all security safeguards by law enforcement agencies, and the evaluating and treatment facility is in no position to provide it.

Therefore, whenever a situation arises in which the court considers a referral of a person under Section 4011.6 of the Penal Code, except in a case of a minor misdemeanor, the deputy in charge should urge proceedings under Section 1368 of the Penal Code instead.

CHAPTER VI

MENTALLY DISORDERED SEX OFFENDERS

I. Scope of the Proceedings:

The processing of the "mentally disordered sex offender" under Sections 6300 et. seq. of the Welfare and Institutions Code presents difficult legal problems in the procedural area as well as unique psychiatric concepts faced by the attorney at the post-conviction hearing.

The District Attorney's Office represents the interests of the state at the hearing to determine whether one is a mentally disordered sex offender (MDSO). Should he be found to be a MDSO and challenges his commitment, the District Attorney is given statutory responsibility to file the petition. Section 6320 WIC states:

> "At the trial the petition and its allegations that the person is a mentally disordered sex offender shall be presented by the district attorney of the county."

Before an individual can be processed as a MDSO there must be a valid underlying conviction for a crime. Conviction of a crime, whether a misdemeanor or felony, is prerequisite to commitment procedures (6302a WIC).

However, the proceedings for commitment are civil in nature and are collateral to the criminal proceedings. A person committed as a mentally disordered sex offender is not confined for the criminal offense but rather because of his status as a MDSO (In re Bevill, (1968) 68 C 2d 854). While a person is under such commitment, the criminal case against him is suspended and when the proceedings relating to the MDSO commitment have run their course, the criminal case may be resumed and sentence imposed; Section 6325 WIC, however, provides that time spent under the commitment be credited in fixing his term of sentence.

An individual who is committed as a MDSO may challenge the underlying conviction on habeus corpus. If he is successful in having the criminal conviction reversed he must be released from the MDSO commitment (In re Bevill, supra, at 862).

MDSO proceedings may result from either a conviction of a misdemeanor in the Municipal Court or a conviction of a felony in the Superior Court. If jurisdiction for the underlying crime lies with the Municipal Court that court must certify the case to the Superior Court for the hearings involving MDSO commitment. In Los Angeles County, a separate Superior Court Department has been set aside for these matters, namely, Departments 95 and 95-A. If the underlying crime is a felony, proceedings are adjourned or suspended after conviction and the MDSO proceedings are held in the Superior Court. It is the

policy of the Los Angeles Superior Court that the MDSO hearing should take place in the same department which heard the felony crime. However, the MDSO procedures, whether they involve an underlying misdemeanor or whether they result from a felony conviction, are the same.

It is interesting to note that the MDSO procedures do not apply exclusively to the sex offender since the underlying crime of which he is convicted need not be a sex offense; Section 6302 WIC states that:

> "When a person is convicted of any criminal offense, whether or not a sex offense, the trial judge, on his own motion, or on the motion of the prosecuting attorney....may adjourn the proceedings or suspend the sentence and certify the person for hearing and examination....".

The MDSO procedures do not apply to those persons ineligible for probation. Section 6301 WIC states:

> "This article (6300 et. seq.) shall not apply to any person sentenced to death nor to any person ineligible for probation under the Penal Code....".(emphasis supplied)

Section 1203 of the Penal Code sets forth certain situations which restrict the accused's right to probation. It is error for the court to initiate MDSO proceedings in those

situations where the defendant is ineligible (People v. Brown (1968) 260 CA 2d 434). However, if the judge finds the case to be unusual and where the interests of justice demand a departure, he may grant probation under Section 1203(d). If the court makes this finding and departs from the usual policy, then MDSO proceedings may follow.

II. Definition of a Mentally Disordered Sex Offender:

Section 6300 WIC legally defines a mentally disordered sex offender as follows:

> "Any person, who by reason of mental defects, disease, or disorder, is predisposed to the commission of sexual offenses to such a degree that he is dangerous to the health and safety of others."

The determination as to whether one is a mentally disordered sex offender is made by a Superior Court judge after hearing the opinion and findings of at least two court appointed psychiatrists (not more than three), a probation report and any other competent or relevant evidence.

The psychiatric definition, then, of a mentally disordered sex offender becomes of prime concern since the court will likely rely heavily, if not exclusively, on the psychiatric opinion. The court appointed psychiatrist is called upon to examine an individual who has just been convicted of an

offense - usually, but not necessarily, a "sex offense". The danger is that the psychiatrist may make an insufficient examination and assume that the defendant is a MDSO, as legally defined, because of the underlying sex offense. This problem is well illustrated in People v. Huskins (1966) 245 CA 2d 859 at 865:

> "The second psychiatrist interviewed the defendant for half an hour in the hospital unit of the....jail. He concluded that defendant was a sexual psychopath because he had been convicted of child molestation and stated if the defendant had not been so convicted, he, (the psychiatrist) would not have classified him as a sexual psychopath.
>
> This psychiatrist confused his function with that of the court when he stated: 'My conclusions would have to be, if he is guilty of the act, he will be considered a sexual psychopath.'
>
> Obviously, if everyone convicted of a sex offense were automatically classified as a sexual psychopath or MDSO, there would be no need for a separate trial on that issue."

Properly, the psychiatrist in forming his opinion must

take into account the defendant's complete behavioral history. And it is incumbent upon the deputy district attorney to probe the psychiatrist's reasoning process and force him to express the underlying facts which lead to his ultimate opinion. For example, what does the psychiatrist "see" in the defendant's personality profile and/or testing protocol which leads him to the conclusion that the person is a MDSO?

Although dangerous predisposition to sexual offenses may, in some cases, be traced to organic causes such as tumor or brain damage, the more common diagnosis is to define the mental disorder as a functional disease. The American Psychiatric Association's Diagnosis and Statistical Manual lists sexual deviations as a form of sociopathic personality disturbance rather than a form of psychosis or psychoneurosis.

The prosecutor handling a MDSO hearing must have some basic understanding of psychiatric terms and approach in order to effectively examine and/or cross-examine the court appointed alienist.

The psychiatrist at a MDSO hearing often expresses the underlying reasons for his diagnosis in psychoanalytic terms. The Freudian or psychoanalytic classification of sexual deviations basically ascribes the deviant behavior to arrested sexual development in early childhood and regression to infantile sexuality. According to Freudian theory, a child undergoes love relationships between the age of 3 to 6 with associated rivalries, hostilities and emerging identifications. The

so-called Oedipus Complex is associated with this stage of development. In the normal situation the child overcomes these Oedipal strivings and progresses to succeeding stages of ego development. However, adult sexual neuroses are traced by psychoanalytic theory to an unconscious clinging to these early love or Oedipal tendencies. The sexual psychopath subconsciously fears the threat of adult sexual contact; he has anxiety and guilt feelings which is often referred to by psychiatrists as "castration anxiety".

Two of the more common psychiatric terms encountered in describing and classifying sexual deviates are set forth as follows:

A. Pedophilia:

The pedophile is one that requires the cooperation of a child partner in order to achieve sexual gratification. The pedophile is said to avoid adult sexual contact because of his overwhelming "castration anxiety"; instead, he is attracted to children who do not elicit the same anxiety because they are weak and aproachable.

B. Sadism and Masochism:

Sadism is commonly defined as the attainment of sexual gratification by inflicting pain upon the sex object; the masochist,

> on the other hand, achieves sexual gratification by enduring pain inflicted upon one's self.
>
> From a psychoanalytic standpoint the sadist is able to rid himself of his castration anxiety by doing to others what he is subconsciously afraid may be done to him. The masochist's ability to achieve normal sexual gratification is similarily disturbed by anxiety and guilt feelings which are alleviated by his own suffering.

Other classifications of sexual deviations such as exhibitionism, fetishism and transvestitism are similarly traced to sexual regression and arrested sexual development. The above psychoanalytic approach,as set forth, represents an oversimplification and the lawyer engaged in a MDSO hearing is referred to the Psychiatric Texts mentioned in the bibliography. A working knowledge of these psychiatric concepts is necessary so that the deputy district attorney can "press" the testifying psychiatrist into explaining the use of these terms as they relate to the behavioral history of the defendant rather than allowing the psychiatrist to merely state psychiatric conclusions.

III. Application of MDSO Procedure:

Section 6302 WIC, differentiates the situations in which the judge may, at his discretion, initiate MDSO proceedings and those situations where it is mandatory that he do so. There are two situations when the judge must institute MDSO proceedings:

1. When a person is convicted of a sex offense involving a child under 14 years of age and it is a misdemeanor and the person has been previously convicted of a sex offense in this or any other state.
2. When a person is convicted of a sex offense involving a child under 14 years of age and it is a felony.

Under Section 6302 WIC, the judge must make a formal finding that such person is an alleged MDSO and the court must fully state the facts upon which the allegation that the person is a MDSO is based. If this is done in the Municipal Court that court certifies the person along with the findings for hearing and examination in the Superior Court. Once the individual is before the Superior Court, Section 6305 sets forth the procedures to be followed, which include:

1. Arraigning a defendant by advising him that he is certified or alleged to be a MDSO and advising him of his right to make a reply and produce witnesses.

2. The judge shall appoint not less than two nor more than three psychiatrists, who have conducted their professional practice pertaining to the diagnosis and treatment of mental and nervous disorders for a period of not less than five years, to make a personal examination of the alleged MDSO; one of the psychiatrists must be from the medical staff of a state hospital or county psychiatric hospital. It is to be ascertained whether that person:
   a. Has a mental defect, disease or disorder;
   b. Is predisposed to the commission of sexual offenses;
   c. That because of this predisposition, whether he is a danger to the health and safety of others; and
   d. Whether or not the person would benefit by care and treatment.
3. The matter must be referred to a probation officer along with a copy of the certification. The judge must give the names of the psychiatrists which have been appointed and request that they make their reports available to them.

4. Set a time and place for the hearing and examination in open court as to whether the individual is a MDSO. It is the policy of the Los Angeles Superior Courts to set the matter down for hearing 35 days after the referral to the probation department and the appointment of psychiatrists. This gives the probation officer 21 days and then an additional 14 days to get the psychiatrists' reports.

5. If the individual is not represented by an attorney, one should be appointed for him.

The hearing to determine whether an individual is a MDSO must comply with due process. The court in Peo. v. Maugh (1969) 1 CA 3d 856 at 863 states:

> "Due process in proceedings for commitment of a convicted person as a MDSO requires that he be present with counsel, have an opportunity to be heard, be confronted with witnesses against him and have the right to cross-examine and offer evidence of his own. A waiver of any such requirements must be expressed and will not be implied."

At this stage of the proceedings, there is no right on the part of the convicted defendant to have a jury decide

whether he is a MDSO. Peo. v. Harvath (1969) 1 CA 3d 521 at 525.

Section 6308 WIC provides that each psychiatrist shall file with the court a separate report of the result of his examination of the defendant. This report must state the conclusions as to whether the individual is a MDSO and the opinion as to whether or not the person would benefit by care and treatment in a state hospital. The code specifically states that each psychiatrist shall attend the hearing and shall listen to the testimony of all witnesses before he testifies, unless the individual upon the advice of counsel waives the presence of the psychiatrists and stipulates that their respective reports may be received in evidence. In Peo. v. Townsend (1971) 20 CA 3d 919, the reports of the court appointed psychiatrists in a MDSO hearing were stipulated to and submitted into evidence upon stipulation of counsel. No waiver of the right to confront and cross-examine the doctors was obtained from the defendant. Prior cases had held that a waiver of confrontation by counsel was sufficient. The court held that there must be a separate and personal waiver on the part of the defendant. The court in Townsend, supra, predicated its holding on the language of Section 6308 WIC which states that:

> "....unless the person upon the advice of counsel waives the presence of the psychiatrist....". (emphasis supplied)

At the conclusion of the hearing, the judge must make a finding as to whether or not the defendant is a MDSO and whether the person could benefit by treatment in a state hospital. If the finding is that the defendant is not a MDSO, the judge should order the defendant back to the Municipal Court if a misdemeanor is involved for resumption of criminal proceedings. If a felony is involved, the Superior Court judge should resume criminal proceedings, order a supplemental probation report and calendar the matter for probation and sentence.

If the court finds the defendant to be a mentally disordered sex offender, the judge has a number of options available to him for the disposition of the matter:

A. If found to be a MDSO and, further, that the defendant could benefit by treatment in a state hospital, the court may:
   1. Commit the person to a state hospital (Atascadero) for an indeterminate period for treatment; a copy of such order of commitment must be served on the defendant within 5 days of the order;
   2. Resume criminal proceedings notwithstanding the finding.

B. If found to be a MDSO and, further, that the defendant will not benefit by treatment in a state hospital, the court may:

1. Resume criminal proceedings and sentence or grant probation;
2. Recertify the matter for further proceedings on the MDSO matter.

IV. Commitment and Right to Jury Trial:

Should the defendant be committed to a state hospital or a state institution as a MDSO, the code then provides that he has a right to demand a jury trial as to whether he is an MDSO. The defendant must make this demand for a jury trial within 15 days of the order of commitment. Since the defendant has this right to trial by jury upon commitment, he should be advised of this right at the time the judge orders his commitment. If the defendant demands his right to trial, the proceedings are as follows:

1. The court shall set the case for trial not less than 5 nor more than 10 days from the date of the demand. (Section 6318 WIC).
2. At the trial the petition shall be presented by the District Attorney of the County (6320 WIC). Deputy district attorneys handling matter will review necessary matter, interview witnesses and otherwise prepare for trial.
3. Civil rules and laws apply and if trial by jury a verdict requires a 3/4 vote. (6320 WIC).

4. If verdict is person is MDSO the court shall make an order similar to the original Order of Commitment to the state hospital. Sheriff delivers person to state hospital.

5. If verdict is person is not MDSO, the defendant is returned to the certifying criminal court for sentence or disposition of criminal matter.

V. Treatment and Recovery:

1. When MDSO has been treated to the extent that a person will not benefit by further care and treatment in the hospital and is not a danger to the health and safety of others, (6325 WIC), the following is applicable:

   a. Hospital superintendent files with the committing court a certification of his opinion including a report, diagnosis and recommendation concerning the person's future care, supervision and treatment.

   b. Committing court shall order the person returned to the criminal court for resumption of the criminal proceedings.

   c. If person is sentenced on the criminal charge, the time spent under the commitment order as a MDSO shall be

credited in fixing his term of sentence.

2. When MDSO has been treated and has not recovered and in the opinion of the superintendent the person is still a danger to the health and safety of others, the superintendent shall file with the committing court a certification of his opinion and the following is applicable: (6326 WIC):

   a. Committing court shall order return of the person from the hospital to the committing court and shall return him to the criminal court for resumption of criminal proceedings.

   b. The criminal court may sentence or otherwise dispose of case or may recertify the person back to the committing Superior Court.

   c. Committing court shall conduct hearing to determine if person is still a MDSO and is still a danger to the health and safety of others.

   d. At such hearing the person is entitled to his constitutional rights. The deputy district attorney handling the hearing usually has as his witnesses the same psychiatrists who examined the person,

the same lay witnesses and the treating physician from Atascadero State Hospital.

e. If at hearing person is found to be still a MDSO and still a danger to the health and safety of others, the court may recommit him for an indeterminate period to the Department of Mental Hygiene for placement in a state institutional unit for the care and treatment of such MDSO (usually the California Institution for men at Chino, California).

f. The person shall remain in said institutional unit until he is no longer a danger to the health and safety of others.

CHAPTER VII

NARCOTIC ADDICTION

There are four Welfare and Institutions Code Sections dealing with the commitment of narcotic addicts and those persons in imminent danger of becoming addicted to narcotics, to the California Rehabilitation Center (CRC) of the Department of Corrections at Corona, California.

Although the legal problems involved in the area of narcotic addiction do not directly involve psychiatrists or psychiatric problems, a discussion of this field is appropriate in this manual since all the narcotic addiction proceedings in Los Angeles County are handled by the District Attorney's Psychiatric Division in the Los Angeles County Hospital (Departments 95 and 95-A).

The petition for commitment and the processing of this petition are functions of the deputy district attorney in the Superior Court. The four sections dealing with the narcotic commitment are:

1. Section 3050 WIC

   This section states that persons convicted of any crime in a Municipal or Justice Court may be certified to the Superior Court if it appears to the judge that the defendant may be addicted or in imminent danger of becoming addicted to narcotics.

2. Section 3051 WIC

   This section states that persons convicted of any

crime in the Superior Court may be processed and a petition filed for his commitment to the California Rehabilitation Center if it appears to the judge that the defendant may be addicted or is in imminent danger of becoming addicted to narcotics, unless in the opinion of the judge the defendant's record and probation report indicates such a pattern of criminality that he does not constitute a fit subject for commitment under this section.

3. Section 3100 WIC

Any person who believes another or any person who believes himself to be addicted or in imminent danger of addiction to narcotics may report the fact to the District Attorney's Office, under oath, who may then, when there is probable cause, petition the Superior Court for commitment.

4. Section 3100.6 WIC

Provides that any peace officer or health officer who has reasonable cause to believe a person is addicted or in imminent danger of becoming addicted to narcotics may take such person into custody and seek his admission to the county facility, designated by the Board of Supervisors, for the examination of such person involuntarily and if found to be a narcotic addict or in imminent danger of addiction lead to his commitment.

Sections 3050 and 3051 are similar in that they deal with the processing of a criminal offender. As such, the District Attorney is involved with these commitments far more often than he is with the latter two sections. The following discussion, therefore, will be limited to the first two sections. The applicability of Sections 3050 and 3051 are limited by Section 3052:

> "Sections 3050 and 3051 shall not apply to persons convicted of, or who have been previously convicted of murder, assault with intent to commit murder, attempted murder, kidnapping, robbery, burglary in the first degree, mayhem, Section 245 or rape, except for statutory rape, any felonies involving bodily harm or attempt to inflict bodily harm, or any offenses set forth in Article I: commencing with Section 11500; or II: commencing with Section 11530 of the Health and Safety Code, or Article IV: commencing with Section 11710 of the Health and Safety Code for which the minimum term prescribed by law is more than 5 years in state prison."

The statutory language of Section 3051, however, provides that in unusual cases, wherein the interest of justice would best be served, the judge may, with the concurrence of the district attorney and defendant, order commitment notwithstanding the fact that defendant may fit within the limiting language of 3052 WIC. In the recent case of People v. Navarro (1972) 7 C 3d 248, the California Supreme Court held that if the judge finds the case to be

an unusual one and one in which the interest of justice requires commitment notwithstanding Section 3052, he need not receive the concurrence of the district attorney in order to proceed.

The legislative intent behind the narcotic commitment procedures was to provide a facility within the Department of Corrections for the treatment of those persons whose primary problem involves addiction to narcotics. A treatment facility is only effective when it can operate as such and not unduly concern itself with disciplinary or confinement problems. Therefore, the Legislature further restricted the scope of Sections 3050 and 3051 by Section 3053, WIC:

> "If at any time after 60 days following receipt at the facility of a person committed pursuant to this article, the Director of Corrections concludes that the person, because of excessive criminality or for other relevant reason, is not a fit subject for confinement or treatment in such narcotics detention, treatment and rehabilitation facility, he shall return the person to the court in which the case originated for such further proceedings on the criminal charges as that court may deem warranted."

As can be seen from the above statutes, the judge presiding in the criminal proceedings first determines whether the defendant may be addicted or is in danger of becoming addicted to narcotics (3050, 3051 WIC), and whether his record or probation report

indicates his fitness or unfitness for commitment for rehabilitation (3052 and exclusionary criteria, infra.) Next, the Superior Court judge presiding at the commitment hearing (Department 95 in Los Angeles County) determines whether the defendant is in fact addicted or in imminent danger of becoming addicted based upon a medical examination; and lastly, the Director of Corrections or his delegate make a determination under Section 3053 as to whether the defendant is a fit subject for confinement or treatment in the rehabilitation program.

In the first instance, it is incumbent upon the deputy district attorney to make the court aware of the defendant's criminal and behavioral history. If this is not done, the defendant may be committed to CRC and returned as an unfit subject. The defendant should be carefully screened by the court initiating the procedures under Sections 3050 and 3051 so that they do not commit somebody who is obviously unfit. The Department of Corrections has set forth certain exclusionary criteria which they use in deciding whether an individual is a fit subject for the civil addict program. This criteria should be used as a framework within which the trial court makes the initial determination to initiate commitment procedures. The exclusionary criteria is set forth in the appendix to this chapter. The purpose of the exclusionary criteria is to ensure that those committed to CRC may obtain significant therapeutic benefit. The provisions of Section 3053 places with the Director of Corrections the final responsibility as to whether the individual is a fit subject for treatment in the

civil addict program. Exclusion of individuals from the rehabilitation program because of excessive criminality has been held to be reasonable and does not deny any individual due process or equal protection of the law. People v. Fuller (1971) 20 CA 3d 159.

One of the leading cases upholding the Director of Corrections' authority to exclude an individual from the rehabilitation program is People v. Hakeem (1969) 268 CA 2d 877. That case held that the question of fitness of a given individual for the rehabilitation program is reserved solely to the Director and his staff. The only recourse the defendant has, if he is excluded under Section 3053 WIC, is to request the Superior Court to hold a hearing to determine if the Director of Corrections or his staff abused their discretionary authority. Although there is no statutory provision for a hearing after the Director exercises his authority under Section 3053 and rejects an individual who has been previously committed, the trial court has both the authority and the duty, if requested, to review the Director's action to determine if there is an abuse of discretion. People v. Morgan (1971) 21 CA 3d 33 at 38.

It must be stressed that the Superior Court, while sitting at an exclusionary hearing ("3053 hearing") does not have the authority to re-determine for itself whether an individual is a fit subject for treatment. The court's only function at the hearing is to determine whether or not there is a clear abuse of discretion exercised by the CRC staff, such as an arbitrary or clearly capricious reason for rejection. People v. Hakeem, supra; People v. Morgan, supra.

In People v. Morgan, supra, the defendant was committed to CRC under Section 3051 WIC. He was returned to court as an unfit subject. The Superior Court held a 3053 hearing and found that the Director had abused his discretion in considering some inappropriate information in determining the defendant's fitness. The Superior Court ordered the Director of Corrections to reconsider his decision and sent the defendant back to CRC. The Director reconsidered and again returned the individual to the Superior Court as an unfit subject, based upon excessive criminality. The court held in Morgan that the defendant was not entitled to a second 3053 hearing and that the defendant was properly excluded since the Director had properly exercised the discretion vested in him.

The Welfare and Institutions Code provides that commitments to the civil addict program be made in Superior Court. The procedure in Los Angeles County is to have all criminal offenders, whether they be misdemeanants or felons, referred to Department 95. It is in Department 95 that the District Attorney petitions for narcotic commitment. The judge in the criminal court should suspend criminal proceedings, refer the defendant to Department 95, and recalendar the matter 21 days later. If he is accepted and committed to CRC, the matter "will go off calendar". If he is found not to be addicted or in imminent danger of becoming addicted, he will have a calendar return date for resumption of the criminal proceedings. The procedures followed are:

A. Upon receipt of the certification from the convicting

criminal court, the District Attorney Psychiatric Section reviews the criminal file, probation reports, and prepares the narcotic addition petition. The file is reviewed in order that crimes enumerated in Section 3052 WIC may be found and brought to the attention of the referring certifying court, the committing court, and/or the California Rehabilitation Center for purposes of exclusion from the narcotic program where applicable.

1. The petition contains the allegation of narcotic addiction, the date, crime, and court of conviction and the prayer for commitment.

B. On filing, the petition results in a court order detaining the defendant pursuant to the petition.

C. The defendant is arraigned in Department 95 on the petition re: Narcotics (3104 WIC). The following occurs at the arraignment:

1. Advised of allegations
2. Advised of constitutional rights
3. Attorney appointed if defendant is not represented.
4. Two examining doctors appointed
5. Time and place for examination set
6. Time and place for hearing set
7. Bail and/or O. R. set

D. The defendant is examined by the appointed doctors in Department 95. Said examination consists of:

1. Review of court file contents, including arrest reports and probation reports.
2. Interview with defendant as to history of use of narcotic, amount and frequency of use.
3. Physical examination of defendant's body for evidence of narcotic use such as scabs, punctures, tracks, and vein condition.

E. If doctors find from examination that defendant is not addicted or in imminent danger of narcotic addition, the doctor's report is filed with the court clerk who will cut an ex-parte order returning the defendant to the criminal court for resumption of proceedings. A copy of the doctor's report is usually filed with the criminal court case file.

F. If doctors find from examination that defendant is a narcotic addict or in imminent danger of narcotic addiction, further proceedings are:

1. Deputy district attorney will review case file, doctors' reports and seek interviews with all witnesses for court trial.
2. At court, trial deputy district attorney must prove by a preponderance of evidence

that defendant is addicted or in imminent danger of addiction to narcotics. The basic criteria of proof of narcotic addiction is:

a. Repeated use of narcotics as evidence by narcotic tracks, puncture wounds, vein condition, history and statements of defendant.

b. Repeated use of narcotics has developed emotional or physical dependence upon the drug. Insofar as the defendant in Department 95 proceedings has been in custody for weeks and observable signs of physical dependence will only last a week or so, the bulk of the Psychiatric Section's burden of proof lies in the area of emotional dependence.

G. At the hearing, the attendance of the physicians who conducted the examination is mandatory, unless specifically waived. (3106 WIC).

H. If the evidence does not satisfy the court of narcotic addiction or imminent danger of addiction, the petition is dismissed and the defendant ordered returned to the criminal court for resumption of criminal proceedings.

I. If evidence satisfies the court that defendant is a narcotic addict or in imminent danger of addiction the court will commit the defendant to the Department of Corrections for placement at the California Rehabilitation Center (CRC) at Corona, California, for a period not to exceed seven years for treatment.

1. There is no minimum time for treatment and release to outpatient status is usually within 6 to 9 months. When placed on outpatient status from CRC he is returned to the community under the supervision of a CRC parole officer.

2. While on outpatient status, if defendant is drug free for two (2) years, he is discharged as having recovered from his illness. Defendant is ordered returned to the committing court for return to the criminal court for resumption of the original criminal proceedings.

J. Jury Trials (3108 WIC): Defendant, if committed to CRC as a narcotic addict, may within 10 days of the making of the order of commitment, file a written demand for jury trial on the issue of addiction.

1. Upon the filing of the written demand for

jury trial the court shall set a date for the jury trial not less than four, nor more than 30 days from the date of the demand.

2. The deputy district attorney handling the jury trial will prepare for trial by reviewing court files and records, and seeking interviews with expert and lay witnesses.

3. Jury trial is governed by rules applicable to civil actions. The issue to be decided by the jury is whether on the date of commitment by the court the defendant was a narcotic addict or was in imminent danger of becoming addicted.

4. A verdict sustaining the original order of the court finding that defendant is a narcotic addict or in imminent danger of addiction requires a three-fourth majority of the jury's vote.

K. Waiver of Court and/or Jury Trial: As over 70 percent of the cases in this classification are 3051 WIC proceedings and concern felonies that may carry a prison sentence in the criminal court, there are a number of cases wherein the defendant decides to waive his rights to court trial and accept commitment to CRC. Procedurally, they are processed as follows:

1. Determination by doctors that defendant is a narcotic addict.

2. The defendant appears in Department 95 on the afternoon of said examination date and waives his rights, in open court, to a court hearing and signs the written waiver made available to him in Department 95, after his earlier arraignment and after consultation with his attorney. (3107 WIC): The doctors' reports are by stipulation received into evidence and a stipulation received that the court may proceed in the absence of the examining physician.

3. The commitment period to CRC is the same as if there had been a court hearing or jury trial.

L. Retention or Exclusion of Narcotic Addict at CRC (3109 WIC): Following receipt of the defendant by CRC, the Director of Corrections has the authority to keep the defendant for treatment or he may exclude him and return him to the criminal court for resumption of criminal proceedings because of excessive criminality or for other relevant reasons. This ties in with the Psychiatric Section's purpose for reviewing the entire criminal file prior to preparing the petition in order that we might call attention to the defendant's criminal background to the courts involved or to CRC itself.

CHAPTER VIII

VOIR DIRE

In the selection of a jury, the voir dire examination properly consists of questions designed to determine the existence of grounds for challenge for cause, and it may be conducted by the court and counsel. (California Penal Code 1078).

Voir dire on the law is generally not a proper subject of inquiry since it is presumed that the jurors will be adequately instructed. However, the court in People v. Love (1960) 53 C 2d 843 at page 852 (footnote), states that such inquiry may be prerequisite to ascertaining the jurors' willingness to apply the principle of law, and to refuse such may preclude "the reasonable examination of prospective jurors to which the parties are entitled." (See Penal Code 1078).

The prosecutor ought to be ever mindful of conducting his voir dire and exercising his peremptory challenges in such a way as to pick a jury that is neither biased in favor of nor against psychiatric concepts.

Prospective jurors should be thoroughly questioned in attempting to determine whether they are predisposed to accept psychiatric concepts at face value as well as whether they are predisposed to accept the testimony of an expert without testing its reasonableness. The deputy district attorney must stress that

it is the jurors' function to determine the facts, and, that the experts' testimony is only being offered to aid them in this endeavor; that if they find the testimony of the expert, or any other witness for that matter, to be unreasonable, it is their duty to reject what appears unreasonable to them. In questioning the jurors during voir dire examination, the deputy district attorney should obtain a "commitment" from the jurors that they will perform their duty of testing the reasonableness of an expert's opinion against the evidence and their common sense judgment.

A jury should be thoroughly examined as to whether or not they have ever taken courses in psychology; whether or not they have friends or relatives who are employed in the field and whether they have been treated or examined by a psychiatrist. The jury should be questioned on their willingness to disregard psychiatric testimony which is unreasonable to them. The difference between the treatment of a patient and the psychiatrist's legal conclusions after a short interview of the defendant as to his mental state at the time of the commission of the crime should be explored. The difference between mental illness and diminished capacity or legal insanity should be emphasized. The nature of the bifurcated trial and the applicability of the various presumptions ought to be defined.

A number of appropriate areas of inquiry are set forth below along with sample questions. The outlined approach and the questions set forth are not necessarily intended to illustrate "the correct way" that voir dire should proceed when dealing with

psychiatric testimony. The actual questions used by an attorney in trial will be determined by the unique nature of his case, the degree of leeway permitted by the judge, the responses given by prospective jurors, and the personality of the lawyer himself.

I. Familiarity with Psychiatric Concepts

A portion of the voir dire examination should be devoted to determining the extent of exposure that jurors may have had to psychiatric concepts. The prospective juror may exhibit either direct or indirect bias based upon past personal experiences with psychiatrists or by exposure to psychiatry or psychology in reading or academic courses.

Q. Have you studied psychiatry or psychology, either formally or informally?

A. No.

Q. Have you read any books which have concerned themselves with psychiatric concepts or theories?

A. No.

Q. Do you have any relatives or close friends who are psychiatrists or psychologists?

A. Yes.

Q. Have you, Mrs. Jones, discussed with this individual the nature of his work or the concepts or theories in which he believes?

A. No.

Q. Has your friendship with this individual caused you to form any opinions either for or against psychiatric concepts?

A. No.

Q. Because of this friendship, Mrs. Jones, would you be predisposed to accept the conclusions of a psychiatrist without testing the reasonableness of his opinion against the evidence and your common sense background?

A. No.

Q. Have any of your relatives or close friends undergone psychiatric care or consultation?

A. No.

Q. Have you ever been treated by a psychiatrist or psychologist?

A. No.

Q. Have you ever taken any psychological tests?

A. Aptitude test, I believe.

Q. Do you believe the results of psychological tests are always correct - infallible?

A. Not necessarily.

Q. Would you agree the results are subject to different interpretations?

A. Yes.

II. Psychiatry: An Art or a Science?

Questions should be posed to prospective jurors which seek to determine whether the individual believes psychiatry or psychology to be an exact science. If the prospective juror so believes, then he will be more inclined to accept the conclusions of the psychiatrist at face value without testing their reasonableness.

Q. Do you think psychiatry is an exact science such as mathematics?

A. Well, I am not exactly sure.

Q. Well, do you think that all medical opinions can be demonstrated mathematically?

A. No.

Q. Although some things in medicine, such as the diagnosing of a broken arm by a set of x-rays can be demonstrated conclusively, would you agree that the field of medicine that deals with the disability of the mind is not subject to that kind of proof?

A. Yes.

Q. Would you agree, Mrs. Jones, that the opinion given by a psychiatrist is necessarily based on his interpretation of what he has examined?

A. Yes.

Q. Have you, in the course of your life, ever come across people in the field of medicine who had differing opinions of the same person?

A. Yes.

Q. You have heard one doctor diagnosing a case one way and another doctor diagnosing a different way?

A. Yes.

Q. You have heard of one doctor prescribing one remedy for a patient and another doctor prescribing another?

A. Yes.

Q. Would you agree, Mrs. Jones, that this comes about because one doctor makes a different interpretation from the set of facts that he sees?

A. I think so.

Q. You do not believe that any of these people are necessarily dishonest because they interpret differently, do you?

A. No.

Q. If you find that a psychiatrist's opinion is unreasonable to you, based upon <u>your</u> view of the evidence and <u>your</u> common sense background, will you be able to reject an unreasonable opinion?

A. Yes.

Q. From your experience, are you aware that there are competing schools of thought with reference to the practice of psychiatry and psychology?

A. I believe so.

Q. And many variations within each individual school of thought?

A. Yes, sir.

Q. Would you agree that if an expert testifies in his field that his testimony is no more valid than the validity of his particular field in medicine?

A. Yes.

III. Diminished Capacity Based Upon the Nature of the Charge

It may be helpful to question the jurors with respect to whether they have any predetermined view of the defendant based upon the nature of the crime. In many instances, the facts and circumstances surrounding the criminal act may be so foreign to the juror's experience that he may be apt to feel that only an "insane" individual could do such a thing.

Q. There are some people, I suppose, who read of a particular crime and might say to themselves, "Well, there's got to be something wrong with an individual who does something

like that." Some people might react that way, don't you think, Mrs. Jones?

A. Yes, sir.

Q. Well, you understand that in this case, where there may be a defense of diminished capacity -- if you start out with that preconceived notion before hearing the evidence, then you will not be sitting as an impartial juror?

A. Yes, sir.

Q. From the nature of the charge itself, would you hold such a preconceived notion?

A. No.

Q. Do you have any feeling that a person who commits murder must necessarily be mentally ill?

A. No, sir.

Q. Did you feel that way as you walked into the courtroom today?

A. No.

Q. Now, since you have been in court, you have heard the terms, "diminished capacity", "psychological testing","psychology", and "psychiatry". Because of this talk, do you believe that there is something wrong with the defendant's mind?

A. No, sir.

Q. You would wait to hear the evidence?

A. Yes.

IV. Function of the Expert Witness

Q. You appreciate, Mrs. Jones, that a so-called expert witness, such as a psychiatrist or psychologist, is only here to help you to decide the facts, but not to tell you what to think? Isn't that true?

A. Yes.

Q. I simply want to point that out, because it is possible that where a psychiatrist or somebody of that sort renders an opinion as to an ultimate issue, that is to say, diminished capacity, or the lack of diminished capacity, he may say exactly what he thinks. You understand if you find it to be unreasonable, you may reject such an opinion?

A. Yes, I understand that.

Q. And you would not be tempted to abandon your function as the judge of the facts by reason of such opinion, would you?

A. No, I would not.

Q. You understand, Mrs. Jones, that you are not bound to accept the opinion of a so-called expert, even though he qualifies as an expert and is permitted to testify if it does

violence to your own good sense after considering all the evidence, isn't that true?

A. Yes.

Q. You do not feel that you have to blindly follow anything that someone is permitted to testify to, as an expert in that field, if it conflicts with what you believe to be reasonable?

A. No.

Q. You would feel that it would be your duty, Mrs. Jones, to reject that portion of any such expert testimony or opinion which fails to seem reasonable to you?

A. I would do that.

In addition to questioning the jurors regarding their function as judges of the facts, as opposed to the expert's function of aiding the jurors in their decision, the deputy district attorney might question jurors on their willingness to analyze the reasons given by the expert in reaching his opinion.

Q. Before giving any weight to the testimony of an expert, Mrs. Jones, would you be interested in the reasons that cause the expert to reach his opinion?

A. Yes.

Q. If he used psychiatric aids, such as psychiatric testing, you want to know if they were

used scientifically and the manner in which they were used, wouldn't you?

A. Yes.

Q. Do you accept the fact that psychiatrists and psychologists are after all human beings and they have to make judgments and decisions based on whatever tools they use?

A. Yes.

Q. Would you agree, Mrs. Jones, that any test in and of itself does not define somebody's state of mind; it has to be interpreted by another human being, doesn't it?

A. Yes.

Q. So that the results which are obtained from the use of any of the diagnostic tools that may be available to the experts are going to depend upon the validity of those tools and how they apply?

A. Yes.

Q. Will you perform your function and decide whether the underlying reasons given for an opinion are reasonable and worthy of acceptance?

A. Yes.

Q. If the expert bases his opinion in part upon what the defendant told him, will you look at

the defendant's statement to see if you think the defendant was telling the doctor the truth or not?

A. Yes.

Q. And, if you should find that the defendant was biased or told the doctor something that you find to be untrue, will you then evaluate the weight of the expert's opinion in light of such fact?

A. Yes.

V. Relate Anticipated Testimony to Juror's Personal History

It is much more effective in voir dire examination to ask questions that the jurors can easily relate to. The deputy district attorney should attempt to talk to the jurors on a one-to-one or personal basis rather than lecturing the jurors in complicated and legal terms, which may ultimately confuse the juror.

Q. Mrs. Jones, you have stated that you were a teacher, is that correct?

A. Yes, it is.

Q. What groups or grades do you teach?

A. Elementary school, mainly 3rd and 4th grades.

Q. Have you had any exposure to psychological concepts in your education or as a part of your work?

A. I had one course in college, when I was getting my credential.

Q. Then you are probably somewhat familiar with some of the basic classifications in psychiatry, aren't you?

A. A bit -- it was primarily to draw attention of the teacher to any particular problem that she might see in the classroom.

Q. Has it been your experience as a teacher that each and every child that you have taught can be fitted into psychological classifications or pigeon-holed, so to speak?

A. No.

Q. Did you find, at times, that a certain child might react to you or others differently from what you learned in a psychology course?

A. Yes.

Q. And, I suppose that in many cases, you reacted or treated a child based upon your personal knowledge of him which might have been different from what was recommended in a particular psychology book or course?

A. Yes.

Q. Now, if an expert comes into court and testifies as to his psychiatric interpretation of an individual, would you be able to accept it

if you found it to be reasonable; but, on the other hand, reject it if it conflicted with your reasonable interpretation of the evidence and facts?

A. Yes, I would.

The above approach might be used in a similar way with an individual juror who has raised children or who has dealt with individual personalities in some other manner.

VI. Jurors' Ability to Follow on the Law

A portion of the voir dire examination should be set aside for questioning the prospective jurors' willingness to follow the instructions that will be given by the court. This is particularly true when a case involves diminished capacity and/or an issue of legal sanity. It will give the deputy district attorney an opportunity to define the role of psychiatric testimony and the complicated procedures and presumptions involved in a bifurcated trial.

Q. Mrs. Jones, as the judge has explained, the defendant has entered two pleas; not guilty and also not guilty by reason of insanity. In this situation, the defendant's guilt or innocence of the crime charged is first determined. And then, if he should be found guilty, a second phase of the trial decides whether or not the

defendant was legally sane or insane at the time of the crime. Do you understand this two-part procedure?

A. Yes.

Q. At the first phase or guilt phase of this trial, you will most likely hear psychiatric testimony regarding the defendant's mental state at the time of the alleged act. This psychiatric testimony at the first phase will be offered to aid you in deciding whether the defendant possessed the particular mental state which is necessary to be guilty of this crime. The psychiatric testimony at the first phase will not be offered to you to determine whether the defendant was legally sane or insane. Do you understand this distinction?

A. Yes.

Q. If the judge instructs you at the end of the first phase or guilt phase that the defendant is presumed to be sane, will you follow this instruction even though you have heard psychiatric testimony on the issue of the defendant's mental state?

A. Yes.

Q. If the defendant is found guilty at this first stage, the burden of proof in the second phase

or sanity phase is on the defendant to prove that he was legally insane by preponderance of the evidence. Will you be able to follow the judge's instructions in this regard?

A. Yes.

Q. Are you familiar with the test for legal sanity in California?

A. No.

Q. Will you follow the judge's instructions regarding the test for legal sanity even though you might happen to disagree with it?

A. Yes.

CHAPTER IX

DIRECT EXAMINATION OF THE PSYCHIATRIST

In most every instance in which the prosecution intends to seriously challenge a diminished capacity or insanity defense, it will be incumbent upon them to elicit testimony which rebuts or controverts the defense psychiatrist. This is true even though the prosecution is successful in impeaching the defense psychiatrists on cross-examination since an appellate court may resolve uncontradicted opinions and conclusions of defense psychiatrists, contrary to the jury verdict (but see People v. Coogler, infra). It is therefore not only tactically advantageous to controvert defense psychiatrists, but may become a legal necessity on appeal.

There are basically two sources in utilizing psychiatric testimony on rebuttal. The first is the psychiatric expert who has been appointed by the court under 730 E.C., 1017 E.C., or 1027 P.C. to examine the defendant and has rendered an opinion which is favorable for the prosecution. The second source is, of course, the psychiatric expert who is brought in or retained by the prosecution independently to examine the defendant and render an opinion. The latter source presents the problem of the defendant's voluntary submission to an examination by the prosecution psychiatrist as well as the initial problems in choosing a psychiatric expert.

The defendant cannot be forced to undergo a psychiatric examination (In re Spencer (1965) 63 C 2d 400.) The defendant may have undergone psychiatric examinations by defense or court appointed psychiatrists who have rendered favorable opinions for the defense. In such a case the defendant, either on his own initiative or by advice of counsel, may refuse to be examined by the prosecution psychiatrist. Although the prosecution may be able to elicit testimony and comment upon this type of tactical refusal, (no appellate court cases can be found on this point but the Los Angeles Superior Court has allowed such comment in some cases) such refusal by the defendant may render the prosecution psychiatric opinion worthless. In People v. Bassett (1968) 69 C 2d 122, defense psychiatrists testified to defendant's diminished capacity during a homicide. The prosecution on rebuttal called psychiatrists to the stand who had not examined the defendant. Their testimony, which was favorable to the prosecution, was elicited as a result of a series of hypothetical questions posed by the prosecutor. The court held, in essence, that in the absence of a clinical examination (personal interview) the psychiatrists' opinions held little weight and proceeded to find against the trial verdict. In the field of diminished capacity, the psychiatrists' opinion as to the requisite mental state is of little or no value if based solely upon hypothetical questions even though the hypothetical questions themselves have been properly phrased from an evidentiary

standpoint. The court in Bassett reasoned that expert psychiatric evidence regarding the defendant's mental state is really an argument of an expert to the court, and is valuable only in regard to the proof of facts and the validity of reasons advanced for the conclusion. All is not lost, however, should the defendant refuse to undergo an examination by an additional psychiatrist chosen by the People. In People v. Coogler (1969) 71 C 2d 153, a psychiatrist testified for the defense. There was no psychiatric testimony on behalf of the People. The prosecutor (Mr. Aaron Stovitz) attacked the psychiatrist on cross-examination showing that the psychiatrist did not speak to any witnesses at the trial, did not review the preliminary hearing transcript, did not read the police reports and relied on the defendant and his wife exclusively to indicate that he (the defendant) had no memory. The Supreme Court stated that the psychiatrists' opinion was improperly based and sustained the conviction of first degree murder despite the fact that the psychiatric evidence presented by the defense was uncontradicted by other psychiatric testimony.

The holding in the Bassett case only applies when the psychiatrist is asked to give an opinion on the ultimate question, namely, the defendant's mental state. There would be no Bassett problem in situations where the prosecution puts on expert witnesses and elicits testimony which would impeach the defense psychiatrist. In other words, even if the defendant has not submitted to voluntary examination, the prosecution

may still validly put on psychologists or psychiatrists to impeach or to controvert the grounds upon which the defense psychiatrist based his opinion. If the defense psychiatrist based his opinion on certain psychological tests, it might be advisable for the prosecution to call its own psychiatrist to testify to the weakness and/or shortcomings of the particular tests used.

Before the prosecution expends the time and effort in selecting a psychiatrist, it is wise to determine whether the defendant will submit to an evaluation.

In choosing a psychiatrist, the prosecution might be well advised to select a "board certified expert" with a background in neurology. This medical specialist deals in organic brain damages and disorders of the central nervous system. Such an expert will more often than not want evidence in the form of an electroencephalogram or other medical tests before expressing the ultimate conclusion of diminished capacity. In other words, this specialist generally requires more in the way of objective medical proof than does the psychiatrist who is steeped in psycho-analytical theory with a firm belief that the subconscious mind dictates and controls the conscious mind. A Freudian psychiatrist trained in psychoanalysis may not accept the concept of moral responsibility and free will; to him the concept of "diminished capacity" or "diminished responsibility" is accepted even before he examines the defendant since he strongly adheres to the philosophy that the subconscious

is dominant. Furthermore, psychiatrists or psychologists who are oriented to the testing and treatment of healthy individuals often produce an expert who is less biased towards the defense. The psychiatrist or psychologist who devotes his career to the testing of a wide spectrum of individuals looks and expects to see a normal person mirrored within the testing protocol. The expert who devotes his professional career to testing of inmates of a mental hospital looks and expects to find within the testing protocol, a mentally ill person.

Once a psychiatrist is chosen, case preparation is crucial. The risk of error in opinion making increases with greater limitations and information. All opinions are necessarily qualified by the accuracy and scope of material upon which they are based. Therefore, it is imperative for the deputy district attorney to make every bit of information regarding his case available to his psychiatrist. This includes each and every report, statements of witnesses, statements from members of the defendant's family, employment and school records, and anything else that bears upon the defendant's <u>behavioral history</u>. The need for obtaining as much valid material as possible about the defendant is obvious. Psychiatrists should also be provided with the reports and opinions of any other doctors who examined the defendant. They must read and know the testimony taken at the preliminary hearing, as well as the testimony of <u>all</u> witnesses at trial as reflected in a daily transcript or daily summary of testimony.

One of the most fruitful areas of information regarding the defendant which is often overlooked by the prosecution is the defendant's actions, behavior, statements and demeanor during and immediately after his arrest (in cases where the crime and arrest closely coincide). For example, in the Sirhan case, the defense psychiatrists painted a picture of a tremendously disorientated individual at the time he shot Senator Kennedy. On rebuttal, the prosecution successfully used statements and behavior of Sirhan immediately after the shooting which demonstrated a more aware and orientated mind.

Since the defendant's mental state is first placed in issue by the defense, the prosecution will commonly put their psychiatric expert on the witness stand in rebuttal. This permits the psychiatrist to have reviewed the testimony of the defense psychiatrists. It is now the duty of the prosecutor to most effectively conduct his direct examination.

The deputy district attorney should always be aware of his role in direct examination, namely, that of acting as a conduit through which the testimony of the witnesses is transported to the jury. In other words, the deputy district attorney in his direct examination is not acting as an active performer as he does in voir dire, cross-examination, and argument, but acts in the passive role in causing the witness to articulate and effectively paint a verbal picture for the jury. The better he can do this, the more convincing and effective will be his case.

Once the psychiatric witness is placed on the stand, the first order of business will be to qualify him in front of the jury. This can be done in either of two ways; first, the deputy district attorney may ask an opening question requesting the expert to qualify himself. In such a case, the psychiatrist will spend 5 to 7 minutes setting forth his background, training, and experience in a narrative fashion. The second method is for the prosecutor to have 5 to 10 key questions in the more important areas of qualification. Prior to placing the psychiatrist on the stand, the deputy district attorney should ask the way in which the expert himself wishes to proceed. As a general rule it is more effective to ask a series of questions, letting the expert proceed to qualify himself in selected areas rather than the uninterrupted narrative. The long narrative form often creates the impression that the expert is a bit boastful and arrogant.

The prosecution is not required and should not, as a matter of strategy, accept a stipulation to the psychiatrist's qualifications in front of a jury. Should the defense offer such a stipulation, the deputy district attorney might merely indicate to the court that he believes that it would be helpful for the jury to hear the doctor's qualifications.

Once having qualified the psychiatrist, the prosecutor will then begin to question the psychiatrist regarding his clinical examination of the defendant.

The deputy district attorney must initially build a structure of what was done in regard to this psychiatrist's contact with the defendant. The deputy should establish when and where the examination or evaluation took place; in what type of setting, how long, and who was present during any interview or contact with the defendant in the clinical environment. Questioning should then proceed to establish what other actions the psychiatrist initiated in making his clinical evaluation, i.e., psychiatry tests, medical examinations, neurological testing, etc. The psychiatrist should set forth as completely as possible his own preparation for giving an opinion. This would include enumerating the reports that were read, interviews with relatives or witnesses, consultations with other professionals in the same or related fields. After covering this basic structure, of <u>what</u> was done, the expert is then ready to express his opinion as to the particular mental state in issue.

It is at this point that many deputies run aground. It is a mistake for the lawyer on direct examination to leave his expert with a conclusionary opinion for this permits the cross-examiner to attack the opinion of his, the defense counsel's, own ground. The lawyer on direct examination <u>must</u> go forward after eliciting the opinion as to the particular mental state and have his expert substantiate and fortify his opinion with detailed information revealing the information upon which the opinion is based.

The lawyer on direct examination can most effectively do this by acting in a supportive role and directing the witness's answer from one area to another in filling the resevoir with reasons resulting in the ultimate opinion. The expert must define how various areas such as basic behavior patterns, demeanor and answers to questions in the clinical evaluation, results of tests, the actions of the defendant during the crime, positively correlate in giving rise to the ultimate opinion.

What the deputy district attorney is attempting to accomplish is to clearly illustrate to the jury that his psychiatrist's opinion is to be given more weight because his psychiatrist was better prepared, thus having a greater knowledge of the defendant and the crime and, therefore, is in a position to give an opinion which is clinically and professionally valid.

It is often helpful for the rebuttal psychiatrist to articulate why his opinion differs from that of the defense psychiatrist. If the defense psychiatrists have testified in terms of mental illness or psychiatric classifications as such, it might be helpful for the rebuttal psychiatrist to explain that what is really important is the degree of mental <u>impairment</u> as it relates to a particular mental state as opposed to mental illness in the treatment or therapeutic sense.

Above all, the professional witness should not react as an advocate or testify in a professionally biased manner. The

professional will only be effective if he remains in fact and appearance to be an objective and impartial friend of the court.

So long as the rebuttal psychiatrist has been thoroughly prepared and has been questioned properly on direct examination, the risk of damaging impeachment by the defense on cross-examination is appreciably lessened. If the prosecutor wishes the services of a professional witness, it is his professional duty to have afforded the professional all relevant information and to have reviewed the case with the psychiatrist before going to court.

CHAPTER X

CROSS-EXAMINATION

Effective cross-examination of defense psychiatrists and/or psychologists is essential if the prosecution expects to successfully challenge and controvert a diminished capacity or insanity defense.

Since psychiatry is such a specialized field, the deputy district attorney must not only become adept at the technique of cross-examination in general, but must be versed in the intricacies of psychiatric diagnosis and classification.

One of the attributes of an effective cross-examiner, whether he is cross-examining a lay witness or an expert, is curiosity and the ability to satisfy curiosity by intensive questioning of the witness. The purpose of cross-examination is, of course, to insure truth and objectivity by subjecting a witness's answers to an adversary in-depth "analysis" by the opposing attorney. The curious cross-examiner is effective in this regard since he is reluctant to accept a witness's answers at face value and insists upon explanation and substantiation.

The cross-examination of a psychiatric witness presents unique problems: the psychiatrist is a highly qualified professional who is generally extremely articulate in expressing an opinion which he believes to be clinically and ethically correct. Because of his professional qualification there is a danger that

the deputy district attorney will be tempted to accept the psychiatric opinion without rigorously subjecting it to the testing process of cross-examination. Since the prosecutor will rarely encounter fabrication or untruthful testimony from the psychiatric witness, the district attorney's method in cross-examination will be to show why the ultimate opinion may lack reliability or validity by attacking any weakness in the underlying basis for the opinion.

An adequate discussion of psychiatric cross-examination first requires a discussion of some of the fundamental reasons why psychiatric testimony is vulnerable within the trial setting. The first part of this chapter will set forth four areas which tend to create a lack of reliability on the part of psychiatric-legal opinions; not because the expert witness himself is inadequate or vulnerable, but because of fundamental conflicts in philosophy and definition. Only by appreciating these basic differences can the deputy effectively apply his technique of cross-examination.

I. Vulnerability of Psychiatric-Legal Opinions:

A. Philosophical Conflict

The psychiatrist as part of the medical profession has an ingrained philosophy directed toward therapeutic and treatment goals. When the psychiatrist is called upon to apply his science to legal ends within the justice system, he often feels that he is

violating a basic medical precept, primun non nocere, (above all, do no harm to the patient). This promotes considerable conflict for many psychiatrists resulting from a clash between what they consider their traditional professional ethics and their duties in forensic psychiatry which are directed to the values of the legal system. This conflict results in a bias which is apt to subvert the objective application of psychiatry for courtroom purposes.

Another basic philosophical conflict faced by the forensic psychiatrist is his predisposition to "find" illness. Just as it is more dangerous in the criminal law to convict an innocent person than to acquit a guilty one; likewise, in the medical profession it is more serious to mistake illness for health than vice-versa. In other words, a mistake in medical judgment-making that is carefully avoided is misconstruing disease as health in not recognizing illness in a person who is actually ill; but on the contrary mistake, namely, that of misconstruing health as illness is not so serious an error. This fundamental medical policy is based upon the greater value accorded to the suspicion of illness than health. The medically trained individual accepts the burden of disproving illness as a condition of establishing

the patient's state of health. This is apt to give rise to a subconscious bias on the part of the psychiatrist that tends to conflict with a basic precept of the criminal law, namely, that most individuals possess the ability to exercise free will and choose between alternative courses of action.

B. Legal v. Psychiatric Definitions

The bias resulting from the above philosophical conflicts creates a reluctance on the part of psychiatrists to accept what to them may be a much too stringent legal definition of mental illness. The law as dictated by social policy considerations, not psychiatric policy considerations, sets a much higher threshold for mental impairment leading to exclusion from criminal responsibility than is acceptable to many psychiatrists. The psychiatrist's opinion is vulnerable and lacks reliability when he fails to recognize and understand that social policy (law) determines the definition of legally significant behavior as well as the threshold levels of this behavior.

The legal system and the psychiatric profession define mental illness and the various classifications of mental illness according to their own goals and purposes. Considerable difference exists between the

two professions with respect to threshold levels of mental impairment that define mental illness. The threshold for mental impairment as determined by psychiatric values is molded by therapeutic and treatment goals and is quite low. The legal threshold for mental impairment as determined by social policy considerations is much higher.

This definitional problem in differentiating the legal from the psychiatric meaning of terms can be illustrated in the area of diminished capacity. For a defendant to be guilty of murder in the first degree, he must be found to possess, at the time of the criminal act, the mental capacity to maturely and meaningfully premeditate, deliberate and reflect upon his act and upon the gravity of its consequences. Similarly, he must be found to possess a level of mental capacity to reflect upon his intent to kill or seriously injure as well as to possess the mental capacity to appreciate his obligations to conform his actions in accordance with the duty imposed by law, (malice aforethought). The term "maturity",when considered for purposes of exclusion from criminal responsibility under the legal definition of diminished capacity, does not carry the same significance as this term holds psychiatrically. Exclusion from the category of first degree murder on this legal basis <u>does not</u> require that

"maturity" connote the fullest psychiatric maturity. The concept of "mature" premeditation, deliberation and reflection, carries legal connotations of a threshold level of maturity that allows for the presence of discernible mental problems in the mature mental state. The psychiatric threshold level for immaturity is considerably lower than the high threshold of legal immaturity; the level of emotional and mental immaturity for treatment purposes is exceeded long before the level of mental immaturity for legal purposes is reached. Were this not so, every defendant charged with homicide would be exculpated from murder in the first degree because such persons could be demonstrated to possess emotional or psychiatric maturity in less than the full sense.

Along the same lines, psychiatrists tend to equate mental illness with legal diminished capacity. However, the clinical classification of any psychiatric disorder, per se, carries little weight with respect to proving the legal issues of mental illness. A psychotic defendant may be delusional, hallucinating, or suffering from other manifest psychotic symptoms, but, unless these symptoms can be shown to impair his mental functions as these relate to a particular legal capacity, the defendant's impaired mental state will not have any probative value, and the psychiatrist's opinion will be vulnerable in court.

C. Psychoanalytic Bias:

A revolution in psychiatric philosophy and approach occurred in the 19th century as a result of the writings and teachings of Sigmund Freud. Basically, Freud believed that one's conscious motivations and actions were in great part due to the functional structure and output of the subconscious mind. Many doctors complete medical school and qualify as psychiatrists by studying and resolving mental illness through an adherence to Freudian psychoanalytic technique. Acceptance of the philosophy of "subconscious mind control" insures that any examined conduct is diminished by definition. A psychiatrist steeped in psychoanalytic training and technique is prone to trace a man's every deed to some cause beyond the actor's own meaning and says that although the man is aware of his actions, he is unaware of the assembled sources in his subconscious or unconscious which determined his course of action.

Within the legal framework, an emphasis on unconscious motivations is often in conflict with overt actions and behavior of the accused, thus exposing an area of vulnerability regarding the psychiatric opinion.

D. Inadequate Basis for Psychiatric-Legal Opinions:

When dealing with insanity or diminished

capacity issues, the law asks the psychiatrist to examine a defendant after his criminal act, and then to give an opinion which must be expressed within the legal definitional framework. This opinion may lack adequate basis for the following reasons:

1. The psychiatric opinion is often based upon a reliance on a clinical evaluation whereby knowledge is gained by an intuitive interpersonal experience between the psychiatrist and the defendant.

   Although the clinical evaluation may be a psychiatrically valid approach, it is often vulnerable within the legal framework since interpretation will oftentimes widely differ between psychiatrists. The vulnerability may increase when the psychiatrist relies solely upon the clinical evaluation for his opinion without aid of neurological and/or psychological testing, or an examination of the defendant's behavior history, which might tend to corroborate or discredit his subjective diagnosis.

2. The level of reasonable medical certainty or reasonable medical probability again suffers when the psychiatrist must extrapolate his clinical findings regarding a defendant's

present mental state back to a previous period in time.

3. Should the psychiatrist rely on neurological or psychological testing in rendering an opinion regarding mental state, the tests themselves present a built-in inadequacy; namely, psychological tests have not been devised with the legal definitional goal in mind. In other words, the test themselves do not, as such, test for "legal capacity" or knowledge of "right or wrong". The tests at best give a valid personality profile upon which the psychologist or psychiatrist must interpret. The test results are only circumstantial evidence that is subject to varying interpretations.

The above four areas, as well as many others that are not covered above, do not represent a criticism of the psychiatrist as such. The problem areas illustrate the difficulty in "mixing" law and psychiatry within the trial setting. On the one hand problems are created by an incomplete knowledge and approach of the legal objective (legislatively determined threshold of behavior) on the part of the psychiatrist. Likewise, problems result by requiring psychiatrists to make a moral judgment, i.e., whether a defendant knew the difference between right and wrong, when he is trained and qualified only to express psychiatric opinions.

II. Approach and Technique:

A psychiatrist's opinion regarding a defendant's mental state must, by definition, be based upon the information which is either made available to the psychiatrist or that which the psychiatrist seeks out himself. Fundamentally, this information comes from two areas: the first by raw source material in the form of neurological and/or psychological tests, statements of witnesses, police reports and material bearing on the defendant's prior behavioral history as shown by school records, employment records, etc.; the second basic area being information derived by the psychiatrist based upon his intuitive findings in the clinical evaluation with the accused.

The most that can be said of any psychiatric opinion is that it is psychiatrically valid based only upon the available information and only to the extent that this information is correct. Consequently, the approach of the prosecutor in cross-examination will be to show that the information upon which the psychiatrist based his opinion is either incomplete or incorrect or both.

The prosecutor's first task, then, in preparing for cross-examination, is to review the reports of the psychiatrist in determining upon what he based his opinion and to listen and take notes during the psychiatrist's direct examination. The prosecutor on cross-examination will then be in a position to confront the psychiatrist with additional relevant information bearing upon the defendant's behavior and ask the psychiatrist whether his

opinion is changed by the additional information. This puts the psychiatrist in the position of either defending his opinion at all costs in the face of additional and contradicting information or stating his opinion would be changed in the face of this additional information, in which case his original opinion is weakened.

The various areas discussed below illustrate some of the specific approaches that can be taken in challenging the basis of the psychiatrist's opinion.

A. Additional Information Regarding Defendant's Mental History

It so often happens that the defense psychiatrist will only be versed in the recent behavioral history of the defendant as it relates to the crime in question. The conscientious deputy may find that the defendant has been previously examined by another psychiatrist or psychologist in his past. If this is the case, the prosecutor is in an excellent position to confront the psychiatrist with this additional information that was not made available to the defense psychiatrist.

To illustrate:

Q. BY MR. CARR, D.D.A.: Doctor, you knew that the defendant has been up in the State Prison for some period of time, did you not? In connection with this matter?

A. Oh, yes.

Q. And you knew, did you not, at that time that there are psychiatrists attached to the State Prison staff?

A. I have been so aware, yes.

Q. And did you check or contact the State Prison medical staff at all as to what records they had concerning the defendant?

A. No, I did not.

Q. In connection with your conversation with the defendant, did he mention a Dr. Schmidt, a psychiatrist at San Quentin with whom the defendant had talked?

A. He may have. This sounds somewhat familiar.

Q. Are you acquainted with Dr. Schmidt?

A. No, I am not.

Q. The psychiatric fraternity of which you say you are a member has various directories, does it not, of specialists in psychiatry in Southern California.

A. Nationally it does.

Q. Did you look in the director to determine the qualifications of Dr. Schmidt

or anything at all about him?

A. No, I did not.

Q. As far as other studies were concerned by possibly other doctors, psychiatrists, you read Dr. McGinnis' report but not his testimony at the previous trial, is that right?

A. That's correct.

Q. You heard about Dr. Schmidt or you may have heard about Dr. Schmidt but you made no inquiry of the medical department at San Quentin concerning the defendant?

A. That's correct.

Q. Now at the time you made the examination of the defendant he was incarcerated in Los Angeles County Jail, was he not?

A. Yes.

Q. Now was it in this building or was it over in what is sometimes called the New Jail Building?

A. I believe it was in the Central Jail. The new jail.

Q. All right. Now, you know that there is maintained over in the whole county jail

system a rather extensive medical department?

A. Yes.

Q. Do you know Dr. Marcus Crahan who is the head of that medical department?

A. Yes.

Q. Did you have any conversation with Dr. Crahan to determine whether or not they had any medical records, either psychiatric, mental or physical records as far as the defendant was concerned?

A. I did not. As psychiatrist for the defense I have been made to understand at the jails that the jail hospital records are not available to me under those circumstances. They have not been regularly, so I did not.

Q. Who made that understood to you?

A. The jail personnel.

Q. Did you talk to Dr. Crahan?

A. No.

Q. You know that Dr. Crahan is the Medical Director over there?

As can be seen by the above cross-examination, the deputy district attorney has accomplished two purposes:

he has by inference impeached the opinion of the psychiatrist by showing that he (the psychiatrist) did not seek out and avail himself of information that is obviously relevant; therefore, impeaching the basis of the opinion; and secondly, the prosecutor, eliciting the above responses, is setting himself up for effective argument since he can now state, based upon the record, that the psychiatrist's opinion is not entitled to much weight.

B. Reliance Upon the Defendant's Statements in the Clinical Interview

In the majority of the cases, the psychiatrist's opinion is based in large part upon a clinical interview with the defendant. At this interview, the psychiatrist receives the defendant's explanation of the criminal act as well as the defendant's explanation of his feelings and/or motivations during and prior to the crime charged. At the very least, the defendant's explanation is a biased one in which he is either consciously or subconsciously structuring his answers in such a way they are beneficial to him. At most, the defendant is telling an outright lie regarding his feelings and mental state during the criminal act. The deputy district attorney must inquire into what extent the defendant was believed by the psychiatrist and to what extent the psychiatrist made any

outside or further investigation tending to support the defendant's version. The psychiatrist may then be confronted with a series of questions in which he is asked that, assuming the defendant was not truthful in a particular area, would his opinion still remain the same?

To illustrate:

Q. BY MR. HOFFMAN, D.D.A.: All right. Now, wouldn't it be fair to say that a great deal of your opinion must necessarily be based upon what he told you?

A. Yes.

Q. And if he is lying to you, that would invalidate some of your opinion, at least; wouldn't that be fair to say?

A. Yes.

Q. In other words, you are like any other doctor, a psychiatrist or medical doctor who practices strictly in the more physical fields, you have to rely on the case history; right?

A. Yes.

Q. And if you get a patient that comes in, say, for a bad knee and keeps saying, "it hurts", and "it hurts", you are pretty much going to assume that there is

something wrong with his knee. And if he is lying, you are probably still going to assume it for quite a while? I mean, a doctor goes on a case history?

A. I lean heavily on information that I secure from the defendant.

Q. Right.

This area of attack can be expanded by confronting the psychiatrist with statements that the defendant made to others which are inconsistent with statements he made to the psychiatrist at the clinical interview.

To illustrate:

Q. BY MR. FITTS, D.D.A.: To the investigators who preceded you, and perhaps to you, he lied about going to the Ambassador on Sunday, didn't he?

A. Yes, I knew about that.

Q. Well, you were interested I suppose in why he lied to the other people and then told you about it?

A. Yes.

Q. Why do you suppose he lied to the other people?

A. Because he did not trust the other people.

Q. He trusted you?

A. Not completely, but he had already been caught in that lie and thought I knew.

Q. How had he been caught in that lie?

A. I don't recall now, but I knew ahead of time that he had and that Sirhan knew.

Q. Do you suppose somebody had told him through the process of discovery that the prosecution had witnesses who had seen him there on that night? Do you think that is what changed his mind?

A. I have no knowledge of that. I don't know.

Not only should the psychiatrist be confronted with statements that the accused told others which are not consistent with the statements told the psychiatrist, but also the psychiatrist should be confronted with the statements of witnesses which conflict and are not consistent with the psychiatric diagnosis. In other words, in making diagnosis, the psychiatrist in the clinical interview must differentiate the information received from the defendant; accept some of the information as true, reject some of the information told him by defendant as untrue. If the deputy district attorney determines that the psychiatrist has accepted some information as true, but there exist statements of

other witnesses to the contrary, this can be used effectively in the cross-examination. This places the psychiatrist in a position of acknowledging the other statement which might tend to weaken or alter a psychiatrist's opinion. If the psychiatrist refused to accept the witness's statement, he is then placing himself in the position of arbitrarily and capriciously rejecting a possibly valid statement.

To illustrate:

Q. BY MR. FITTS, D.D.A.: With reference now to the things that you knew, did you know at the time that you interviewed Sirhan that at sometime after the death of Martin Luther King, on a Wednesday, that Sirhan, in a political discussion with a trash collector named Alvin Clark, had said in those circumstances: "Why are you voting for him? I am going to kill that s. o.b.", or words to that effect?

A. I read that testimony.

Q. You didn't know about that until this trial started, is that true?

A. No, I did not.

Q. Was that Sirhan in a disassociative state speaking or was that the usual Sirhan speaking?

A. I do not believe he said that, sir.

Q. Well, the witness testified to it from the stand.

A. I think the witness was incorrect.

Q. Is that a polite word for saying that the witness was lying?

A. No. It is just that he was incorrect.

Q. And the basis for your belief -- You did not see the witness on the stand?

A. No.

Q. You did not know anything about the witness except for the statement which you read?

A. No.

Q. You weren't here when he was present, testifying?

A. I prefer to believe Sirhan.

Q. Why do you prefer to believe Sirhan?

A. Because Sirhan's information is consistent with a large number of other things that he told me. This particular witness's story is not consistent. I think it is quite possible that the witness wasn't correct.

Q. Now, you told us yesterday that throughout your interviews with Sirhan, when he was his usual aware self, that there was a sort of a war going on between the two of you?

A. Yes.

Q. You have told us that from the first to last he was uncooperative with you. Is that right?

A. Yes.

Q. There is no question in your mind that Sirhan was consciously selecting certain material to give you and consciously withholding other material because he did not trust you?

A. Yes, that is correct.

The psychiatrist in the above examination placed himself in the untenable position of passing upon the credibility of a witness who had testified under oath. By doing this, he has, of course, confused his function with that of the jurors.

C. Actions of the Defendant as they Relate to Mental State

In analyzing the criminal case from the standpoint of diminished capacity or insanity defense, the attorney must keep in mind the basic proposition that

one's behavior and actions reflect or mirror his intent. Most psychiatrists will agree with this basic principle that one's actions reflect in large part his existing mental state. However, this basic principle does not hold true if the individual is truly psychotic. If the prosecution is proceeding on the theory that the defendant was not psychotic at a particular time, then an effective approach to cross-examination is to confront the psychiatrist with the defendant's actions showing purposeful and "step-by-step" behavior leading to a foreseeable result. By confronting the psychiatrist with each of the defendant's purposeful actions leading up to the crime, the deputy district attorney is illustrating to the jury inferentially that the defendant was aware and oriented sufficiently to carry out meaningful activity leading to a foreseeable result.

Even though the psychiatric witness may disagree with your questions or may equivocate, this technique again places in front of the jury the facts pertaining to the criminal act as well as placing in front of the jury the prosecution's theory of presentation.

To illustrate:

Q. BY MR. HOWARD, D.D.A.: Well, I am not sure, doctor, but I will ask you if you heard the defendant testify that he

worked, that he left the Ambassador and he went to his automobile and he got in his automobile and determined that he was too drunk to drive, that he worried about car insurance and the possibility of an automobile accident and thereafter decided to go back to the Ambassador Hotel to get a cup of coffee to sober up and did you hear that portion of the testimony?

A. Yes, I believe I did.

Q. Does that indicate to you a diminished capacity?

A. It doesn't indicate a diminished capacity.

Q. Does it indicate a thinking capacity?

A. Of a kind.

Q. What do you mean by"of a kind"?

A. Well, it indicates that he was consciously aware of it, that he did not want to go out on the road and hurt somebody because he was in a state of mind, because of his apparent or alleged drinking that he might hurt somebody while intoxicated, so he decided "I have got to get coffee", meaning, I want to be sober, and that is

all it means to me.

Q. That is pretty reasonable thinking process, is that your statement under that hypothesis?

A. Reasonable as to what?

Q. As to the set of facts I gave you.

A. Reasonable in that he wanted to sober up?

Q. Yes. Reasonable considering the consequences of an accident without insurance.

A. Up to that point, yes. I had not thought of the insurance, but that would be reasonable.

Q. And it shows some type of thinking process, does it not, as a psychologist?

A. Yes. There is some logic to that up to that point.

Q. Well, does it break down at some point?

A. Yes, it does.

Q. Where, right after I have given you those four facts?

A. I don't know exactly where the breakdown is but the last thing he consciously remembers is re-telling of the story he has got to get some coffee, and from that point on he can't recall.

Q. Will you stick with the facts that I have given you for the purpose of this cross-examination and may be up to what point would you say that it was pretty reasonable thinking?

A. Well, for this man it would be exceedingly good thinking.

Q. Well, for any one it would be pretty reasonable thinking?

A. For any man that would be normal thinking.

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Q. BY MR. HOFFMAN, D.D.A.: All right. Now, as he assaulted him with a 1969 Buick, don't you think, in your opinion, it might have crossed his mind that running over him might kill him? Don't you suppose that might have gone through his mind there?

A. Well, as I testified, I felt that the state of his mind at that time was not such as to permit the calm, rationality that you suggest in your question.

Q. Well, I am trying not to suggest that. I am going to ask you though and try to

get it directly responsive to what I ask. Don't you think that after the other man said, "Run over him", and he turned the car and went at least 200 feet from where he started and ran over him, that the thought at least crossed his mind that this may kill the fellow?

A. I felt that his state of mind at the time did not permit him to reflect, to consider, or to decide.

Q. Do you think it ever occurred to him as he approached the man with his 2-ton Buick that it might kill him?

A. I don't feel that his state of mind at the time permitted him to reflect or to consider or to decide.

Q. I guess your answer is no, then? You don't think that that thought crossed his mind?

A. I feel that the -- I mean to suggest the disorganization of thinking during the psychotic process, and the calm -- the orderly, meaningful progression of thoughts and consequences relating from actions is not inherent by people dur- a psychotic episode.

Q. I want to ask the same question: As he approached him with this 2-ton Buick, drove some 200 feet before he got to him, turned the Buick, ran over his chest with it, after the other fellow said, "Run over him", don't you think the thought ever went through his mind at least once that this may kill the man?

A. I don't feel in any meaningful sense -- (Objection by Mr. Hoffman) Discussion by the court personnel.

THE COURT: Will you answer the question "yes" or "no", please?

THE WITNESS: No.

Q. BY MR. HOFFMAN: Never entered his head that it might kill him?

A. No.

Not only is it fruitful to examine the psychiatrist on purposeful activity leading up to the crime as set forth in the above illustrations, but it is also fruitful to probe into purposeful activity of the defendant after the commission of the crime which might tend to show motive or consciousness of guilt. Actions that tend to show motive and consciousness of guilt inferentially establish that the defendant is and was aware of

what he had done and the fact that it was wrong.

To illustrate:

Q. BY MR. CARR, D.D.A.: Now, in picking up this knife -- when he told you of picking up this hunting knife, were you of the opinion at that time that he was dissociated, engaged in random thinking?

A. Let's say his thinking was disorganized and somewhat irrational, impulsive. He was not dissociated in the sense that -- that he did not know exactly what he was doing.

Q. Well, at one time, Doctor, I believe you used the words that he was "showing poor judgment".

A. Yes.

Q. Is that your opinion as to this conduct at that time?

A. Yes.

Q. Well, Doctor, a criminal, one who sets out about committing crimes, if he's subsequently apprehended hindsight shows us that he used poor judgment then, doesn't it?

A. May or may not.

Q. All right. Now, he went to the residence and I believe you indicated that in addition to being dissociated, irrational thinking, and so on, that in connection with the killing he panicked, is that correct, sir?

A. Yes.

Q. And I think that you also indicated that this panic state that he was in went on for some period of time, days, and you characterized his beating this man in Phoenix, Arizona, that had given him a ride from Vegas to Phoenix, as being part of the panic?

A. I would have to qualify that as reference to the panic, counsel. I do not and did not have that as a psychiatric term for an entity which existed, such as,for instance, a state of dissociation or being under the influence of unconscious mind. I'm using the "panic" to mean irrational, impulsive, random, relatively thoughtless behavior in a state of relative disorganization or lower functioning, in the sense of panicking and acting quickly and on impulse with poor judgment.

Q. Well, after the killing, he was engaged in trying to get away and hid from the consequences of that killing, isn't that right?

A. That's right.

Q. And is that a condition that is unusual as far as a person who commits a terrible crime is concerned?

A. No, not in itself.

Q. All right. Now, the killing occurred -- he's told you that he got blood on his clothing, didn't he?

A. Yes, he did.

Q. Now, after the killing, did he tell you that he went through the house looking for some clothing that he could wear in lieu of his bloody clothing?

A. Yes, he did.

Q. And he told you he found some clothing that he changed into?

A. Yes.

Q. Now, did he also tell you that he went through the house looking for money and valuables?

A. Yes.

Q. Did he also tell you that he took some jewelry and left some other so-called jewelry in the premises?

A. Did not speak of leaving any. He said that he took some.

Q. Well, did he say he took some? I'm using the word "some" s-o-m-e. Did he use the word?

A. Yes.

Q. Now, when someone says he took some jewelry, did you ask him whether or not there was any jewelry which he left behind?

A. No.

Q. Assume, Doctor, that the jewelry which he took amounted to approximately $3,000. in value and that what he left behind was what is referred to as costume jewelry, less valuable, would that still leave you in the same opinion that the defendant was dissociated, irrational thinking, and in a panic state?

MR. WALTON: Object to that on the ground the evidence does not really show that. Shows what he left behind also included the wedding ring and engagement ring, which is the most valuable of all the jewelry.

MR. CARR: I'm sure the --

THE COURT: Counsel has a right to include that in his hypothetical question. Overruled.

MR. CARR: Also forgot to include, Mr. Walton, what was on her fingers.

I don't think there's an answer to that question.

THE COURT: There is not.

MR. CARR: May we have the question?

(Whereupon, the last question was read by the reporter.)

THE WITNESS: I used the word "dissociated". I'll still have to say no, because of your inclusion of the word "dissociated".

Q. BY MR. CARR: Go ahead and answer the question.

A. No, he was not dissociated. The period that I referred to before as dissociated was from the time he blacked out, which he dated as of seeing the movement of Mrs. Doctors toward the telephone and at which time she had a knife in her hand. And from that time until he said he came to, at which time he observed the results of what he took to have been

his own action, her death, and the blood and so forth. That is the period of dissociation. The time from then on until his apprehension by the police and for some time thereafter would be a time that I referred to as being disorganized, also the time before this, from the affairs surrounding the pending of the love affair with Elizabeth which ended in arrest and incarceration, that he was at those times disorganized in his behavior, relatively disorganized and breaking down before.

And he remained in a disorganized state after the period of dissociation, that is, during his flight.

Q. Well, Doctor, you used in the early part of that answer the fact of his, the defendant's, seeing Mrs. Doctors with a knife in her hand. Did he at any time tell you that he was afraid of Mrs. Doctors because she had this knife?

A. No, his comment on that was that it reminded him of his mother flourishing a knife while talking to his father in their quarrels.

Q. So at no place in his statement to you did he indicate that he had stabbed Mrs. Doctors while the defendant, he, was acting in self-defense?

A. No, he did not so state.

Q. Now he did indicate to you while he was there on the premises that he changed his clothes from the skin out?

A. He did not so describe it, but I gathered from what -- or that he had changed most or all of his clothing, yes.

Q. And did he tell you that while there on the premises that he attempted to take the Doctors' automobile that was in the garage?

A. No, I think he did not.

Q. Did he tell you he was out in the garage at all after the killing?

A. Yes, I think he said that he threw some pieces of bloody clothing as he stated he had used -- had wiped in the blood some of his bloody clothing in a barrel in or near or beside the garage.

Q. When he talked about wiping he indicated the shorts were what he wiped or claimed to have wiped into the blood, didn't he, Doctor?

A. No, he didn't.

Q. What garments did he say he had wiped into the blood?

A. My impression was that he used several of his garments to wipe up blood and discarded them, as he described, at two or three places.

Q. Well, assume that at a previous time the defendant had stated that the shorts were the only thing that he had wiped in the blood. Would that still indicate to you that during this period of time that he was acting in a panic?

A. Yes.

Q. Now did he tell you that he had thrown some of these garments into the Doctors' automobile in the garage after the murder?

A. Into the automobile? No, counsel, he did not.

Q. Did he make any statement to you that he had endeavored to open the garage door?

A. No.

Q. Did he make any statement to you that he had taken the keys out of Mrs.

Doctors' purse to the automobile?

A. No.

Q. Did he tell you that he had taken any money, currency, out of Mrs. Doctors' purse?

A. I believe he stated that he took money but he didn't -- I don't remember that he said exactly from where he took it in the house.

Q. Did he tell you that this jewelry which he had taken was jewelry that he removed from one of the drawers rather than jewelry that was openly displayed, we'll say, on top of a dresser or some item?

A. No detail as to exactly where he got it.

Q. Now, Doctor, did he tell you -- strike that.

I believe you testified previously that he had stated to you that he had disarranged the clothes upon the body of the murdered Mrs. Doctors to create the impression that a rapist committed this murder, and thus throw investigation away from him?

A. Yes, he did so state.

Q. Did he tell you that he had done this before or after he had changed into the clothes that he took there on the residence?

A. Neither, counsel.

Q. Did you question him in that area?

A. No.

Q. Assume that he had done whatever it was that he did to the body of the decedent and to the clothes of the decedent before changing the clothes rather than afterwards, would that make any difference as to your opinion of his mental state?

A. No.

Q. Now, Doctor, did he tell you that he had subsequently left the residence there and gone back to the hotel room?

A. I believe he did.

Q. Did he tell you that he had gone over to a place in the general vicinity of the Doctors' residence and placed a phone call for a taxicab?

A. No, I believe not.

Q. Did he tell you that he waited approximately 20 minutes or so for a taxicab to come?

A. No, I think not.

Q. Let us assume that he did wait around for that period of time, for a taxicab to take him away from the general vicinity there, would that still indicate to you that he was operating in a state of panic? It's the time element I am trying to emphasize, Doctor.

A. I see no connection now to answer one way or the other, counsel.

Q. All right, now, let us assume that he got back to his hotel room and then took some of this clothing which he had stolen from the residence there, and proceeded to try to sell it and did sell it for 50 cents. Is he still in a state of disorganization, dissociation and panic?

A. Not disassociation, counsel.

Q. In a state of panic?

A. Yes, that sounds to me like behavior in a panic.

Q. You mean the selling of his clothing for 50 cents?

A. Yes.

Q. You don't find any profit motive in this killing then, do you, Doctor?

A. Yes, his intention was to get money.

Q. And his intention was to get money from the very beginning, wasn't it, Doctor?

A. Beginning of what, counsel?

Q. From the time that he decided to go over to the Doctors' residence?

A. No, I believe not.

D. Nature of the Mental State

The forensic psychiatrist is asked to examine a defendant and render an opinion as to a mental state which has been defined by the law, i.e., deliberation, premeditation, malice aforethought, and intent. A deputy district attorney, in cross-examining the psychiatrist, should delve into the definitional framework being used by the psychiatrist in applying these terms which carry a legal significance. It might be the case that the deputy district attorney may wish to later argue to the jury that the type of intent or other mental state which is in issue is not as complex as it has been made to seem by the psychiatrist.

To illustrate:

Q. BY MR. HOFFMAN, D.D.A.: All right. I think you indicated he was in such a condition at the time Silva was killed

that he couldn't have entertained a reasoned intent for any complex act. I think that was your diagnosis. Now, actually the intent to steal is not a very complex intent, is it, Doctor?

A. I would -- in my intention of making that remark, I would include the intent to steal as complex.

Q. You would categorize the intent to steal in the human mind as a complex intent?

A. Yes. The meaning I had in using the phrase was to include such organized behavior as complex in contrast to somewhat more automatic behavior such as driving. People who have driven are are able to drive in a severely intoxicated state, although they may not be able to reason, to exercise any judgment. If they could exercise any judgment, they wouldn't be driving.

Q. I just want to get it. You would categorize the intent to steal as a complex intent?

A. In the sense that I used the phrase earlier, yes.

Q. You wouldn't categorize it as a rather basic intent that even small children have the power to maintain?

A. I feel that it is a complex act.

Q. You think theft is a complex act?

A. In the sense that I have used the phrase.

Q. What sense do you use it in that it's different from the ordinary sense of theft?

A. There are some acts that are committed in a somewhat robot-like, somewhat automatic fashion. There are some that require more planning and organization, and I use the phrase complex for those acts that require somewhat more planning and organization.

Q. In your opinion, lifting a man's wallet would be a complex act?

A. That forming the intent to steal --

Q. Taking another fellow's wallet and taking off with it, you indicated that might be a complex act or intent?

A. What I'm suggesting is considering the act, reflecting upon it, coming to some decision about it and performing it is a complex function.

Q. Well, all right. Let's try the other one. How about the intent to kill, would you categorize intent to kill as a complex intent really?

A. I feel that forming the intent and committing the act represents a complex function.

Q. Did you ever watch a dog chase a cat?

A. Yes, I've watched a dog chase a cat.

Q. Did you ever see a situation where it was pretty obvious that the dog had an intent to kill?

A. Well --

MR. FLAHERTY: Your Honor, I'm going to object to this on the basis of relevancy. I don't see --

MR. HOFFMAN: I am exploring the nature of the complexity of intent to kill.

THE COURT: The witness is an expert in the field.

MR. FLAHERTY: I don't know what this has to do with dogs and cats.

Q. (BY MR. HOFFMAN): Let me reframe it. All I was going to ask you is this: Isn't it a fact that even an animal can entertain the intent to kill?

A. Animals can form the intent.

Q. All right. So, of whatever complexity, even an animal can entertain the intent under some circumstances?

A. Yes, a healthy animal can form intent.

E. Prior Criminal Behavior

Since the psychiatrist bases his opinion upon a consideration of many areas, including the behavioral history of the defendant, the deputy district attorney is able to question the psychiatrist regarding particular aspects of the defendant's prior behavior. It is fruitful to confront the psychiatrist with past behavior which is either criminal or antisocial in nature and ask him to explain that behavior in light of the pending criminal charges. By doing this, the deputy district attorney is inferentially showing that the cause of the defendant's crime is not a diseased or psychotic mind but rather because the defendant is sociopathic.

To illustrate:

Q. (BY MR. CARR, D.D.A.): We have a defendant here who in 1961, while in the naval service, issued a series of checks for which there were no funds in the bank.

That in your opinion the defendant knew that that was wrong at the time he did it, is that right?

A. Yes, he probably did.

Q. Now, that is a -- do you understand the act of securing money from someone or goods or merchandise from someone for a check that does not have any money to meet it constitutes, let us say, a form of theft?

A. In general I would so understand it.

Q. Yes. Now, theft or stealing is an anti-social act, is it not?

A. Yes, it is.

Q. And a person -- let us assume that you had not talked to the defendant at all, gotten his story about his family and so on, that would classify him basically as a sociopath, antisocial individual, is that right?

A. No, not necessarily.

Q. Let's go on to the next one, then. As a result of that issuing of the checks and the punishment he suffered therefor, he was released from the Navy, and within a few months thereafter, in 1961, he commits the civilian criminal offense of issuing checks without sufficient funds, and secures some money and/or merchandise,

you would likewise classify that as a form of stealing, an antisocial act, is that right?

A. Yes.

Q. Now, we have the appreciation of -- from the first one at least, that the crime has been committed and that there's a penalty that follows that. We have the second one that occurs. Without having talked to the defendant or received any knowledge at all concerning what the defendant tells us about his family, would you then classify the second one as falling within the category of antisocial acts?

A. The acts themselves are antisocial, yes, counsel.

Q. Now, as far as the person that commits those acts, do you classify him as a sociopath?

A. No, I would not from such meager information.

Q. I beg your pardon?

A. I would not from such meager information.

Q. Now, a sociopath is an antisocial individual, is that right?

A. By definition, yes.

Q. All right. Now let's go on. Let's take the second one.

Following the commission of the second act, he is again granted probation -- strike that "again", I'm sorry.

He is granted probation for that particular act, and then after approximately a year or less than a year he then enters into a person's home without their permission, takes without that person's permission, some blank checks, and using those blank checks forges the name of the individual in the residence and secures some money and/or merchandise from that.

Now, I think we are agreed, are we not, that that is a form of theft, first, of the taking of the checks without permission and then getting the money and/or the merchandise likewise, is that true?

A. Yes.

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Q. BY MR. HOFFMAN, D.D.A.: Doctor, how many times, in your opinion, does he

have to reenact the same kind of behavior before we attribute to him the intent to deliberately do what he does?

A. When you say "do what he does" --

Q. Well, he robs these people and beats them and, then, they die, and you indicate that there are two episodes that you have no intent to kill or steal. And how many times would he have to reenact this out before you would attribute that intent to him?

A. Well, there were numerous preceding occasions during which the assault was not fatal and, as I have been led to understand, there were occasions when no robbery was involved or, at least --

Q. Could you stop right there? Did somebody tell you that there was a time when he beat up a homosexual when there wasn't any robbery?

A. Yes.

Q. Who told you that?

A. Jack.

Q. He told you that?

A. (Witness nods his head).

Q. All right. Can you give us the details -- when and where it took place and who was present?

A. The details I can give are only that the first times that he participated in these pickups and harrassment, that there was no robbery involved.

Q. Did he tell you how long that was before the weekend that he took this other fellow out to 19th and Brookwood and, then, came back to the park and assaulted a man one week before the killings? Was that one week before that or how long was it?

A. Well, it would have had to be before that.

Q. Do you know how long before?

A. As I understand it, the first of such activities preceded the slaying of Mr. Silva by only several months. So it would be within the range of two to three months before.

Q. Did he tell you how many people he had assaulted before he got to Mr. Silva?

A. He enumerated a number -- I don't --

enumerated a sequence of events preceding the crime.

Q. How many?

A. Which to a greater or lesser extent he was involved in, sometimes as very inactive participant along with others.

Q. Well, how many times, inactive or active, did he tell you that he was involved or with a group that assaulted somebody before Silva?

A. I would put the number at approximately four or five.

Q. All right. Did he tell you that in some of these, no money was taken?

A. Yes.

Q. Did he tell you who was with him to verify the fact that no money was taken?

A. Well, there are a large number of different fellows involved at different times. And I didn't document the associates on each episode.

Q. So, then, he has told you not just about the two that we had evidence of here that preceded Silva? We only had evidence here of two. But he told you that there were others?

A. In which there were harrassments or ridicule or abuse of other individuals.

Q. Would it surprise you, Doctor, that in the course of investigating this case, no one has been able to discover any incident where there was not a robbery along with the beating?

A. It doesn't surprise me. It is not consistent with what Jack reported.

Q. What he told you?

A. To me.

F. Set

An area that should be explored by the deputy district attorney is the effect of the defendant's mental state during any clinical interview or psychological testing. The term "set" generally refers to one's mental disposition, general attitude, awareness, the person's readiness to respond or to think in a particular predetermined fashion. Many determinants will mold one's mental state at any given time. Certainly such things as pending criminal charges and custodial environment have an effect upon the defendant's mental state and any clinical evaluation or testing of the defendant is bound to be reflected in part by the environment in which the testing is taking place. The motivations of an accused person who is in custody and pending trial

will be much different than the same person's motivations would be if he were outside of the custodial environment. The cross-examiner should inquire of the psychiatrist as to how much this was taken into consideration in arriving at his ultimate opinion.

To illustrate:

Q. BY MR. FITTS, D.D.A.: With respect now to the difficulties that you had in communicating with Sirhan, the first time that you ever did this, of course, was on the 23rd of December, 1968. Isn't that right?

A. Yes.

Q. And that is something more than 6 months after the commission of the crime which occurred in the early morning hours of the 5th of June, 1968. Right?

A. Yes.

Q. And you were perfectly aware, of course, that before you got to him a number of people had attempted to elicit information from him?

A. Yes.

Q. Including his own lawyers?

A. Yes.

Q. Including investigators?

A. Yes.

Q. ....the story he gave you was obviously a structured one?

A. The first story I got was essentially the story everybody knew. I wasn't satisfied with that.

Q. And in his conscious state all of the stories that you got from him were constructured ones, and that in his aware state, his usual state?

A. What do you mean "constructured"?

Q. Let's consider the circumstances. You didn't have any doubt that Sirhan had access to reporters, talked with his lawyers, talked with investigators, knew what he was accused of doing, knew that he was facing a trial for a capital offense -- all these things are true, aren't they?

A. Yes. I certainly knew all of those things.

Q. And there is no question in your mind that in anticipation of the trial and the things that he knew of that sort, that he had adopted an attitude of what he was going to say and what he wasn't going to say?

A. Well, no, that was the difficulty....

III. Psychological Testing:

The assistance of psychological testing in a criminal case presents unique problems. Usually, only a psychologist is qualified to interpret the results of psychological tests, although the psychiatrist very often uses the psychologist's interpretations as a basis for his psychiatric opinion regarding the defendant's mental state. If the psychologist is testifying, the deputy district attorney should first determine whether the psychological tests were given by the psychologist himself or by one of his assistants such as a psychological social worker or technician.

When sanity or capacity is an issue, psychological testing may or may not have been done. If done, the expert who relies upon such tests may or may not in fact be qualified to use them. If they were properly administered and interpreted, and the expert who shows up in court is in fact eminently qualified to testify about their results, the tests themselves may be shown fallible.

So there are several ways in which the cross-examiner can proceed:

1. If the expert is a psychiatrist who used psychological tests to bolster his opinion, he may lack sufficient qualifications to do so.
2. If the expert is a psychiatrist who refused to

rely on psychological tests and failed to have them done, it may be shown, depending on the case, that psychological tests would have been valuable and could have provided an objective check on his own opinion.

3. If the expert is a psychologist, his qualifications (especially the number of years experience with each test administered) should be gone into. (You will find that the requirements for expertise on any given test in the literature surrounding such test are invariably stringent.)

4. If the expert proves to be sufficiently qualified in both administering and interpreting (the latter bearing a much higher standard) every kind of test administered, each individual test should be inquired of (and there is no lack of literature in the psychological publications attacking, if not demolishing, the usefulness of any given test.)

5. It would be rare that only one test would be given. Psychological tests are normally given in a "battery", to make up for the shortcomings of any individual test. When a group of tests has been administered, it will be possible, weighing the values and disadvantages of each test, to challenge the effectiveness of the group itself, on

the basis that it may comprise an incomplete combination of tests.

There are hundreds of psychological tests. Some (such as the Rorschach, the Word Association test, the M.M.P.I., the Thematic Apperception test, the Wechsler-Bellevue, and the Babcock Story Recall) are more commonly used than others, but there is no assurance as to which tests a given defendant will have been furnished.

It would be fruitless for any lawyer to spend a great deal of time learning about "psychological tests", because there are simply too many of them. Moreover, among the psychologists, few professional clinicians become recognized as truly "expert" in interpreting any one test. For a lawyer's purposes, it is more important to be able to locate the literature both pro and con on any individual test, so that he can bring out to the jury the recognized shortcomings of each test administered, and the possibility that its results were correctly interpreted.

I. Researching for Cross-Examination

In order to cross-examine a psychiatrist, a lawyer might desire to research certain areas of psychiatry or neurology and he might want to read what the medical witness himself has written in the past. To do this, the lawyer would go to the library of a medical school. There he would familiarize himself with an enormous set of books called the Index Medicus which is something like our own Index to Legal Periodicals, carrying listings by author and subject.

But as a general rule you are not likely to find much in a medical library to help prepare you for the cross-examination of a psychologist. Psychology, at least for these purposes, is not considered a branch of medicine. You would instead go to a graduate school general research library, bringing with you a copy of the report of the psychologist or psychiatrist listing the names of the psychological tests which were administered and relied upon.

There are several general reference works which can get you into the card catalogue and the main areas of research. There is a Dictionary of Psychology by J. P. Chaplin presently available in a Dell paperbound edition (1968) which includes common abbreviations, symbols, and statistical formulas used in psychology. One textbook often recommended is Psychological Testing by Ann Anastasi (1961). One of the most valuable is entitled Diagnostic Psychological Testing by Rapaport, Gill, and Schafer (Rev. edition edited by Robert R. Holt, 1970). The latter text is limited, however, to the Wechsler-Bellevue, Babcock Story Recall, the Sorting test, the Word Association test, the Rorschach, and the Thematic Apperception test.

Updating can be done by reviewing the psychological periodicals, including "The Annual Review of Psychology", "Psychological Bulletin", and "Psychological Abstracts". Be certain to consult Buros, "Mental Measurements Yearbooks", which, in addition to updating, provide comprehensive bibliographies on tests (Cf. 1938, 1941, 1949, 1953, 1959, 1965).

The lawyer will usually discover, in reading the literature about a specific test, that his work has been done for him. Not only has the test itself been discredited by psychologists, but even the research underlying the test has been attacked. Each test has opponents both as eminent and as vociferous as its proponents, perhaps more. In fact, by concentrating on weaknesses, the critics often overlook even compensating strengths of each others' tests.

Basic to an understanding of psychological tests is to realize that each test is designed to test <u>for</u> some mental quality or another. None really tests "sanity" as such. Therefore, in studying the field one should develop the habit of grouping tests with the others that test for the same mental factor.

For example, the Wechsler-Bellevue Scale is an intelligence test. It tests <u>for</u> intelligence. The Thematic Apperception Test tests <u>for</u> a picture of actual thought content, attitudes, and feelings of the subject. The Word Association Test seeks those verbal ideas which touch off conflicting attitudes. The Bender-Gestalt looks for organicity, i.e., brain damage or retardation. The Rorschach gets at ego stability. The M.M.P.I. obtains a description of the subject's personality type.

When properly put together in a "battery" several tests can support and supplement each other, and indicators in some of the tests may call attention to more subtle indicators in others which might otherwise go unnoticed. But the main reason

for using more than one test is that each is designed to reach some different aspect of the subject's mental life, and all must be viewed together to obtain a picture of the totality.

Once a specific test is understood in terms of what it tests for, its benefits and its limitations can then be understood. If the witness will admit to the propriety and usefulness of a known test which the witness failed to administer, it may be inferred that the witness was to that extent incomplete in his testing or fearful of the results. This would be particularly relevant where the quality such test examines for is of a type not specifically reached by any of the tests that were given.

While each individual test has its own weaknesses, certain objections crop up again and again in critical writings about psychological testing in general. Briefly, many objections cluster around the following points:

1. Tests seek to categorize people, when in fact people rarely fit into categories, and in so doing the "results" leave out, or read into, personality, to make the subject conform to the test.
2. The problem of replication: While great pains are taken to administer the tests under standardized instructions and conditions, the results of the test depend upon the subjective interpretations of the person scoring. This

interpreting faculty is at basis artistic, and something which few professionals ever develop to a reliable degree. Of course, it also means that the same answers to the same test receive a different "score" depending on who is doing the scoring.

3. When results of several tests in a battery disagree, as commonly happen, the scorer has to resolve the disagreement, which can lead to overinterpretation and the interpreting of error variance. This is further complicated by the tester's bias to prove himself and justify his interpretations. Yet, if resolution is not attempted, the tester is left with two or more contradictory "explanatory" statements, only one of which can be "scientifically" true.
4. All tests are limited by the extent of the subject's compliance with the instructions. This can be hindered by the absence of any one of a number of factors: linguistic ability, good faith, ability to take directions, freedom from anxiety and situational stress, and so on.
5. There is seldom any follow-up to the battery. The results are not checked by repeated observations, confirmation, or consistency.
6. The role of the tester during the period of

actual testing is essentially passive. Performance relies upon the person tested and depends on his, not the tester's, skill. This raises the question, "Who is really in charge here?"

7. There is never any objective criteria which states that an answer means such and such. This lack of agreement about the validity of objective criteria, like so much of this whole area, takes you ultimately back to the artistic (rather than automatic) nature of psychological interpretation.

A psychologist might even be made to cross-examine himself, simply by asking him about some of the requirements and problems of testing in general. For example, if asked to explain the requirement of "identity of conditions of testing" he will defeat his own test, for when can the conditions of testing actually be identical to those of the model? The only way out is to relax the standard and say, "Well, the conditions really don't have to be identical." But to that extent, the tester is relinquishing control over variables, and the test becomes that much less "scientific".

The same holds true with common problems in responses on the part of the subject tested. Thus, the psychologist-witness should be asked to explain such concepts as malingering, blocking, (especially in regard to the Rorschach), "resorting to cliches", (especially with the Thematic Apperception test),

"coarctation" (meager and inhibited responses) and "dilation" (over-production of responses). Once a witness has been pinned down to the possibility of such problems, they can be used effectively; for when will there ever be a consensus as to what comprises a cliche, or the exact amount an examinee should come up with, (no more and no less), or whether he could be malingering? The jurors can be made to realize that it is their common sense against that of the witness in many areas.

CHAPTER XI

BASIC NOMENCLATURE OF MENTAL DISORDERS

INTRODUCTION

While there are several kinds of therapy now in use, and disagreement exists about their relative effectiveness, psychiatrists do, by and large, adhere to certain diagnostic categories of mental illness. The American Psychiatric Association, located at 1700 - 18th Street, N.W., Washington, D.C., through its Committee on Nomenclature and Statistics, publishes and updates a "Diagnostic and Statistical Manual" for mental disorders which sets forth a nationally accepted standard nomenclature of mental disease. In 1968, the 2nd edition (DSM-II) was published with the major additions of emphasizing the importance of diagnosing mental retardation whenever present, regardless of cause, and encouraging the use of multiple psychiatric diagnoses in order to account adequately for the clinical picture.

For purposes of reading psychiatric reports and understanding psychiatric testimony, the trial lawyer should have a basic knowledge of what these categories signify. Each diagnosis of a psychiatrist is based upon his observation of certain clusters of behavior traits presented by his patient. A diagnosis, therefore, is merely descriptive, and not a theory as to why a patient behaves the way he does. The psychiatrist's observations include

both that which is furnished in the content of the patient's story, and the manner and process by which the patient relates the story itself.

This section will attempt to summarize the components of the diagnostic categories included within the following major groups of psychiatric disorders:

I. Mental Retardation

II. Organic Brain Syndromes

III. Psychotic Disorders

IV. Psychoneurotic Disorders

V. Personality Disorders

This section will not deal with the other major groupings of Sexual Deviations, Addictions, Psychotic Disorders of Old Age, or Psychophysiologic Autonomic and Visceral Disorders (which includes psychologically-initiated reactions in the organs of the body such as neurodermatosis, myalgios, bronchial spasm, hyperventilation, vascular spasms, peptic ulcer, migraine, colitis, spastic colon, etc.). Nor will this section review the so-called transient situational personality disorders, such as gross stress reaction or the adjustment reactions of infancy, childhood, adolescence and late life. Diagnoses falling within these groupings will be more rare to the prosecuting lawyer and when they arise should be researched as a specific medicolegal problem.

In this connection, the trial lawyer should be aware of the Psychiatric Dictionary by Leland E. Hinsie, M.D. and Robert Jean Campbell, M.D. (N. Y., Oxford University Press, 1970) a

continuing work now in its 4th edition.

Since theories as to the causes of mental illness are as varied and obscure as the theories of treatment, the causative factors as well as therapeutic techniques involved in a particular case must be approached in terms of the particular psychiatric "school" to which the psychiatrist adheres. Where the cause of the mental disorder is believed to be a physical condition (for example, mental retardation and various organic brain syndromes), the condition will be noted with a separate diagnosis in addition to the one specifying the mental disorder.

In summary, this section is intended only as an introduction to the language most psychiatrists use in discussing the way certain types of people behave. Discussion here is limited to those groupings which occur most often in the psychiatric reports submitted in connection with criminal proceedings where there is a triable issue as to sanity or capacity.

DIAGNOSTIC CATEGORIES

I. MENTAL RETARDATION

Under DSM-II, the diagnostic classification of mental retardation relate to IQ as follows:

MENTAL RETARDATION	IQ
Borderline	68 - 83
Mild	52 - 67
Moderate	36 - 51
Severe	20 - 35
Profound	Under 20

The diagnosis of mental retardation is not made solely on the basis of IQ. Such factors will also be evaluated as the patient's developmental history and present functioning, academic and vocational achievement, motor skills, and social and emotional maturity.

The condition of mental retardation may be associated with the entire organism or an organ system other than the central nervous system. If so, it will be coded additionally in the specific field affected. For instance, mental retardation may be the result of residual cerebral damage from intracranial infections, serums, drugs, or toxic agents (e.g., congenital Rubella, syphilis, toxoplasmosis, encephalopathy); or the result of trauma or physical agent (e.g., encephalopathy due to prenatal, birth-process, and postnatal injury); or the result of metabolism, growth or nutrition disorders (e.g., cerebral lipoidosis, porphyria, and galactosemia); those associated with gross brain disease (postnatal) which are not secondary to trauma or infection; those due to unknown prenatal influence, chromosomal abnormality, prematurity, (those retarded patients who had a birth weight of less than 5.5 pounds and/or a gestational age of less than 38 weeks at birth and who do not fall into any of the preceding categories); and mental retardation following psychosis or other major psychiatric disorder in early childhood when there is no evidence of cerebral pathology. (This final category requires good evidence that the psychiatric disturbance was extremely severe. DSM points out, for example, most retarded young adults with residual schizophrenia

should not be classified here.)

Psychiatrists feel that people may suffer from mental retardation where they have been culturally deprived (just as they can be intellectually deprived). These cases are categorized as "mental retardation with psycho-social (environmental) depreviation", and are categorized either as "cultural-familial mental retardation" (here, degree of retardation is usually mild) or as "associated with environmental deprivation", (this type more severe and may result from severe sensory impairment otherwise rich in stimulation).

II. ORGANIC BRAIN SYNDROMES

Organic disruptions of the brain result in behavioral responses or syndromes characterized by impaired memory, judgment, and orientation for time and place, and particularly by lability and shallowness of emotional response. Those disorders caused by or associated with impairment of brain tissue function are usually divided into those which are acute and those which are chronic.

ACUTE - In general, this category refers to those due to or associated with:

a. Infection (intracranial and systemic)

b. Intoxication (drug, alcohol, or poison should be specified; and any acute hallucinosis or delirium tremens would be noted)

c. Trauma (specify trauma)

d. Circulatory disturbance (cardiovascular disease

should be noted as additional diagnosis)

e. Convulsive disorder (manifestation such as epilepsy should also be indicated)

f. Disturbance of metabolism, growth, or nutrition

g. Senile or pre-senile brain disease

h. New growth (intracranial neoplasm)

CHRONIC - Usually, those due to or associated with:

a. Prenatal (constitutional) influence (Principally: Congenital cranial anomaly, congenital spastic paraplegia, Mongolism and prenatal maternal infectious diseases)

b. Infection (Principally: Central nervous system syphilis and intracranial infections other than syphilis)

c. Intoxication (including Korsakov's psychosis and alcoholic paranoia)

d. Trauma

e. Circulatory disorders

f. Convulsive disorders

g. Disturbance of metabolism, growth or nutrition

h. New growth

i. Unknown or uncertain cause (Includes multiple sclerosis, Huntington's chorea,

Pick's disease and other diseases
of a familial or hereditary nature)

In general, the acute brain syndrome has a sudden onset but is usually temporary and reversible. Such a patient may present motor disturbances such as tremors or picking at imaginary objects. He may appear physically ill and be sweating profusely. His thought and communication patterns will be characterized by disorientation, impaired memory for recent events, disorganized and rambling speech or perseveration upon a fixed idea, inability to think in abstract terms, and shallowness of affect. The content of illusions, delusions, hallucinations and dreams often revolves around the patient being threatened by people or events over which he has no control.

The chronic brain syndrome, on the other hand, results in relatively permanent, irreversible brain damage. It progresses by gradual deterioration to a state of vegetative existence. Criminal sexual behavior, such as child molestation, often accompanies the chronic brain syndrome. In fact, any anti-social impulses, previously controllable, may become unmanageable because the brain is here undergoing broad organic change.

Certain patients may have an organic brain syndrome yet not be psychotic. If so, the diagnosis of organic brain syndrome (OBS) will be preceded by the term "Non-psychotic".

These syndromes are all dealt with in greater depth in the section on psychological testing and electroencephalography technique.

III. PSYCHOTIC DISORDERS NOT ATTRIBUTED TO PHYSICAL CONDITIONS

The term "psychotic" refers to those patients whose chaotic and bizarre behavior is evidence of personality disintegration. The psychotic disorders fall into four diagnostic categories:

a. The Involutional Psychotic Reaction

b. The Affective Reactions
(manic depressive, psychotic depressive)

c. The Schizophrenic Reaction
(simple, hebephrenic, catatonic, paranoid, acute undifferentiated, chronic undifferentiated, schizo-affective, childhood, and residual types)

d. The Paranoid Reactions

1. "Involutional Psychotic Reaction". People (mostly women) who experience depressive or paranoid reaction between the years of 45 and 60 may be evidencing this reaction, even though they have had no previous history of psychiatric illness. Such individuals are usually of the compulsive personality type. Differentiation from other psychotic reactions with onset in the involutional period is, of course, difficult and a reaction should not be inferred merely on the basis of the patient's age at the time of occurrence. Two specific syndromes here are Involutional Melancholia (where the patient, typically, complains of extreme agitation,

hopelessness and worthlessness, and the patient may show delusions centered around his own moral or legal guilt and deterioration of his bodily organs) and Involutional Paranoia (in which the delusions are dominated by anger and recriminations toward members of the patient's family).

The involutional psychotic patient, whether primarily depressed or primarily paranoid, must be considered by the psychiatrist as actively suicidal and treated accordingly.

2. Major Affective Disorders (affective psychoses)

A. Manic Depressive Illnesses

This group of psychoses is characterized by extreme depression or elation as a single mood disorder whose onset does not appear causally related to any precipitating life experience (and is therefore distinguishable from psychotic depressive reaction and depressive neuroses.)

Marked by severe mood swings, with a tendency to remission and recurrence, the manic depressive illness is classified by whichever aspect usually predominates, the manic type (elation, or irritability, overtalkativeness, flights of ideas, increased motor activity) or the depressive type (mood depression, perplexity, mental and motor inhibition). The category of "manic depressive illness, circular type" is

reserved for those cases where both phases are mixed or continuously alternating, and also for other varieties of manic depressive illness such as manic stupor and unproductive mania).

Pre-morbid history will usually indicate such patients have had mood swings throughout their lives, and both reactions (the hopeless depression and the euphoric recoil from it) may occur during the course of a single psychotic episode, though the diagnosis here does not depend upon the appearance of both phases in the course of an attack. Depression occurs more frequently than manic states. And in the depressive state, suicide should be viewed as an ever-present danger.

B. Psychotic Depressive Reaction

Severe depressions occurring in the absence of a history of repeated depressions or mood swings of psychotic proportions (and frequently in the presence of environmental stress at the onset) may be placed in this separate category even though the symptomatic features of the manic-depressive reaction, depressed phase are presented. If reality testing or functional adequacy are not seriously impaired, then these are properly classified as depressive neuroses.

3. Schizophrenia

The group of psychotic disorders (formerly termed dementia

praecox) which are marked by a strong tendency to retreat from reality and from interpersonal involvement, bizarrely regressive and unpredictable behavior, flat and inappropriate emotional response. Hallucinating and altered perception is a common feature, along with highly illogical thought and speech patterns, including word invention. The schizophrenias are primarily reflected in thought disorder (as opposed to the affective illnesses which are dominated by a mood disorder.

A. Schizophrenia, Simple Type

The characteristic symptom here is emotional withdrawal from other people. Delusions and hallucinations are rare with this type. The patient's history shows a gradual deterioration and progressively hermit-like life pattern.

B. Schizophrenia, Hebephrenic Type

Giggling, silly mannerisms and behavior, along with delusions (often somatic) characterize this type. The regressive behavior is intermittently interrupted by sudden, inexplicable rages, and then the patient returns to his usual giddiness. Delusions and hallucinations, if present, are transient and not well organized.

C. Schizophrenia, Catatonic Type

The characteristic of this subtype is the patient's alternatingly increased and lowered musculature, conveying mood by the body through posturing,

gestures, immobility or exaggerated movements, excessive movements, excessive motor activity and excitement. Through mutism he may shut off all external stimuli. Or he may repeat everything anyone says to him (echolalia) or imitate movements and postures he observes in others (echopraxia). He may repeat his own statements or actions over and over (called verbigeration and stereotypy). The common quality of all such behavior is that it represents the patient's complete giving up of his own identity and taking on that of his environment. Catatonic schizophrenia is frequently distinguished between "excited" (violent motor activity) and "withdrawn" (inhibition, mutism, negativism, inflexibility) subtypes.

D. Schizophrenia, Paranoid Type

Autistic thinking, primarily composed of fantasies of persecution and/or grandeur characterize the mental life of this type of patient, while his behavior remains hostile and aggressive. The onset frequently occurs suddenly, during the patient's late 20's and early 30's. Other characteristics include excessive religiosity, sexual fears (often homosexual), grandiose schemes, hypochondria, extreme jealousy and suspiciousness. There may also be an elaborate

delusional scheme of omnipotence, genius, or special ability.

E. Acute Schizophrenic Episode

As with the catatonic and paranoid types, the onset here may be sudden, resulting from a panic-inducing event. The wide variety of schizophrenic symptoms often clear in a matter of weeks, although they may recur. If the reaction progresses, it usually does so into one of the other definable reaction types.

F. Schizophrenia, Chronic Undifferentiated Type

Patients presenting mixed schizophrenic symptomatology beyond that of the schizoid personality but not classifiable as any other type of schizophrenic and whose symptoms tend to be chronic are placed in this category.

G. Schizophrenia, Schizo-Affective Type

This type, representing a mixture of schizophrenia with manic and depressive mood swings, often has its onset during adolescence. With recurrences the affective feature tends to abate and to be replaced by hebephrenic, simple, or paranoid symptoms.

H. Schizophrenia, Residual Type

This diagnosis is applied to patients who have improved considerably after a schizophrenic episode but retain residuals of their psychosis. It is

also applied to cases viewed as in a state of relative remission or improvement between psychotic episodes.

I. Schizophrenia, Latent Type

Patients having schizophrenic symptoms but no history of a psychotic schizophrenic episode. Such disorders as "incipient, pre-psychotic, pseudo-neurotic, pseudopsychopathic, and borderline schizophrenia are included.

4. Paranoid Reactions

Separate from those reactions classified under schizophrenic reaction, paranoid type, are Paranoia (a rare disorder featuring an intricate, complex and slowly developing paranoid system isolated from normal consciousness without hallucinations and with relative intactness of the remainder of the personality) and Paranoid State (which includes paranoid delusions but lacks the bizarre fragmentation and deterioration of the schizophrenic reactions).

Paranoid states are distinguished from schizophrenia by the narrowness of their distortions of reality and by the absence of other psychotic symptoms.

IV. PSYCHONEUROTIC DISORDERS

Today, the term "neurosis" is used interchangeably with the term "psychoneurosis", although it originally referred to any

somatic nerve disorder (what is now called "neuropathy") or disorder of the nerve function. Neuroses differ from psychoses in that only a part of the personality is affected, language remains usual, the unconscious is expressed only symbolically (rather than directly, as it often is in psychoses) and instead of exhibiting gross distortion or misperception of reality through delusions, hallucinations, and illusions, neurotics exhibit anxiety taking the forms of specific fears and avoidances, memory disturbance, unwanted thoughts, troublesome impulses, sexual disturbances, instinct inhibitions, feelings of inferiority, sleep disturbances, and so on.

In DSM-II, neuroses are listed in the following classes:

Anxiety neurosis

Hysterical neurosis (conversion type and dissociative type)

Phobia neurosis

Obsessive compulsive neurosis

Depressive neurosis

Neurasthenic neurosis

Depersonalization neurosis

Hypochondriacal neurosis

Other neurosis

More than one of these patterns will be found in most patients, so that overlapping and mixed psychiatric pictures are common. In fact, "normal" people may possess them to varying degrees without being properly classifiable as "neurotic".

A. Anxiety Neurosis

Formerly called "anxiety state", this diffuse, indefinite kind of reaction is characterized by a free-floating irritability or anxious expectation which looks to attach itself to any suitable stimulus. Common dangers such as snakes or heart disease are exaggeratedly feared, and this condition is to be differentiated from normal apprehensiveness or fear. Commonly associated somatic symptoms are: nausea, sweating, blurring of vision, dizziness, hyperventilation, muscular rigidity (which may result in headache, backache, stiff neck), fatigue - in fact, any or all of the bodily systems. Concentration suffers since the patient is preoccupied with his state of apprehension.

B. Hysterical Neurosis

The so-called hysterical personality is generally histrionic or flamboyant in behavior. Cognition is impressionistic rather than technical or detailed. While the hysteric gives an initial impression of warmth and responsiveness, he is in reality quite egocentric, frigid, and manipulative. Flirtatiousness, provocativeness, dependency, and suggestability are concommitant features. The hysteric tends not to feel like a very substantial human being

with a real and factual history, and often complains of feelings of weightlessness and floating.

1. Conversion Type

   Anxiety feelings are here replaced by a somatic symptom consisting of a functional loss of a motor or sensory activity in a given organ, body part, or cutaneous area. These disturbances are called conversions because the anxiety is literally converted into the bodily dysfunction with the result that the anxiety is diminished or disappears altogether. The symptoms (ordinarily symbolic of the underlying mental conflict) will be specified as anesthesia (anosmia, blindness, deafness), paralysis (paresis, aphonia, monoplegia, or hemiplegia), dyskinesis (tic, tremor, posturing, catalepsy). This type of hysterical neurosis must be distinguished from psychophysiologic disorders, which are mediated by the autonomic nervous system; from malingering, which is done consciously; and from neurological lesions, which cause anatomically circumscribed symptoms.

2. Dissociative Type

   In this type, alterations may occur in the

patient's state of consciousness, or his identity. Here, the repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expressions (e.g., depersonalization, multiple or dissociated personality, stupor, fugue, amnesia, dream state, somnambulism, etc.) which will also be specified in the diagnosis. Personality disorganization is gross here and may appear psychotic. Differential diagnosis is extremely difficult here, especially with the malingerer seeking to avoid the consequences of antisocial behavior.

C. Phobic Neurosis

In this process, anxiety becomes detached from a specific idea, object, or situation in the daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear which may then be avoided.

Common fears include syphilis, dirt, high places, enclosures, open areas, animals, and blood. The specific object feared (and hence avoided) will be indicated in the diagnosis. Usually only one or two fears are utilized, but some patients are pan-phobic. Panphobic patients are often incipiently schizophrenic.

While phobias may be found in other diagnostic categories, the phobic neurosis diagnosis should be reserved for those patients who have minimal anxiety when they are not exposed to the specific situation which they fear. When confronted with that particular situation, however, the intensity of anxiety and its characteristics is like those described under anxiety neurosis.

D. Obsessive Compulsive Neurosis

Patients in this category are marked by extreme cleanliness, neatness, cautiousness, orderliness, economic and emotional frugality, argumentativeness, stubbornness, ritualistic behavior, and prone to ruminate on a single topic to the exclusion of all others. Magical and superstitious thinking is also characteristic. The diagnosis will specify the compelled rituals, such as touching, counting, ceremonials, hand-washing, or recurring unwanted thoughts (accompanied often by a compulsion to repetitive action).

E. Depressive Neurosis

The difference between neurotic and psychotic depression lies in the degree and depth of the depressed mood. The neurotic reaction is a response to a current, acute situation, frequently some loss sustained by the patient, (as of a love object), and is often associated with a feeling of guilt over past failures

or deeds. Unlike patients with psychotic depressions, these patients are able to work although with much discomfort. Psychotic symptoms, such as thought disorder, hallucinations, or delusions, are absent.

F. Neurasthenic Neurosis

A psychophysiologic nervous system reaction characterized by hypersensitive emotional debility having such symptoms as: chronic weakness, malaise, fainting, low blood pressure, fatigue, hypersensitivity to light and noise, dizziness, cardiac manifestations, inability to use the bodily organ employed in the course of patient's occupation, and vasomotor instability. Differs from hysterical neurosis in that patient is here genuinely distressed by his complaint, rather than enjoying any side benefits (secondary gain) from the illness.

While the constitution is disordered here, the causative factor is emotional stress and thus the neurotic element is the more important from the standpoint of management.

G. Depersonalization Neurosis

A non-specific syndrome in which the patient feels estranged from his self, body, or surroundings; that he has lost his personal identity and is somehow different, strange, or unreal. Derealization (the feeling that the environment is also strange and unreal)

is usually part of the syndrome. It commonly occurs in the third and fourth decades and is more common in women. The patient may also complaint of "numbness" or "deadness" of the brain, swaying feelings, fears of collapse, or loss of self-control in public. DSM-II states, "A brief experience of depersonalization is not necessarily a symptom of illness."

H. Hypochondriacal Neurosis

Somatic overconcern and morbid attention to the details of one's body functioning, with exaggeration of symptoms. If the patient uses reaction formation as a defense, hypochondriacal concern may ultimately be expressed in a total neglect of his health and well-being. This condition differs from hysterical neurosis in that there are no actual losses or distortions of function.

I. Neurosis, Other

Under this classification will come all reactions considered psychoneurotic and not elsewhere classified, and also for incomplete diagnosis, but not for "mixed" neuroses. Includes occupational neurosis (such as "writer's cramp").

V. PERSONALITY DISORDERS

The personality disorders are diagnostic categories referring

to people whose life-long difficulties are evident in their relationships with other people in patterns recognizable by the time of adolescence or before. In DSM-I (the 1952 revision of psychiatric nomenclature), these were grouped under three headings: personality pattern disturbance, personality trait disturbance,and sociopathic personality disturbance. The distinguishing characteristic of these people is that their illness breaks out in their ineffective and unsatisfying interpersonal relationships rather than in neurotic or psychotic symptoms. They experience minimal subjective anxiety and little or no sense of continuing distress, though their life-long behavior pattern has been maladaptive and provoking of undesirable counterreactions. The following classification is according to DSM-II (1968 revision of psychiatric nomenclature):

1. Paranoid Personality

   Very much like schizoid (infra) personalities, but with these people the main theme of their interpersonal relationships is oversensitivity. They carry grudges, are extremely jealous and suspicious, and always expect rejections. They accuse others of their own (the paranoid's) faults and mistakes (projection mechanisms). Their thinking is rigid, devoid of humor, and without rejecting or denying facts, they pay attention only to those features which lend confirmation to their original suspicious idea.

2. Cyclothymic Personality (Affective Personality)

The personality of the cyclotheme is the exact opposite of the schizoid's (infra). Warm, ambitious, enthusiastic, cheerful, at times even elated. But he is prone to mood-swings (though not of psychotic proportions.) There are some who almost always display mild elation and there are others who normally exist in a mild state of depression. If a psychosis develops it will be, not surprisingly, an affective disorder rather than schizophrenia. Diagnosis may specify whether predominant mood is depressed, hypomanic, or alternating.

3. Schizoid Personality

Shy, withdrawn, seclusive people who avoid close or competitive relationships with others may be schizoid. Other inherent features of this type of personality are autistic thinking, day-dreaming, and a preference for the inner life over social relations. They are incapable of expressing direct hostility or even ordinary aggressive feelings. Eccentricity often occurs. May react to set-backs and stress with apparent detachment.

4. Explosive Personality

Also called the "epileptoid personality", this type is characterized by explosive outbursts of emotion and extreme rage reactions when frustrated, and a tendency to a kind of morose egotism. Fantasies of death and rebirth are more common here than in any other illness. The gross outbursts of rage may

be verbal or physical, and the patient may be amnesic for them or regretful and repentant. It is the intensity of the aggressive outbursts and the individual's inability to control them which distinguishes this group.

5. Obsessive Compulsive Personality (Anankastic Personality)

Such individuals show excessive concern with conformity and adherence to standards of conscience. They may be over-inhibited, over-conscientious, over-dutiful, rigid, indecisive, unable to relax. This disorder may lead to an obsessive-compulsive neurosis, from which it has to be distinguished. Distinction may be made on the basis that here there is no evidence of disturbing obsessions or of consuming compulsive rituals.

6. Hysterical Personality (Histrionic Personality Disorder)

This type of individual is marked by theatricality, suggestibility, excitability and tendency to over-react. Their self-dramatization is always attention-seeking and often seductive, regardless of whether the patient is aware of its purpose. Their interpersonal situations are often dependently demanding and immature. This disorder must be differentiated from hysterical neurosis (usually in that here there is no psychogenic loss or disorder in function).

7. Asthenic Personality

This behavior pattern is characterized by easy fatigability,

low energy level, lack of enthusiasm, marked incapacity for enjoyment, and oversensitivity to physical and emotional stress. This disorder must be differentiated from neurasthenic neurosis.

8. Antisocial Personality (Psychopathic Personality)

This type of person is irresponsible, emotionally barren, impulsive, but superficially charming. Their relationships are brief, as the other partner gains insight into the psychopath's behavior. They live by their wits, and both lie and cheat without any qualms of conscience. They never seem to learn from experience, but move from one disastrous outcome to the next, quite unconcerned about long-range goals. They are incapable of commitment to any other person, job, ideal, or goal. "Group delinquent reaction of childhood or adolescence" and "social maladjustment without manifest psychiatric disorder" should be ruled out before making this diagnosis.

9. Passive-Aggressive Personality

This type of individual is adept at controlling and manipulating others by being passive and helpless. Such behavior often arises from resentment at failing to find gratification in a relationship upon which the patient is overdependent. It manifests itself in such ways as obstructionism, accidents, pouting, procrastination, inefficiency and stubbornness.

10. Inadequate Personality

While this type of patient is neither physically nor mentally deficient, he responds to demands (emotional, social, intellectual, physical) in a way which is ineffective. He lacks judgment and/or stamina sufficient to meet the demands.

11. Other personality disorders of specified types (immature personality, passive-dependent personality, etc.)

12. Unspecified personality disorders.

CONCLUSION

It should be remembered that while the foregoing is by and large the official classification system of the American Psychiatric Association, diagnostic labels as applied to an individual are the product of the diagnostician's interpretation. Different psychiatrists may diagnose differently the same individual based on the same clinical data. The trial lawyer is equally free (given the same data as the psychiatrist admits to having been limited) to reasonably argue the more apt application of other diagnostic categories, thus attacking the very underpinnings of the psychiatrist's testimony. Since symptoms generally overlap, and few people can be fitted neatly into any one exclusive category, the opportunities to attack a particular diagnosis will be frequent. To a lesser or greater extent, most people possess within their personalities some traits representative from almost every category.

CHAPTER XII

ORGANIC BRAIN DAMAGE

INTRODUCTION

Nothing is more disconcerting to a prosecutor than to find upon reading a psychiatric report, that that defendant has some signs of organic brain damage. Most trial attorneys have had some experience with psychiatric reports whose conclusion regarding the state of mind of the defendant is based almost entirely upon a psychiatric interview. As a layman, the attorney tends to look upon the conclusions formed from such a meeting as being vague, insubstantial and largely subjective. Consequently, when he receives a report whose conclusions are opposite to those he has already reached, he approaches the trial with a positive and confident attitude, secure in the belief that he can make substantial inroads into the positive assertions of the report.

In view of this attitude it can readily be imagined that the trial attorney suffers considerable shock in reading that the usually subjective conclusions of the psychiatrist, which are often viewed as pure speculation by the layman, are now corroborated with actual physical findings to the effect that the defendant's brain is not all that it should be. The attorney instinctively realizes the jury is prone to give far more effect to the conclusions of psychiatrists when they are backed up by concrete evidence of brain damage. It is

because of this latter fact that more attention should be given to these cases, in making the jurors realize that these findings are far from conclusive on the issue of legal insanity or diminished capacity and that in fact they may have no bearing on the defendant's state of mind at the time the crime was committed.

The following chapter will be an attempt to orient the reader to certain theories, terminology and procedures with respect to neurologically oriented psychiatry. It is not an attempt, of course, to be a complete treatment for space would hardly permit that. The conclusions stated herein have been discussed with a great number of psychiatrists and neurologists and represent as far as is known the latest findings in the field. A great number of texts have been consulted but in all cases the conclusions herein expressed have been checked out as still valid. However, despite these precautions, the field is one that is rapidly growing and ever changing. The validity of the statements herein will vary inversely with the period of time that lapses between this writing and the actual trial to which they are applied. Therefore, a consultation with experts should be conducted in every case prior to trial to eliminate the possibility of new findings that modify what is contained herein.

It should be borne in mind that no disease mentioned is automatically a form of insanity and is not presented as such

unless it is otherwise stated to be so. In dealing with the nervous system of the human body, one must realize that he is of necessity dealing with the human mind which by its nature is variable and responses to given situations will not always be the same. There are different variations upon the standard response in almost any given case in either brain damage or drug ingestion. A severe head trauma in one person may cause serious brain damage, while the same blow in another may cause little or no damage at all. Therefore, the reader must expect to find variations from the norm in neurological diagnoses. For instance, tranquilizers tend to have sedating or tranquilizing effects on the human mind. Some people react adversely to tranquilizers and they have a reverse effect. They may cause a stimulant-like effect which would give rise to the supposition they they were either an agitated drunk or using amphetamines.

As will be seen below, many times an epileptic will have seizures without any discernible evidence of brain damage and on the other hand, there are persons with the type of electroencephalographic report that would indicate seizures who are perfectly normal. It should be borne in mind, however, that since these atypical variations are relatively infrequent, an idiosyncratic effect should not be accepted based upon one occurrence. Repeated verifying procedures should be indulged in by the physician to substantiate his suspicions. It should at all times be borne in mind that the

conclusions regarding the defendant's mental state at the time of the commission of the crime, the psychiatrist or neurologist is dealing in probabilities only. There is no such thing as a one to one correspondence between a particular symptom and legal insanity and diminished capacity. All a psychiatrist can do is to reason backward from the symptoms that the defendant exhibits at the examination to said mental state. With respect to organic brain damage it is true, as it is with respect to purely functional disorders, that the behavior of the defendant during the commission of the crime is a far more reliable index of his state of mind at that time than any subsequently performed psychiatric or neurological procedure.

It is particularly important to have a basic understanding of the limitations of legal conclusions derived from neurophysiological data when it comes to cross examining a psychiatrist. A psychiatrist who is neurologically rather than analytically oriented will tend to be more hesitant to conclude that the defendant is insane or unable to form a specific mental state. Generally, such a psychiatrist will require some physical finding to corroborate what he suspects in an interview before so concluding. While this operates to the prosecutor's benefit, there is a corresponding tendency to relate any neurological defect that is found to the defendant's behavior, thus unconsciously indulging in the logical fallacy known as post hoc ergo propter hoc, (a happening which follows another must necessarily be its result.)

When such a defect is found, neurologically oriented psychiatrists have a natural tendency to go overboard in attributing the crime to the said defect. Because of this it is necessary on cross-examination to particularize the psychiatrist's findings and to expose the gaps in his reasoning. The cross-examiner must lay bare all possibilities that are not articulated on direct examination and force the psychiatrist to ascribe to each possibility its appropriate weight. To do this a basic understanding of neurological terms, neuroanatomy, and of organic brain disease is essential. Furthermore, it is necessary to understand as precisely as possible the nature of those tests that are performed upon the defendant to determine whether or not such neurological defect exists. Particularly important are the limitations of these testing procedures, what they can show and what they definitely do not show. In testifying for the defense, most psychiatrists will be asked questions which present that side of the picture which is most favorable to their conclusions. They will often not be asked questions regarding the limitations of either their tests or of their opinions. It is the function of a prosecutor to force the psychiatrist on cross-examination to supply these deficiencies. It is toward the acquisition of sufficient knowledge to do this effectively that this chapter is intended as a beginning.

PHYSIOLOGY OF THE NERVOUS SYSTEM

A knowledge of the brain, its various parts, their locations and functions is completely essential for the trial attorney. (Refer to Figures 1 through 3 on following page). Not only is it valuable for interpreting psychiatric reports and testimony but a basic understanding forms a framework upon which to place new items of knowledge uncovered in each specific case that is tried. The basic anatomical unit of the brain is called a neuron. (Figure 1.) This is one cell that is composed of a cell body, a long filament called an axon which usually conducts impulses away from the cell body and dendrites which are numerous very fine filaments emanating from the cell body in a branching pattern and whose usual function is to receive impulses from other neurons. The cell body itself, as well as the dendrites, serves as a terminal for incoming impulses.

The brain is covered by a rind-like structure called the cortex. (Figure 3.) The cortex is composed largely of cell bodies with very few axons. The cortex, only a few millimeters thick, is folded and refolded upon itself so that a maximum area can be contained within the confines of the skull. These folds form furrows and ridges. Technically, the furrows are called sulci and the ridges are called gyri. Each major gyrus or sulcus in the brain is assigned a name. Aside from these differentiations the brain is divided into two hemispheres, the left cerebral hemisphere and the right cerebral hemisphere.

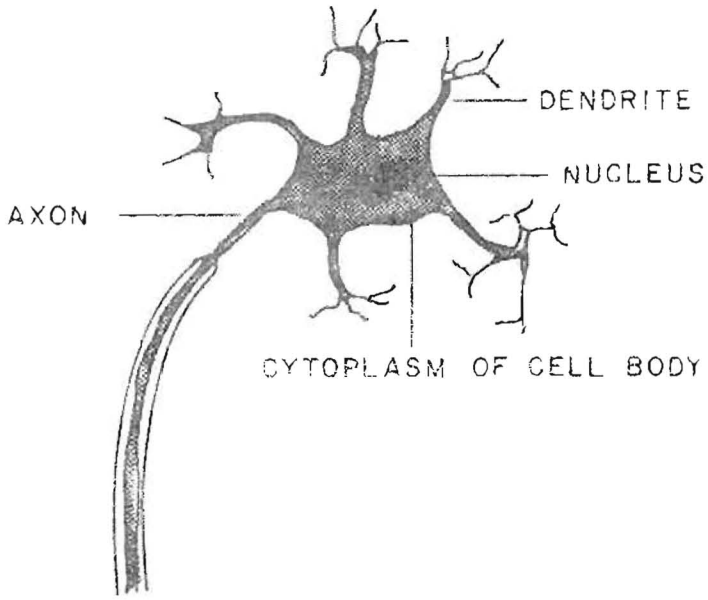

FIG. 1 - NEURON

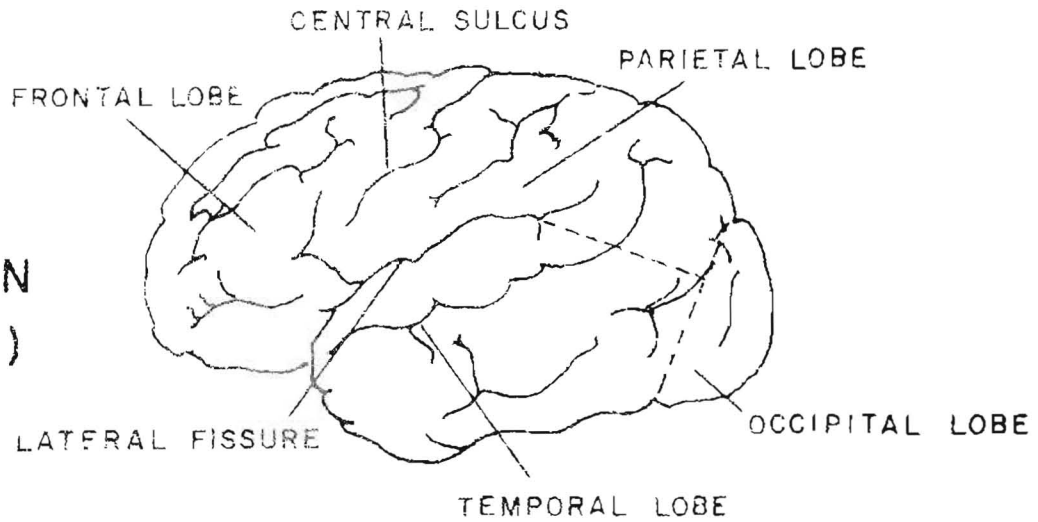

FIG. 2 - HUMAN BRAIN
(SIDE VIEW)

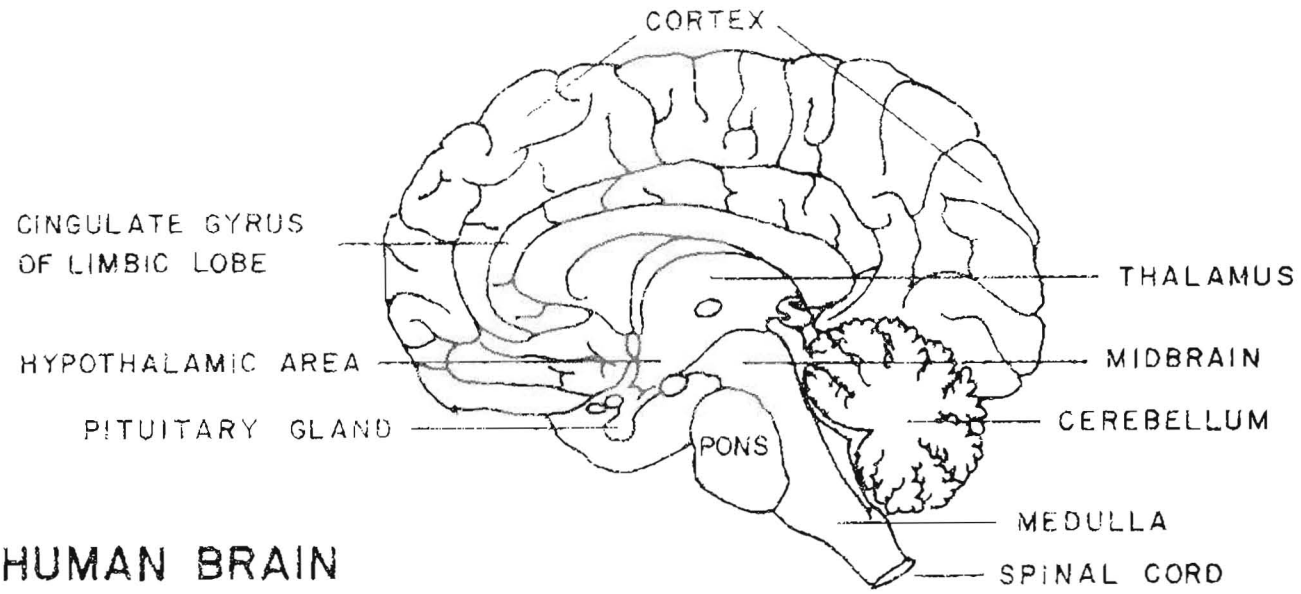

FIG. 3 - HUMAN BRAIN
(SAGITAL SECTION)

Each hemisphere in its turn is divided into four lobes, the frontal lobe, the occipital lobe, the temporal lobe and the parietal lobe. (Figure 2.) The topmost portion of the brain is called the cerebrum.

Beneath the occipital lobe is a structure that looks something like the cortex, but is a ball-shaped mass with much more finely spaced furrows and ridges. This structure is known as the cerebellum and is concerned with coordinating movements of the body. (Figure 3.) The cerebellum receives information from the muscles as to their state of contraction and as to the exact position of the limbs of the body. Furthermore, it coordinates this information with input from the auditory nerve regarding balance and the state of acceleration of the head. This organ has absolutely no function with respect to the high mental abilities and does not affect behavior except by coordinating it.

Beneath the cortex are various structures which serve as relay stations and receive nervous impulses from the spinal cord and from the cranial nerves. The spinal cord is well known even to the layman.

Cranial nerves are nerves which supply structures about the face and head with both sensory and motor fibers. These nerves do not pass through the spinal cord but rather innervate the structures they are responsible for directly

from the brain, passing through small holes in the skull known as foramen. The only value of cranial nerves for criminal purposes is that the severing or injury of one of these nerves and its consequent paralysis or loss of sensory function will corroborate the existence of an old basal fracture that might give substance to a claim of permanent brain damage.

A great deal of research has been done during the last eighty years in attempting to localize the various areas of the cortex with respect to their functions. To a certain extent, this has been possible. However, it should be borne in mind not only that some functions of the brain appear to be diffuse and scattered throughout the cortex, and that even as to those functions that have been localized there is a considerable amount of overlap and intermingling of function.

For the purposes of forensic psychiatry, the frontal and temporal lobes of the cortex are more important while the parietal and occipital lobes are less frequently involved. The occipital and parietal lobes are both essentially concerned with sensation. The occipital lobe is concerned with visual sensation and the parietal with other types. Despite the above statements, it should be noted that the temporal lobe has very important functions with respect to both the sense of smell and the sense of hearing. This accounts for the high prevelence of olfactory and auditory

auras preceding psychomotor epileptic attacks. The frontal lobe is generally thought of as being concerned with the higher intellectual functions including morality. If the superego or "conscience" can be localized, certainly it would be in this lobe. Damage to the frontal lobe can cause severe disturbances in personality and loss of control over one's behavior. It is important to note at this point, however, that such damage would have to be extensive since the aforementioned functions are apparently diffusely scattered throughout the anterior portions of the lobe.

While psychomotor epilepsy is essentially a temporal lobe phenomenon, as stated below there are documented instances of lesions in the frontal lobe causing this syndrome. While some aspects of "memory" are according to the latest research, scattered throughout the cortex, some of the most important functions with respect to memory are contained in the temporal lobe.

Beneath the cortex of the brain are a great number of bodies which serve as relay stations between the cortex and impulses arising from the cranial nerves and those coming from the spinal cord. The function of these centers is to integrate and elaborate such messages, quite frequently they have direct connections with the cortex. The most important relay station is the thalamus. An important structure called the medulla oblongata resembles a transitional phase between the spinal cord and the brain itself. This appears

as a thickening of the spinal cord at the point where the spinal cord enters the skull through an opening known as the foramen magnum.

The importance of the medulla oblongata is that it has centers for the control of respiration and cardiac activity. A subdural hematoma displacing a significant portion of the brain may press the brain upon this structure thus inhibiting respiration causing coma and death. Also, deeply imbedded within the medulla (as well as several other structures above it) is the reticular formation, which will be discussed in the section on the electroencephalograph. This structure is also known as the reticular activating system and it is responsible for awareness and concentration in the human being. It is this structure that apparently operates so as to cancel out the alpha rhythm upon eye-opening or concentration.

Also under the cortex and adjacent to the aforementioned relay stations in the brain are the ventricles. These are cavities within the brain that contain large amounts of cerebro-spinal fluid. The importance of these structures in diagnosing brain changes is discussed below.

It is important to recognize some of the terminology with respect to the membranes which cover and encase the brain, since bloodclots occurring within the skull are frequently designated with reference to these structures. Between the

skull and the brain itself, there are three membranes. The upper most is called the dura mater and is a leather-like tough structure immediately below the skull bone. When a physician refers to a subdural hematoma, he means a bloodclot that occurs below this membrane. Below the dura mater is a complex web-like structure called the arachnoid. This is a very filmy membrane but its importance is to suspend the brain and the external blood vessels servicing it. A subarachnoid hemorrhage would be below this structure. The last and least significant membrane for our purposes is the pia mater. This is at the very surface of the brain and adheres very tightly to it, conforming to its convolutions.

In setting forth this short summary of the neuroanatomy of the brain, no attempt was made to be complete. We have concentrated on those aspects of neurology which have some relevance to criminal forensic psychiatry. In each case in which the trial attorney encounters one of the structures described above, he should consult both competent medical advice and more detailed texts.

NEUROLOGICAL X-RAY EXAMINATIONS

When a psychiatrist becomes aware of certain symptoms of a defendant or of behavior during the commission of the crime that might be indicative of some sort of brain abnormality he generally will have the defendant examined through the use of various radiological techniques and also submit defendant to an electroencephalographic examination. A few of the more commonly used tests will be documented here in a short digestive form.

1. The Skull Series

The skull series is a routine X-ray of the skull. Usually three views are taken, one from the rear of the skull looking forward, one from the side and a third called a Towne's view which is from front to rear with the chin flexed on the chest. The value of this series is to visualize specific, internal skull structures. In these X-rays, the shape and integrity of the skull is exposed, the possibility of recent or old fractures is explored. Simple X-ray techniques have little utility in detecting changes in the soft tissue of the brain without the aid of additional procedures outlined below. Basically, hard structures are revealed. However, many brain tumors and diseased arteries become calcified in such a way that they show up in a simple X-ray technique. When this happens, abnormal pressures or restrictions on the blood

supply to various areas of the brain can be detected. Neurologists, however, upon seeing such indications will go further and have some specialized technique used to further delineate the extent of either the tumor of or the arterial defect.

2. The Brain Scan

This procedure is frequently used when some sort of lesion or tumor is suspected within the brain. A brain scan is performed by injecting a radioisotopic compound, then scanning the head with a moving camera to detect any unusual concentrations of this compound. Abnormal tissue within the head, in contrast to normal tissue, tends to absorb radioisotopic compounds and to emit radiation which is detectable by this means. A major drawback of this procedure is that one cannot generally differentiate mass lesions from other abnormal tissues such as tumors. The brain scan is more valuable than the X-ray itself, however, since no calcification of the tumor or lesion is necessary in order for it to be detected.

3. Cerebral Angiogram

In the cerebral angiogram, solutions that are opaque to X-ray are injected into the common carotid artery from which they flow throughout the larger blood vessels of the cerebral hemisphere. The blood vessels are then seen on X-ray examination and any abnormality in or around

these vessels may be noted. This procedure is particularly useful for detecting four types of defects. A narrowing of an artery can readily be seen. Also, an aneurysm or a bulging of the wall of a blood vessel becomes distinctly outlined. Defects of the brain which do not directly involve the blood vessels may also be noted. A tumor will distort the usual shape of these vessels while a lesion may interrupt them.

4. Pneumoencephalography and Ventriculography

These two procedures both involve injection of air into the cerebrospinal fluid. The brain and the spinal cord are both bathed in a clear, almost protein-free, fluid which serves to cushion these structures from impact and other physical disturbances. This fluid not only surrounds the brain on the outside between the dura mater and the surface of the cerebral hemispheres, but, also, is found inside the brain in cavities known as ventricles. The cerebrospinal fluid is invisible in an X-ray as are those surfaces which it outlines. The substitution of air for this fluid, however, enables the X-ray to outline the shape of both the cerebral surface and the ventricles. In cases where there is atrophy of the brain, not only will the furrows or sulci of the cerebral cortex become enlarged, but also the ventricles widen since the material surrounding them lessens in quantity. These findings are important in senile dementia, a condition frequently associated with

child molestation and murders arising therefrom as well as a condition called Alzheimer's disease (presenile dementia) which is a similar condition occurring in persons much younger. Presenile dementia generally begins in the forty's and while rare, it should always be ruled out in cases where a person of that age manifests behavior that is not characteristic of his usual personality.

In the pneumoencephalograph, air is injected into the cerebrospinal fluid in the lumbar region of the spine and allowed to rise to the head so that the subarachnoid space in the ventricles are filled. X-rays are then taken of the brain from various angles showing the outlines of these structures. In cases in which the patient has exhibited signs of abnormally high pressure in the spinal fluid, this procedure is not used but rather air is injected directly into the ventricles by the process of boring a hole in the skull adjacent to said structure.

Not only are these procedures valuable in detecting brain atrophy, but also other abnormalities of the brain may change the shape of the ventricles or of the surface of the cerebral hemispheres. A tumor in the brain may cause an indentation in the ventricles to accommodate the invading structure. It should be noted, however, that there is some variation in the shapes of these ventricles even in normal persons. Brain abscesses quite frequently

will have an effect on the ventricles although in a typical small temporal lobe abscess which might give rise to psychomotor epilepsy the ventricles would tend to remain in a normal shape.

The value of these procedures is not only in diagnosing present defects in the brain but knowledge of these procedures is valuable in those cases in which a psychiatrist claims that some previously existing condition due to either a blow or some disease process caused permanent brain damage the effects from which the defendant was still suffering at the time the crime was committed. It is important to examine the physician regarding his knowledge as to what procedures were engaged in to verify the extent of any damage at the time the condition was fresh. In addition to abscesses and tumors compressing the ventricles, sometimes a growth will obstruct the flow of cerebrospinal fluid so that it is trapped in the ventricle and does not leave said structure as readily as it should. It will result in severe pain to the sufferer.

THE ELECTROENCEPHALOGRAPH: ITS USE AND IMPLICATIONS

The science of electroencephalography may be defined popularly as the recordation and interpretation of brain waves. Although it is not known precisely what cerebral activity brain waves reflect, there are a number of theories that account for their periodicity. The brain wave can be obtained in two ways, either by using bipolar leads which compare the electrical activity at two different points of the brain or by monopolar leads which record the activity of one point alone. The EEG is taken by placing electrodes on the scalp. These electrodes are connected to a machine which records the brain waves on a graph, recording the reading of each lead separately. Typically, the electroencephalographic leads are placed one on each lobe of the brain in a stereotyped location. Generally speaking, it is correct that the electroencephalograph measures the electrical activity of only a few millimeters of the cerebral surface. Despite this fact, the activity of lower brain centers often is reflected in cortical recordings. Examples of this are as follows: (1) The desynchronization or blocking of the alpha rhythm which occurs due to the activity of the reticular formation. (2) According to one theory, delta waves (one to two cycles per second) appear to arise from the deeper regions of the brain, possibly from the hypothalamus. These waves tend to appear during sleep, but also appear from the cortex in areas where there is a substantial lesion or tumor.

For the purposes of criminal prosecution, as well as for neurological study, three types of waves must be distinguished and understood.

1. Background activity is the general continuous activity which is constantly present in the brain and is in contrast to any focal or paroxysmal activity. Background activity is of four types and are distinguished by the frequency of each wave. These four types of waves are not always present in normal persons, but in all persons whether normal or abnormal, there is some background activity upon which focal or paroxysmal activity may be superimposed.

   A. Alpha waves are eight to thirteen cycles per second, appear mainly in the occipital lobes in most normal persons and are cancelled by either concentration on a particular complex task or by simply opening the eyes if the person whose waves are being recorded. Complete absence of alpha waves does not indicate any pathology whatsoever. In fact, according to some neurologists, absence of alpha waves merely indicates that the patient exhibits a type of thought pattern which does not depend on visual imagery.

   B. Beta waves are greater than thirteen cycles per second. These waves come mainly from the frontal lobes and tend to be superimposed on the alpha rhythm in these lobes.

C. Theta waves are four to eight cycles per second. In normal persons, central regions of the brain tend to exhibit activity within this range concentrated at about 6.5 cycles per second.

D. Delta waves are less than four cycles per second and are definite indications of abnormal brain function in adults except during sleep. These waves may occur in perfectly normal children but are later outgrown.

With respect to brain waves as a whole, perhaps it is best at this point to define a few terms.

1. Amplitude. This term is synonymous with voltage and is a measurement of a particular wave's height from the lowest to the highest point in the wave.

2. Frequency. This term refers to the number of times a complete wave appears per second on the graph.

3. Spiking. The spike wave is one that is distinct from the background activity and has a duration of less than 80 milliseconds. A spike would therefore have a frequency of higher than 12.5 cycles per second. These waves are easy to distinguish because of their needle-like appearance. Recognition of these waves has

particular importance with respect to focal brain damage and also in the interpretation of artifacts (to be discussed below).

2. Focal activity is abnormal activity of a non-paroxysmal nature which is confined to a specific area of the brain. This can be spiking or a slowing of the waves that come from a particular lobe or a particular area of that lobe. While focal activity generally indicates an abnormality in that region it can easily be confused with artifacts.

3. Paroxysmal activity is the type of activity that is exhibited on the electroencephalograph during an epileptic attack. Furthermore, bursts of paroxysmal activity can be indicative of a tendency toward epilepsy, but not actually indicate a seizure in progress. Therefore paroxysmal activity can either be a generalized convulsion or intermittent abnormal activity which might even be localized in one lobe of the brain, but which is spasmodic in nature.

Evaluating electroencephalographic indications of abnormality

1. The electroencephalograph in juvenile cases. The electroencephalograph of a child may show a pattern which, if appearing in an adult, would be abnormal but falls within the normal range for children. The occurrence of

delta waves is the most obvious example. Most neurologists state that in order to impose a diagnosis of neurological impairment on a child based on an abnormal electroencephalograph, the examination must be repeated over an extended period of time. In children, very seldom are two separate electroencephalographic records compatible. Since, however, a normal pattern begins to emerge in a child at the age of fourteen, most juveniles who are charged with major offenses, will have begun to exhibit a more adult pattern. While this fact may appear to be of dubious utility, to a trial attorney in an appropriate case some reference can be made to these discrepancies in cross-examination to show the general unreliability of the electroencephalograph as a diagnostic instrument.

2. Electroencephalographic Artifacts. An artifact is a reading on the electroencephalograph that is not due to the electrical activity of the brain. An artifact may have a physiological source, that is be due to something in the physical makeup of the person tested or may be in the machinery. It may result from improper connection of electrodes to the skin and may even be due to outside disturbances. Below are listed some of the more common artifacts. This list is not intended to be exhaustive by any means. It should be noted in considering artifacts that not all of them will be confusing to the operator of the instrument or to the psychiatrist

interpreting the graph. A good example is a muscular artifact caused by opening the eyes. During the taking of a reading, the technician may wish to eliminate the alpha rhythm by causing the subject being tested to open his eyes at a particular point in the examination. The eye opening is due to muscular contraction and anytime a muscle is contracted in the head this would be recorded on the graph. However, if this eye opening artifact is immediately followed by a cancelling of the alpha waves which rhythm is re-established upon reclosing the eye, the cause of the artifact is readily ascertainable and can be ignored by the psychiatrist interpreting the graph. Bearing this in mind, a few of the common artifacts are as follows:

A. The electromyographic Artifact -- Electrical discharges from the scalp and jaw muscles will produce a rapid brain wave potential. High frequency filters in the electroencephalograph machine can attenuate the recording of these discharges.

B. The electrocardiographic artifact -- This is a particularly confusing artifact since it has a tendency to produce what appears to be spikings in the temporal lobe. Since that lobe is the location of most lesions causing psychomotor epilepsy, it should be closely watched for. Since it is based on

the heartbeat, it tends to follow that organ in frequency, therefore, an electrocardiograph can be taken separately and simultaneously with the electroencephalograph and the two readings compared so that the electro-encephalograph can be corrected for the apparent discrepancy.

C. The Pulse Artifact. If an electrode is placed directly over a scalp artery, it will move in sympathy with the pulse. This would give rise to spike waves in the electroencephalograph and may give a false picture of petit mal epilepsy when the spike occurs adjacent to a slow wave. This again would be distinguishable by its periodicity as discussed in the electrocardiograph artifact.

D. Eye Movement Artifact. Movements of the eyeball during the examination can give a false reading with respect to the frontal lobes. This is due to the fact that one of the two fluids of the eye is positive with respect to the other. If the relationships of these fluids are shifted by turning the eye, this electrical activity will be picked up by the electroencephalograph. Since eye movements as opposed to heartbeat tend to occur at random, there is no periodicity or regularity in their occurrence. Therefore, they are much harder to distinguish from abnormal readings. A careful EEG technician will place cotton pads over the patient's eyes to minimize eye movements.

E. Sweat Artifacts. Since sweating causes the skin resistance to be greatly reduced (a fact which is utilized to the utmost in the polygraph or lie detector test) sweating during the EEG will result in large slow waves being recorded which are not cerebral activity. Since persons who are very nervous during the examination will tend to perspire more, the technician should be careful that perspiration is promptly eliminated. The electroencephalograph should always be performed in an air conditioned room because of this danger.

F. Movement Artifacts --Physical movements on the part of the subject of the test can produce artifacts in the graph. Particularly, this is true when large drape-type garments are worn. The operator should instruct the subject to remain motionless during the test and should watch for movements, note when they occur and take steps to see that they are considered in evaluating the patient.

G. Electrode Artifacts -- These may appear as an epileptic disorder and must be carefully watched for. Usually they are due to a discharge from a condenser in the machine. Other electrode artifacts result from a failure to adequately attach electrodes to the skin.

H. Electromagnetic Disturbance Artifacts. A radio or other source of electromagnetic radiation either in the room

or in adjoining rooms can disturb the electroencephalograph and give readings which may be falsely attributed to abnormalities in the brain.

3. Who interprets the electroencephalograph?

Generally, in cases that come before the criminal courts the EEG is interpreted by a psychiatrist. It should be noted here that usually a psychiatrist is not the most qualified person to interpret the EEG and if the occasion does arise, an attack is in order based on the psychiatrist's qualifications to testify on this subject. Bear in mind, however, that many psychiatrists do not rely on the electroencephalograph and might have a tendency to avoid its use unless they have extensive experience. This is particularly true if they have been subjected to a searching cross examination on that subject and have been made to look less than knowledgeable. Therefore, in approaching a psychiatrist, his training and experience with respect to this instrument should be known prior to a full-scale attack on his qualifications. While training in medical school is not extensive with regard to the use of this instrument, many psychiatrists acquire an expertise in their practices.

The electroencephalograph is a tool of the neurologist and the neurosurgeon and requires quite a bit of sophistication to be understood correctly. Most generally,

the psychiatrist receives only four months of neurological training, which is hardly enough to make psychiatrists sufficiently conversant with the use of the instrument to be an adequate witness in court. Furthermore, since a psychiatrist generally does not personally conduct the electroencephalographic examination, he will not have personal knowledge regarding the possible causes of artifacts, a state of affairs which can be fruitfully exploited on cross-examination. Since the physician was not actually present when the test was given, he cannot authoritatively eliminate the possibility of body movements, skin conditions and the possibility of the condition of the machine affecting the electroencephalographic reading itself.

4. Theoretic Foundations of the EEG. It should be noted that an abnormal EEG is not ipso facto evidence of neurological impairment. Statistics indicate that many people with no neurological symptoms at all produce abnormal electroencephalographic patterns. It is also well documented that people with known neurological problems may produce, from time to time, normal electroencephalographic patterns. It is extremely difficult to document such neurological phenomena as psychomotor seizures on an electroencephalograph unless there is a continuous pattern being perpetrated by the brain. This latter state of affairs is highly unusual in the criminal courts.

It should be noted that neurologists have various theories regarding what an electroencephalograph shows, the type of neuroactivity that it reflects, and why certain chemical changes in the brain also change the pattern of its electrical activity.

The background activity of the brain is a rhythmic summation of all the neurons that comprise the brain cortex itself. Why these discharges should be rhythmical, rather than completely at random, is not known. Another area of relative ignorance is the precise mechanism by which the brain can be activated so that abnormalities will be discovered more readily. There are several ways to produce these changes. The usual method resorted to in the criminal courts are either alcohol ingestion or hyperventilation. Hyperventilation consists of having the subject take several rapid and deep breaths. Other activation techniques include inducing hypoglycemia (low blood sugar) by injecting insulin, photic stimulation which consists in exposing the patient to a rhythmically flashing light, and the injection of the drug metrazol.

The effect of these techniques is to make the brain more sensitive and hence more likely to exhibit abnormalities that exist in the brain through a showing of either focal or paroxysmal disturbances. Focal disturbances of

the brain usually indicate some abnormality at the point in which it is recorded. It is important to note, however, that a focal disturbance indicating possible psychomotor epilepsy or some other form of seizure is not a recording of the seizure itself, but merely evidence of an abnormality that might give rise to a seizure. While the electroencephalographic tracings taken during a seizure itself are unmistakable signs of that seizure, focal disturbances indicating a possible susceptibility are far from conclusive. Due to the difficulty in actually producing a seizure, particularly of the psychomotor type, psychiatrists and neurologists generally must rely on these focal abnormalities and other clinical data to determine whether or not a person is subject to such seizures. As was stated above, apparent focal abnormalities may be due to some type of artifact and may even be present in a perfectly normal brain, or at least one that is free of neurological symptoms.

One way in which a focal abnormality appearing on the electroencephalograph can be said to give rise to seizures is in the following manner. A trauma to the cortex will cause scar tissue to accumulate in the area immediately surrounding the injury. This tissue is termed a lesion, and is not formed from the actual neurons themselves but occurs with respect to secondary brain cells called neurolgia whose function is to provide nutrients and structural

support to the neurons and which may have some undetermined function with respect to memory.

These cells, as opposed to neurons, do have the power to multiply and build scar tissue. Such scar tissue serves as an irritant for the surrounding and relatively healthy neurons. In periods of stress or chemical change, these irritated neurons become hypersensitive and tend to fire. The firing of these neurons will excite surrounding neurons and when this activity spreads sufficiently to disturb consciousness there is actually an epileptic seizure in progress. Since neurons directly metabolize alcohol and most drugs, its presence in the brain greatly increases the sensitivity of these cells. This would account for the fact that seizures are more likely to occur when someone is undergoing emotional stress or has ingested certain types of drugs or alcohol. However, barbiturates have a calming effect on the brain and are in fact prescribed by physicians to control epileptic seizures.

The electroencephalograph has lately come into use as a tool to diagnose drug intoxication. Coma associated with drug ingestion can be readily differentiated from coma due to metabolic or physical problems by use of the EEG. It obviously cannot give the specific chemical agent ingested. However, in most sedative or hypnotic drug intoxication, the electroencephalograph will show a

combination of very fast brain activity and normal sleep patterns.

The electroencephalograph then is basically a tool to be used with other diagnostic procedures to access central nerous system disfunction. Not only is the machine not infallible, but its interpretation falls considerably short of Papal standards. It should be approached with caution when it appears in court.

CONVULSIVE DISORDERS

Recurrent convulsive disorders, or as they are more commonly known, epileptic seizures, of various sorts affect approximately 700,000 people in the United States. Needless to say, these seizures produce widely divergent and specialized phenomena incident to the particular causative factors involved. Epilepsy can be defined as a disorder of the nervous system characterized by sudden and disorderly discharge of cerebral neurons. This discharge results in an almost instantaneous disturbance of sensation, loss of consciousness, convulsive movements and/or involuntary acts. Epilepsy may begin at any age. It may occur only once in a lifetime of an individual or it may be a chronic recurring affliction that stays with the person for his entire life.

It should be understood that a seizure disorder is a clinical manifestation of some underlying pathological process which originates in the nervous system. The most important aspect of a seizure disorder for criminal purposes is that one of the primary manifestations of a seizure is the loss of consciousness or awareness. Thus if a person commits an "act" while undergoing an epileptic seizure, he is unconscious under the provisions of Section 26.5 of the Penal Code and would not be capable of committing any crime. Statistically, about 51% of all epileptic patients have generalized convulsions. This type of seizure is known as a grand mal attack. In these attacks,

a person suffers a sudden loss of consciousness, and falls to the ground. His muscles go into what are known as tonic contractions. The diaphragm and chest muscles contract and hold in that position. The subject of the seizure utters involuntary screams or cries. Face muscles become set in a rigid posture, often resulting in a biting of the tongue. Shortly thereafter, a series of clonic or jerking movements set in. At this time the limbs thrash about in a disorganized fashion. After several moments, the movements become slower and stop altogether. The person then goes into a coma or sleep. Upon awakening, there is no memory of the seizure and at best the person remembers only the beginnings of the seizure or what is called the aura.

An aura is a strange feeling which precedes very many epileptic attacks. This may manifest itself as a funny smell, a feeling of detachment or any other unusual sensation before the seizure beings. Quite common are deja vu phenomena in which a person is convinced that he is experiencing something that has happened to him on some previous occasion. Abdominal or pulmonary discomforts frequently occur.

In contrast to grand mal episodes, petit mal seizures are so brief that they are often overlooked to the extent that many people have suffered from this type of disorder for many years before a diagnosis was actually made. A petit mal seizure comes without warning and most generally consists of a loss of consciousness in which the person either ceases all activity

or continues to engage in automatic activity such as driving or walking. In contrast to the grand mal seizure, the petit mal seizure does not generate major convulsions. In fact a person witnessing another undergoing such a seizure will notice it only if he tries to communicate with that person or in other respects to stimulate him. The person undergoing such a seizure while watching a television show will have no memory of the attack but will be mystified by what appears to be a jump in the plot of the movie or an unexplained rapid change of score in a ball game. He will not realize that he has been unconscious for a few seconds to a minute. Petit mal seizures do not result in violent behavior, however quite frequently they degenerate into a grand mal seizure or are corroborative of more dangerous types of attacks.

Two other seizure disorders are more closely related to petit mal seizures than to any other type. In the Akinetic seizure, a person suddenly loses consciousness and falls motionless to the ground. This is often mistaken for a fainting spell. In a myoclonic seizure, there is a sudden violent contraction and loss of control of a part of the body sometimes with a falling and loss of consciousness for a few seconds. The electroencephalographic patterns in these two types of seizures are similar to those of petit mal. These seizures tend to occur more frequently in childhood and adolescence than at any other time.

The importance of these types of seizures for our purposes is that the person who has had petit mal seizures in childhood may tend to develop other types of epilepsy in later life. Thus a person who claims he has psychomotor epilepsy might be corroborated by relatives who have seen him stare blankly off into space on numerous occasions and to be unresponsive to their statements and inquiries. Petit mal seizures are not dangerous in themselves but they may disturb the mental processes to such an extent that the sufferer does poorly in school and presents himself as a behavior disorder. Many such persons are seen in juvenile courts as chronic "acting out" offenders. This syndrome is characterized by a long history of antisocial behavior coupled with a learning disability and a periodic "spaced-out" appearance. This obviously would interfere with listening to lectures in school and the consequent behavior difficulties that would develop therefrom are obvious. Petit mal seizures can be well documented by the use of the electroencephalograph because they occur so frequently in a particular time span. On the electro-encephalograph petit mal seizures present what is called a spike and dome pattern occurring at a frequency of approximately three per second. The appearance of a spike and dome pattern is that of a sharp wave followed immediately by a rounded longer wave. Usually the spike and the dome have approximately the same height (voltage).

While violence is rarely the direct result of a petit mal seizure, this is not the case with respect to grand mal. It is obvious that a person actually undergoing a grand mal seizure could be of no harm to anyone unless he fell on them. However, since certain auras preceding the seizure may be paranoid feelings towards other persons which result in violent behavior if those persons are present, any violence which is followed by an actual seizure should be thoroughly explored. Bear in mind that emotional disturbance can precipitate an attack and that a person who is already an epileptic and decides to commit a crime will be more likely to have an attack either during the crime and immediately following it than he would be when not excited. Furthermore, the patient is not unconscious during the aura preceding a grand mal attack as evidenced by the usual capacity to remember the aura itself. While this aura may be relevant for diminished capacity and may have some effect on a determination as to whether the defendant was sane at the time of the crime's commission, it certainly does not amount to unconsciousness under Section 26.5 of the Penal Code.

There are documented instances of violence occurring during a period of disorganization after an epileptic attack which disorganization continues long beyond that occurring in the usual case. This is called post-ictal confusion. During such a state the defendant's consciousness would be very clouded and the attack might well interfere with his capacity

to understand the nature and quality of his act. Because of the dramatic nature of a grand mal seizure, however, it should be easy to document whether or not such a seizure did occur in the time immediately preceding the crime.

Legally, the seizure disorder that we must, because of its nature, concern ourselves with mostly, is the psychomotor seizure and its variants. The psychomotor seizure differs in several ways from the grand mal and petit mal types previously discussed. First, the lesion causing it is generally located within the temporal lobe of the brain. While some cases of frontal lobe seizures approximating psychomotor epilepsy and their general effects have been noted, the term "temporal lobe seizure" is often used as a synonym for this condition. Secondly, the aura leading to the actual seizure very often may take the aspect of a complex hallucination or visual illusion. Unpleasant odors may occur or visual scenes involving past experiences resembling a dream state may occur. Deja vu is also a common aura. A person's visual or auditory perception and his relationship to the real world will be grossly altered. Objects around him may appear to be unreal. Familiar friends may appear unfamiliar. Doctor Hughlings Jackson, a pioneer in this area, applied the term "dreamy state" to these psychic disturbances. During the actual seizure, the person appears to be conscious even though medically he has a complete lack of consciousness. He may continue to proceed doing the same act he was doing before, either driving a vehicle which is possible even under a petit mal seizure,

or performing more complicated and involved tasks. When verbally approached, it is evident, however that he is not in contact with the speaker and does not understand what is happening around him except that with respect to his immediate activities he may APPEAR to have a purpose and awareness. If restrained, he resists violently and can be extremely dangerous. The person acts like a robot or an automaton and his behavior is thought to be automatic. Convulsive movements are minimal or absent. They may amount only to rapid eye movement, turning of the head, smacking of the lips or violent chewing.

Defenses based on psychomotor epilepsy are very commonly asserted in the criminal courts of Los Angeles County. This defense is particularly difficult to deal with since it often appears to be corroborated by electroencephalographic findings and since unsophisticated witnesses to the crime do not have a real basis for telling whether or not the defendant was undergoing a seizure. An actual seizure of this type is very difficult to reproduce in the doctor's office when he is giving an electroencephalographic examination. If the defendant were to undergo such a seizure when the electrodes are attached to his head and the machine is in operation the reading of the EEG would be unmistakable as to this issue. However, in the overwhelming majority of cases, what the electroencephalographer sees in the graph is a rather normal background activity superimposed on by occasional spikings of a focal nature in the temporal lobes. As previously discussed, there are many artifacts that can cause this sort of reading. These focal discharges could indicate an abnormality in the brain which

could give rise to a seizure. This of course is not equivalent to an actual attack and can be caused by many things other than actual damage to the brain. A very sophisticated, careful and exacting electroencephalograph must be taken in order to adequately evaluate these spikings.

Furthermore, a significant percentage of otherwise normal persons show abnormalities on their electroencephalographs which are indicative of psychomotor epilepsy and they have never had a seizure. Many psychomotor epileptics show no abnormalities on their graphs. In the latter case, the percentage decreases if instead of relying on one reading, a number of graphs are taken over a great period of time. To really corroborate electroencephalographic findings, there should be a history of seizures, some evidence of trauma to the brain, some physical findings accounting for the abnormal reading perhaps in a brain scan or angiogram.

One characteristic that seems to pervade all acts committed while undergoing a psychomotor seizure is the persistent directedness toward one objective, being totally oblivious to obstacles and other persons around the subject while committing the act. Anyone who answers a question posed by a witness would not be undergoing this type of seizure if the answer is relevant, complex and coherent. Persons undergoing a psychomotor seizure tend to appear dogmatic and singular of purpose. They are fixated on one idea and either not responsive to attempts to deviate them from their purpose, or else they react violently.

Under the present state of the law contained in Penal Code Section 26.5, an act committed during a psychomotor seizure would fall under the category of unconsciousness. Therefore, the defendant would be incapable of committing a crime. In determining whether or not the person had a seizure at the time the crime was committed, it should be kept in mind that (1) there are no tests that can tell us if a man has had a seizure in the past. (2) There is absolutely nothing that prevents a person with a history of seizures from also being a criminal. Epileptics are no more honest or moral than anyone else. (3) To reason that because someone has an abnormal electroencephalograph or even a history of seizures, he must have been having a seizure at the time of the crime is a gross example of the post hoc ergo propter hoc fallacy mentioned previously.

While it was stated above that a history of trauma should be looked for to authenicate a seizure, it should be borne in mind that not all seizures are due to trauma. Trauma is merely the cause most often asserted for seizures in the criminal courts. Epileptoid seizures can result from insulin reactions, brain tumors and other toxic reactions to drugs. Since these pathological conditions can be more easily verified than the effect of some ancient trauma on the defendant's brain, we have tended to concentrate on trauma in this section.

The value of a section such as the one just presented is to give the trial deputy a basic understanding of the nature of these seizures and the inter-relationship between the various types.

While the writers have reviewed a great number of psychiatric reports alleging that the defendant was undergoing a psychomotor attack during the commission of a crime he has yet to see one which either mentioned an aura that the defendant experienced before committing the crime or an inquiry to that effect by the psychiatrist. The frequency of auras preceding psychomotor epileptic attacks would tend to indicate that this is a gross omission in these reports. In each case where this defense is asserted the deputy should go through all the usual manifestations of these attacks to render it improbable in the jury's mind that the defendant was actually in such a state at the time the crime was committed. One should feel absolutely no hesitancy in creating a doubt in this manner since it should be realized that all that the physician is dealing with himself, is probability, and usually not a very strong one at that.

TRAUMA TO THE NERVOUS SYSTEM

The most common form of trauma to the nervous system is a concussion. The word concussion is a catchall for any trauma to the central nervous system that causes a loss of consciousness, although sometimes the term is loosely used to indicate a lowering of conscious awareness due to a blow. It generally implies the violent shaking and agitation of the brain or the functional impairment which results therefrom. In order for a significant brain trauma to occur, a physical force of a considerable magnitude must be exerted to the head. Unless the head is struck, the brain will not suffer except in rare and controversial cases of chest injury with raised intrapulmonary blood pressure. Also a large amount of brain tissue must actually be traumatized. In some cases a relatively high velocity missile such as a bullet may destroy a very small portion of brain matter without causing extensive damage. It is interesting to note that in many of these cases, a person may suffer severe and fatal injury to the brain without immediately losing consciousness.

The most common injuries are those in which either a rapidly moving blunt object strikes the head or the head strikes a hard surface with great force. These types of injuries have two common attributes: (1) They almost always induce at least a temporary loss of consciousness; (2) Even though the skull is not penetrated, the brain may suffer gross damage such as lacerations, contusions, hemorrhage or swelling.

A blow which is severe enough to cause skull fracture may not necessarily result in severe brain damage, and even in fatal head injuries skull fracture is absent in approximately 30 per cent of the cases. The existence of a basal skull fracture may be indicated by signs of cranial nerve damage as indicated above.

A word should be said here about what is known as a contrecoup injury. In most head injuries there is a displacement of the brain within the skull. This is particularly true when instead of being struck by a blunt object, the head strikes an immovable object with great force. Since the brain is suspended in cerebrospinal fluid it will not strictly follow movements of the head but tend to lag behind on its own inertia. When the head is stopped by said immovable object, the brain continues to move in the direction of the fall, resulting in the brain being torn loose from its moorings on the side of the head opposite to the one which struck the object. This tearing generally severs blood vessels, resulting in a clot being formed which continues to grow until natural processes of the body seal the opening. Furthermore, there is a possibility of a stretch in the midbrain and brain stem and temporary paralysis of the reticular activating mechanism can occur. This would result in loss of consciousness and the suppression of reflexes in the body.

The type of brain injury that causes the most problems for the criminal attorney is the relatively minor one. In a severe injury, the person suffering it would, in the overwhelming majority of cases, be so incapacitated as to be either unable or disinclined to commit a crime. However, in some relatively minor types of trauma to the head, edema or swelling of the brain can result and pressure can be put on nerve centers within the brain causing changes in personality and behavior. In evaluating one of these cases it is particularly important to ascertain what note was taken by persons surrounding the event and by treating physicians of corroborative signs of actual edema.

It is well known that many persons upon being struck by another will become so enraged that they will commit crimes of violence then later assert that they blacked out as a result of the initial blow and have complete amnesia for their criminal act. While this series of events is possible, it should be noted that only very infrequently do minor blows result in this symptom. Therefore, cross examination should include whether or not the psychiatrist examined the defendant for signs of headache, dizziness, loss of confidence in himself, inability to concentrate, nervousness, poor sleep subsequent to the blow, fatigue and depression. These are all symptoms that may appear, and in the absence of any of these symptoms violent behavior on the part of the defendant would be attributable to his own emotional state rather than to any organic changes to his brain.

It is also possible for a person who is struck on the head to lose consciousness and in a state somewhat similar in its outward manifestations to psychomotor epilepsy continue to engage in their previous activity and in some cases commit violent although unconscious acts. Apparently this syndrome is due to localized edema as opposed to edema of the entire brain. In these cases the violent act should occur almost immediately after the trauma and again should be corroborated by physical symptoms such as weak or numb legs, acute drowsiness, evidence of confusion, etc. In some cases, confusion resulting from a concussion can continue over a longer period of time. In this case the confused state of the defendant should be obvious to all those who observe him.

DISEASES OF THE CENTRAL NERVOUS SYSTEM

There are a few diseases of the nervous system which can result in behavior disturbances, but their occurrence is so infrequent that they deserve only passing mention in a chapter of this nature.

Multiple sclerosis affects the entire nervous system, but usually does not cause crime. Due to the fact that it is a severely disabling disease, many persons become paranoid and suspicious and furthermore, disability makes them unable to cope with their environment as well as they had been prior to the onset of the disease. Hence, any abnormal behavioral tendencies that they had while well would tend to be exaggerated. This disease poses no difficult diagnostic problem since the physical symptoms are far more clear than any mental alterations of behavior. It would be difficult for the writers to conceive any situation in which a person suffering from multiple sclerosis would be insane under the M'Naughton test, unless the person was also psychotic.

Senile Dementia has been discussed previously as frequently resulting in child molestation and sometimes in fatalities during the course of the commission of such crimes. Senile dementia is a progressive mental deterioration that commences after the age of sixty in afflicted individuals. This condition

is easy to detect by psychological testing (particularly with respect to memory) and by basic neurological examinations. Any crime that is committed after the age of sixty and which is out of character for the defendant should be evaluated with respect to possible senile dementia. While this disease is easily detected, its effect on the defendant's capacity to commit a crime is less easily ascertained. In the early stages of the disease, there would be more of a lessening of controls than an obliteration of the defendant's cognitive facilities. Therefore, while the defendant may not be able to control his conduct, he still would be able to appreciate its criminality and thus would not be insane. It is hard to picture however, a senile person who commits a crime connected with this disease who would have the capacity to maturely and meaningfully reflect and hence to premeditate a murder. Therefore senility would have a great deal of bearing on a diminished capacity defense asserted in the crime of murder. Senile dementia is an irreversible process which eventually results in death. Hence, a second degree murder conviction would protect society as much as a first degree.

Presenile Dementia should be noted. This is also known as Alzheimer's disease and is pathologically similar to senile dementia. The major difference is the much younger age of onset. Another significant difference, however, is the greater prominence of severe neurological deterioration. This usually

results in more pronounced and sudden physical deterioration than in senile dementia. The electroencephalograph in both these diseases shows a diffused, generalized slowing which is more marked than the normal slowing due to age.

Huntington's chorea is a heritary disease that is relatively rare. The Los Angeles County District Attorney's Office has been presented with a few cases in which crimes have been committed by persons suffering from this disease. While these crimes are bizarre, they are not necessarily violent. The causitive factor is brain damage of a progressive nature which does not invariably affect the patient's personality to the extent that he will commit crimes. This disease pursues a fatal course within approximately sixteen years from the onset of symptoms. Violent and other criminal behavior usually results only when the disease is superimposed upon a previously existing personality disorder, usually of a paranoid nature.

Vitamin Deficiency. Certain vitamins, particularly those in the "B" group are necessary for proper neurological function. A severe deficiency in these vitamins may cause a person to be unable to cope with his environment in such a manner that he reacts irrationally or violently. Particularly in connection with the use of alcohol is this important. In Korsakoff's psychosis and Wernicke's syndrome, crimes are not uncommon. These two diseases are characterized by severe disturbances

of memory and can be somewhat amelibrated by the administration of thiamin and niacin. Unless one is dealing with the early stages of these diseases, the symptoms are quite clear and pose no substantial medicolegal problem. When not treated both these diseases produce death. Korsakoff's psychosis is the more commonly seen in the criminal courts. Extreme memory defects expecially for recent events is marked, and the person tends to confabulate and to make up events that did not occur to cover for this obvious memory defect. Quite frequently he will accept the suggestion of others regardless of what bearing it may have on fact. One of the writers has successfully handled a first degree murder case where the allegation was Korsakoff's psychosis.

Inflammatory Diseases of the brain. Encephalitis and abscesses of the brain are both inflammatory diseases. While these result in severe erratic behavior, the person is usually so debilitated as to preclude any acting out. With respect to small abscesses that are localized in the temporal lobe, they may however give rise to psychomotor epilepsy and will be considered with respect to the convulsive disorders.

Brain tumors can account for a whole spectrum of symptoms depending on their size, location and rate of growth. A small tumor with a small rate of growth can cause symptoms quite similar to lesions or abscesses. If located in the temporal or frontal lobes, they can give rise to epileptic seizures quite frequently to psychomotor epilepsy. Again, these symptoms are covered under the heading of "Convulsive Disorders." If the tumor is located in

either the occipital or parietal lobes while it may have some effect on the person's vision or other senses, it is not as likely to influence the commission of crimes. It should be emphasized that the mere presence of a brain tumor in a person who commits a crime is not automatically a defense to that act. Careful consideration should be given to the location of the tumor and compare that with eye-witness accounts of the crime itself. It is a truism that persons who commit crimes are not confined to those who are neurologically healthy. Our jobs as prosecutors is to distinguish those persons who are criminals and who happen to have a brain lesion from those who were previously normal but engaged in erratic or violent behavior because of brain disease.

ORGANIC BRAIN DISFUNCTION DUE TO DRUG INGESTION

Specifically, all physical reactions to drugs, as we recognize them and are concerned with them, are acute physical processes directed toward the central nervous system. It would, therefore, be beneficial to examine the extent of the various commonly-used drugs and narcotics and their effects on the central nervous system from the point of view of examining both the end result and the acute functioning of the user.

GLUE OR PAINT DERIVATIVES

The first substance to be discussed will be that of glue or paint. The most common organic solvent used for intoxication is Toluene. Glue and paint contain varying amounts of organic solvents that will give a person somewhat of a "high" when inhaled. These substances are inhaled and absorbed through the mucous membrane and will give the appearance of a person heavily under the influence of alcohol. The substance found in glue and paint, however, is highly toxic and dangerous to the body, and documented cases of brain damage due to absorption of the toxic materials into the blood stream are in existence.

A person under the influence of one of the glue or paint derivatives is not more apt to act out violently than the common drunk and, in fact, may be less mobile and have a lower level of conscious awareness than the person under

the influence of alcohol. Glue and paint intoxication is readily detected due to the smell and eye and mucous membrane irritation caused by the intoxicating agent. The eyes will be red and watery. The nose will be red and tender. Persons heavily involved in the sniffing of glue or paint may suffer extensive brain damage due to oxygen deficiency (hypoxia). This is generally due to the process by which these agents are inhaled, which is by pouring them into a plastic bag and sticking one's head inside to the exclusion of surrounding oxygen.

The organic solvents present in glue and paint are also very toxic to the kidneys, liver and bone marrow. The aerosol cans of paint containing various gases may also cause throat spasms in the user, cutting off the oxygen supply. A heavy glue or paint sniffer also risks pneumonia because of the irritants contained in the solvents getting into the lungs.

The glue sniffers or paint sniffers, therefore, will present themselves on the street generally as a common drunk. The dangers from the use of these agents, however, are much more acute and serious. Brain damage, possibly leading to diminished capacity, is not unusual and should be noted, especially in those who are chronic users of these agents. Acutely, however, one will be hard put to find any organicity relating to criminality other than voluntary intoxication.

MARIJUANA

Much has been written about the medical and legal implications of marijuana. Therefore, we will attempt only to bring some of the more important aspects of marijuana into focus and cover some of the legal areas of medical-legal thought.

Initially, marijuana is medically not a narcotic. In effect, it is probably more closely related to the hallucinogens than to any other agent. However, it is not a true hallucinogen either. Apparently, the primary active chemical in marijuana that we are concerned with is T.H.C. (tetrohydrocannabinol). Medically, marijuana affects perception, especially those areas of perception relating to time and distance. Marijuana will mildly lower inhibitions, but generally relaxes the user to a lesser extent than alcohol. Studies indicate that marijuana is generally not strong enough to alter behavior or self control, and there are no accepted valid studies that find marijuana as a direct causative factor in violent acts. Marijuana is not physically addictive. Medical studies indicate that physiological dependence upon marijuana is rare. However, psychological dependence is not uncommon. Barbiturate users have been known to use marijuana as a depressant to come down from a bad trip, but this is not common.

Marijuana has a reverse tolerance effect on a habitual user. The first-timer will need more marijuana to get high

than the veteran user and will characteristically be a heavier user until tolerance has been increased.

Adverse effects from the use of marijuana are rare, and psychiatrists indicate that these adverse effects generally are more setting-oriented than drug-oriented. The time, place, condition and other surroundings tend to have much more effect on the so-called bad sensation of the marijuana user than the drug itself. Therefore, if a user smokes marijuana in a noisy, agitated surrounding, he may become mildly agitated himself, but rarely to the point of action. Overdose or toxic reaction to marijuana is extremely rare. Los Angeles County General Hospital reports that they see on the average of 5.3 patients per year with complaints relating to marijuana use.

One characteristic of marijuana users on a long-time basis is a syndrome reported by Harold Kolansky, M.D., and William T. Moore, M.D., in the Journal of the American Medical Association as the Amotivational Syndrome. This syndrome generally relates to the person's arrested social development. Indications are that people who are chronic users of marijuana tend to relate to reality through the artificial high of marijuana, and over a period of time relationships to society as a whole become somewhat distorted. In this syndrome we see a lack of motivation, very little drive, poor social judgment, poor attention span, some confusion and indifference, and a rather overall apathy. This syndrome appears to be more prevalent among

younger users, and is a reason why many psychiatrists are not in favor of the generalized usage of marijuana.

Physiologically, marijuana will increase the pulse rate approximately 10 to 20 beats per minute; will, with any time of extended usage, redden or irritate the eyes; will cause a dryness of the mouth or mucous membrane, while giving the user the appearance of a very mild intoxication. Marijuana does not either dilate or constrict the pupils of the eye.

An important marijuana product is a concentrated resin derived from the marijuana plant, known on the street as hasheesh (hashish) or hash. "Hash" most generally is produced in the Middle East, with a very large amount of it coming from Turkey. It is derived from the marijuana plant and is generally of a better quality, richer in THC, than the typical Mexican marijuana that we see here in California. Hasheesh is generally 8 to 10 times more potent than marijuana. While there are few studies concerning the effects of hasheesh in the United States, several have been done in the Middle East and in the Far East, indicating that hasheesh is a much more formidable and dangerous form of the drug marijuana than was formerly supposed. Hasheesh is used two ways, either smoked in a pipe or eaten. Hasheesh that is smoked will have a quicker, stronger and more long-lasting effect than marijuana plant cuttings. It does not appear to have the self-limiting effect of smoking the marijuana

leaves; that is, the more you consume, the higher you appear to get.

Eating hasheesh will produce a much more immediate toxic effect than smoking hasheesh. The effect is more long-lasting and medically more difficult to readily identify because of the lack of apparent symptoms.

Medically, authorities have been able to determine in the Middle East a very common organic brain syndrome, or documented brain damage ascribed to the chronic hasheesh eater. This chronic brain syndrome appears to be much the same as a chronic alcoholic's, producing progressive organic deterioration of the cerebral cortex with extended hasheesh use. There are, however, little in the way of documented studies in the United States.

There have been rumors for quite some time that pure THC, or tetrohydrocannabinal, in a distilled form is available on the market. This, of course, would be marijuana in its purest form. The isolation of THC, however, is exceptionally difficult, and, in reality, most of what is purported to be THC that has been recovered and tested by the police or other authorities has proved to be LSD. And for some time in the future it should probably be assumed that what purports to be THC is, in reality, one of the hallucinogens, probably LSD.

The jury certainly is not in on the use of marijuana. Legally, and for our purposes, medical science indicates that its mind-altering properties, on an acute basis, are

not conducive to criminal acts. This is certainly not to indicate that criminals do not use marijuana or that the extended use of marijuana, along with other contributing factors, is not harmful to a person. However, in a trial where the defendant or a witness was purportedly under the influence of marijuana and performs, or appears to perform, an act, it is important to remember that marijuana is generally felt to be of less mind-altering properties than alcohol, and, absent brain damage due to any chronic usage which has been documented, any plea or defense concerning insanity or diminished capacity due to marijuana usage would not appear to be valid.

There are some problems in dealing with the crime of driving under the influence of marijuana. Medical authorities indicate that marijuana in its purest form is not as dangerous to the driver as alcohol; and, in fact, studies have indicated that persons under the influence of marijuana have actually increased reaction time on driving simulators. However, the increased reaction time most certainly does not make up for distortion of time and distance caused by the marijuana.

Marijuana and its derivatives, hasheesh and tetrohydro-cannabinal (THC), are probably the most discussed, researched and litigated areas of the drug culture. At this point, suffice it to say, that with the copious amount of research presently underway, new developments are coming out daily.

It is somewhat unfair to lump together the smoker of marijuana with the hasheesh user or the person using THC. The best scientific evidence would indicate that the effects are different and while medical authorities, at this point, indicate the relative non-involvement of pure marijuana smoking and crime, we have little empirical evidence of the criminology of the user of the more strong and dangerous marijuana derivatives.

Therefore, it would be important for a person trying a case where the issue is organicity due to the use or ingestion of marijuana or a marijuana derivative to remember that while the smoker of the cut marijuana plant has been well researched, the user of the derivative of this plant in other forms has not, and, therefore, the dangers are relatively obscure. The latest medical research, therefore, should be carefully scrutinized on preparing such a case.

STIMULANTS

Stimulants, as are used illicitly on the streets, are most generally either of the amphetamine family or ritalin or preludin. Both of the latter drugs have amphetamine-like effects, but are not chemically similar.

Stimulants are probably the greatest legal problem area among commonly used street drugs for several reasons. They are easy to obtain on the street. They are addictive. And they appear to have the greatest potential toward

violence of any street drug. Physically and emotionally, the person using uppers or stimulants behaves as if he is under increasing mental pressure, and indicates a need to be increasingly more active. This is dose related. The more stimulants a person takes, the more active he becomes. A state of euphoria or wellbeing may be present, directly antagonistic to depression. However, as more stimulants are ingested, this can proceed to a mania or an extremely agitated state. In this state, the user of stimulants may well lose judgment, become inappropriate, become preoccupied, and may behave very impulsively and dangerously.

In the state of increased stimulant intoxication, inhibitions are lowered along with the ability to control one's impulses. Chronic usage or acute high dosage will trigger a paranoid psychosis or possibly a toxic psychosis, parallel to the same diagnosis in mental health and producing the same classically dangerous person. Susceptible individuals may exhibit psychotic behavior at very low dosages.

High chronic levels of stimulants may produce what is commonly called a paranoid life style, a person who is chronically suspicious, looking out for danger, and acting out against real or imaginary threats to his existence. Violence from this type of person is common, and violent crimes or anti-social acts are just as common.

One of the more serious aspects of stimulant disuse is the intravenous injection of meth-amphetamine or speed. Speed freaks, as meth-amphetamine users are generally called, are generally the least controlled of the stimulant users, and can very often be found in a toxic, stimulated condition or psychosis. Violent crimes relating to these speed freaks' inability to cope with reality and their environment are common and well documented. They often will lose the ability to reason rationally and to understand the nature of the act they are doing or its wrongfulness. On a long-term basis, speed freaks very often will become heroin addicts, using heroin to bring them down from the crash of amphetamine withdrawal. Chronic use of amphetamines can bring about violent personality changes. Medicine has documented several cases of chronic, residual psychosis in speed freaks not related to the toxic overuse of the stimulant. It has been difficult, however, to establish any chronic brain damage pattern from the use of amphetamines. There is a possibility of vascular problems with intravenous meth-amphetamine use, and seizures and heart disorders have been documented with excessive stimulant usage.

The overdosed stimulant user becomes more and more manic or high until he appears to others as an uncontrolable psychotic. The criminal who commits a crime under

the influence of stimulants or who is a chronic stimulant user creates legal problems for the court. Medical authorities are much more apt to ascribe a toxic legal insanity or diminished capacity to stimulants than to any other commonly-used drug. The general medical feeling is, apparently, that a person heavily strung out on a stimulant is not capable of forming the specific intent to commit those crimes which require specific intent.

While medically this may be true, legally it is hard to accept voluntary drug intoxication as an excuse for some of the very serious crimes that have been committed under the influence of stimulants. In the case of the acute stimulant user, the best argument would appear to be not only that this is a voluntary intoxication, but that the user may well have taken the stimulant to give him the courage to commit the criminal act, thus forming the intent before taking the drug.

In the case of the chronic overuser of stimulants, however, where you have a psychotic-like life style, a showing of the ability to reason rationally and form specific intent will be difficult, and extensive organic and psychological testing should be utilized to indicate the amount of damage and present psychological condition of the person in question, along with the establishment of the chronicity of his habit, and whether, in fact, he was acting under the influence of the stimulant at the time of the crime.

A stimulant seen more and more on the street is cocaine. Cocaine is a natural stimulant sold in powder form. It is commonly sniffed through the nose and absorbed by the mucous membranes. All of the previous discussion as to stimulants applies to cocaine. However, medical authorities feel that cocaine is much stronger, and, therefore, may produce more emotional change. It is generally much more expensive on the street than amphetamines, and, while we are seeing more of it in general usage, it will probably not receive the wide use seen with amphetamines.

Drug intoxication is readily discernible on the electroencephalograph. In coma or drug-induced sleep, it can be differentiated from coma due to metabolic encephalograph by the electroencephalograph. In fact, this can be the most accurate test in determining this diagnosis. The electroencephalograph does not give the specific evidence as to the type of drug ingested. Dangerous drugs and hypnotic drugs show the same pattern of the combination of alpha activity and normal sleep. No basic alpha rhythm is generally discernible and the electroencephalograph record is dominated by a constant beta activity of from 22 to 26 cycles per second.

SEDATIVES

Sedatives, or "downers", as they are generally called on the street, consist of the general barbiturate family,

in capsule form. The most well-known street barbiturates are Seconal or "reds", Amytal or "blues", Tuinal or "rainbows", and Nembutal or "yellow jackets". Doridan, a non-barbiturate sedative, is also coming into frequent street use and symptomatically is very close to the barbiturate family.

As the street name might indicate, "downers" lessen the level of awareness. They generally induce relaxation, lethargy and mental depression. All of these sedatives are central nervous system depressants, the opposite of "uppers" or stimulants.

A person under the influence of "downers" or sedatives will think, talk and move slower, and will look very much like a person under the influence of alcohol. There are, however, some major differences. A person using barbiturates as an intoxicant will reach a level of intoxication faster with a lower dosage and maintain the intoxicated condition much longer than if he were using alcohol. Many young people use barbiturates in a social setting as a substitute for alcohol. Like alcohol, barbiturates in controlled dosage reduce inhibitions and promote social interaction. If alcohol is consumed along with barbiturates, the effects and dangers of both drugs are enhanced, and the presence of alcohol on the breath of an unconscious user may mask the grave dangers of the mixed drug ingestion.

Medically, the barbiturates are probably the most self-damaging of the dangerous drugs. They are toxic at relatively small dosage and are very addictive, both physically and psychologically. A rapid tolerance is built up by the user, requiring more and more barbiturates to create the desired intoxication level. The central nervous system, however, does not build up the same tolerance to barbiturate use, and the habitual user, when ingesting at a high level, is generally very close to fatal overdose level without knowing it.

As a central nervous system depressant, barbiturates will slow the body processes, ultimately to a halt. Reflexes become slower, then nonexistent. Spontaneous breathing becomes labored, then stops completely. The cough and gag reflex is retarded and the user may gag on his own saliva.

In between non-use and overdose, however, there exists various toxic conditions in the user that can lead to crime and violent acts. As we have indicated, barbiturates have an intoxicating or alcohol-like effect. This effect tends to be of a stronger duration, however, and will tend to lower impulse control which can lead to anti-social activity.

Toxic delirium, which is a disoriented, agitated state associated with the overuse of barbiturates, is a state in which the user may become increasingly paranoid and anti-

social. In this paranoid state, acts of violence are not uncommon, both against others and against himself. Herein lies the problem area of diminished capacity for violent crimes. Medical authorities indicate that in the toxic delirium the barbiturate user does not have the requisite mental facilities to provide the specific intent needed for those violent crimes requiring specific intent. Medical research indicates that this is especially true in the area of violence with the barbiturate user. Impulse control problems, coupled with the rather severe paranoia of the barbiturate user, is often most conducive toward physical acting out against others. Medical authorities do indicate, however, that the reflective ability of barbiturate users in the toxic delirium state is solid enough to allow them to reflect on the wrongfulness of their acts as to other nonviolent, non-impulsive crimes. For instance, most psychiatrists interviewed indicated that if a person were to complete an act of forgery under the influence of barbiturates, they would not feel that the barbiturate toxic delirium was as involved with the criminal act as if he had committed a violent act.

Barbiturates tend to have a much worse "hang over" effect that alcohol. This is to be expected, as the drug has a more addictive quality than alcohol has and some of the "hang over" effects are, in reality, withdrawal symptoms. Persons coming down off barbiturates will generally

experience a rebound anxiety syndrome, and, as with all addicts to drugs or narcotics, may become preoccupied with supply, and in this state can be extremely violent.

Withdrawal from barbiturates produces a much higher anxiety and pain level and is generally more severe than heroin withdrawal. Withdrawal from barbiturates can lead to seizures and fatal convulsions, and medical problems related to the misuse of barbiturates is cited as the highest incidence of drug-oriented treatment by the Los Angeles County General Hospital over a yearly basis. It should be noted that acute fatal overdoses are considered quite common among casual users because of the relatively low toxic level of barbiturates.

Barbiturate users over a long period of time have been known to demonstrate a chronic neurological brain syndrome or manifestation of brain damage. This generally appears as a loss of mental functioning, often with an ongoing depression or a psychotic state due to the toxic effect of the barbiturate on the brain cells. It has frequently been suggested medically that barbiturates will cause increased loss of brain cells with extended use.

Quite frequently, acute toxic brain syndromes will be found in barbiturate users. This toxic effect is produced from a singular, very high dosage of barbiturates, and, while appearing the same as the chronic brain syndrome, the acute syndrome will generally resolve itself in two or three days, if the person lives.

While in the acute brain syndrome state, the user is unable to act rationally or to deliberate on the nature of his acts. However, it must be remembered that this is a self-induced intoxication, and, again, the differentiation must be made where a criminal act is present as to when the intent to commit the act was made, as very often in the criminal element barbiturates are used as a means of courage, and the intent to commit a crime may very well have been formed before the intoxication. If the person is a chronic user, it is unusual to see an acute reaction to the drug. The more normal manifestation is a lifelong style of living, frequently marked by violent outbursts and lack of physical control. The first-timer, however, is susceptible to an acute reaction, and it is very difficult medically to forecast how this reaction will manifest itself.

Withdrawal from barbiturate addiction must be medically controlled. It is much more serious and much more dangerous than any other narcotic or drug withdrawal. Medical authorities indicate that psychotic-like states have resulted from withdrawal from barbiturates, and that incidence of violence among barbiturate addicts going through withdrawal is generally much higher and more severe than those going through heroin withdrawal.

HALLUCINOGENS

The hallucinogens, of which lysergic acid diethylamid (LSD) is the prime offender, generally induce artificial,

psychotic states. Generally, the hallucinogens will provoke changes of sensation, thinking, self-awareness and emotion. They may also provoke alterations of time and space and perception. Illusions, hallucinations and delusions are common adjuncts of the hallucinatory "trip".

As previously indicated, LSD is the most well-known and generally used of the hallucinogens. Aside from LSD, there are a large number of synthetic and natural hallucinogens. PCP or Sernyl, a veterinary tranquilizer, is being seen more frequently on the market, with a general LSD effect; Mescaline, from the peyote cactus; Psilocybin, from the Mexican mushroom; morning glory seeds; STP; DMT and MDA and many others are known to have hallucinogenic qualities.

As LSD is the most common street hallucinogen and the most common hallucinogen seen in court, the discussion will relate basically to the properties of this hallucinogen and the problems concerning it. LSD is generally taken in tablet form, and the onset of symptoms is from 20 to 40 minutes. The average LSD "trip" is from four to six hours, depending on the amount taken. A person who has taken LSD will have dilated pupils, a flushed face, a slight increase in blood pressure, sometimes a rise in temperature and/or heartbeat, sometimes a feeling of being cold. These effects will disappear as the action of the drug subsides.

The LSD "trip" or state will vary greatly, according to dosage and the purity of the drug ingested. The mental

state of the user and the setting under which the drug is used also have a great bearing upon the severity of the "trip".

The LSD or hallucinogenic "trip" is generally divided into two types by the user: the good "trip" or the "bummer" or bad "trip". The "trip" itself generally will cause changes in sensation and perception of external stimuli. The sense of time itself is strangely altered. Emotions ranging from ecstasy to horror are common reactions to the distorted perception of images seen and felt by the person on the LSD "trip". If the perceived images are terrifying or threatening, creating an emotional state of fear or horror, this is called a bad "trip".

Because of the massive mind altering caused by LSD and the other hallucinogens, it is impossible to predict what a person under the influence of LSD can and will do. From experience, we do know what some people under the known influence of LSD have done. Persons with no known tendencies toward violence have committed murders or have inflicted grievous injuries on others, and there have been numerous reports of suicides under the influence of LSD. These violent acts appear to be related to the type of "trip" being experienced by the user, and often the user committing the violent act appears to be under the delusion that he is defending himself or society from an unknown

evil presented in a distorted fashion during the "trip". The reason for the violent act has little or no relationship to reality, as a general rule.

What physical organic damage can be caused by LSD or hallucinogens has, at this point, not been resolved. There is some evidence that the extended use of the hallucinogens might cause chromosome impairment. However, there is, at this point, no absolute medical proof of this.

As to the actual brain damage potential of the hallucinogens, there have been cases of LSD users going on a "trip" and never coming back, i.e., remaining in a psychotic state. It is thought that this is relative to the personality of the user rather than to any organic effect of the drug. However, extensive research is currently going on in this field. Chronic users of LSD sometimes develop impaired memory and attention span, mental confusion and difficulty with abstract thinking. These are signs of organic brain changes, and it is not known whether these alterations are acute, reversible symptoms of the hallucinogens or a more permanent brain damage. It should be noted, however, that all users of LSD and/or other hallucinogens do not manifest these signs of organic brain damage.

The use of LSD and the other hallucinogens appears to be on the decrease. This is probably due to the greater awareness by the street users of the side effects inherent in hallucinogen usage, such as flashbacks and the possibility

of permanent physical or psychological damage to the user. Thus, the more intelligent and aware user has begun to shy away from the use of the drug.

This creates a double problem, however, because it leaves the person less able to handle the drug still using it, and from these persons we seem to be seeing more manifestation of a general "acting out" or anti-social behavior pattern. This manifestation, coupled with what we already know about the hallucinogen family, has given rise to the defense of diminished capacity from persons committing violent acts, such as murder or assault under the influence of LSD.

Medically, it is generally accepted that persons under the influence of LSD or most of the other hallucinogens are not capable of specific intent required for those crimes that require specific intent, but, again, this is a self-induced intoxication. Therefore, the intent needed for general intent crimes should still be present.

A problem arises here, however, when the user either remains in a psychotic-like state due to the drug or experiences a psychotic-like flashback phenomenon due to prior use of the drug, and commits a crime in either of these states. The law is well settled as to voluntary intoxication, but there is little law on a voluntary psychosis; and until more study can be done as to the nature of the LSD-induced psychosis, we are most certainly going to be faced with insanity pleas based on this state. It

is going to be difficult to argue voluntary intoxication or the voluntariness of taking the drug six months after the drug is ingested and the user is still psychotic. A further problem arises in arguing the voluntariness of the intoxication where the person took the drug six months before, and during a flashback committed an illegal act. Because so little is known medically about both of these states, it is difficult to determine whether they relate to the drug or to the personality of the user and/or both or to some permanent brain damage. The most useful tool here would seem to be extensive neurological and psychological testing coupled with a careful investigation, if possible, of the past usage by the defendant of hallucinogenic drugs.

OPIATES

The opiates, or as we see them, morphine and heroin, are generally classed as narcotics. A narcotic medically is a drug that relieves pain and induces sleep.

Narcotics include morphine, heroin, which is morphine chemically altered to make it approximately six times stronger than morphine, and a series of synthetic chemicals, such as methadone and meparidine, and, sometimes, paregoric and cough syrups containing codein, all having a morphine-like action. Of the narcotics, the most commonly addictive substance is heroin.

The most realistic estimate of heroin addiction in the United States is between 150,000 and 200,000 persons.

Generally, a discussion on narcotic addiction will focus on heroin addiction, not to the exclusion of other narcotics, but because heroin is the most commonly used street drug. Morphine addicts generally have become medically addicted, that is, have become addicted to morphine given them for medical purposes, generally due to an illness or injury engendering great amounts of pain. These addicts are generally medically controlled addicts, and infrequently come before the court.

Some of the acute symptoms associated with heroin use may be a sniffling, drowsiness, and flushing of the skin. The heroin user generally has severely contracted eye pupils that do not react to light. Many addicts have an unhealthy, underfed appearance. This is not due to the drug itself, but to the fact that great amounts of their money must go to support the habit, leaving little capital left over for food expenditures. Therefore, the hospitals see the heroin addict generally appearing as a very malnourished person commonly with blood infections, hepatitis and other "dirty needle" syndromes.

While under the influence of heroin, the addict is probably the least dangerous of drug users. He functions quite well under the influence of heroin, and as long as he remains on a constant dose level, he remains comfortable and reacts well to the presence of the drug. The ability to perform tasks, stay awake and alert, and function on a maintained

level of narcotics has been demonstrated by the use of both the heroin maintenance program and the methadone maintenance program.

There are dangers, however, inherent in the use of narcotics. Initially, narcotics are very addictive, both physically and psychologically. The more the user takes, the more he needs. There is a constant danger of overdose. Narcotics are central nervous system depressants. When the central nervous system is depressed to the point of not working, the vital functions necessary to the maintenance of life are also depressed. The addict ceases to breathe and death ensues.

Because heroin, the most common narcotic sold, is rarely sold in a pure state, the amounts of heroin actually being injected will vary according to the strength of the narcotic bought. A user may have been using very poor-grade heroin or a mixture containing little heroin and great amounts of milk sugar, and may, all of a sudden, by accident get a very rich mixture. This may result in an overdose, sometimes resulting in death.

When addiction exists, withdrawal generally takes place 12 to 14 hours after the last injection. The addict may start with the shakes, go into a sweat with his nose and eyes running, and later go into severe muscular aches and spasms, also with accompanying diarrhea and vomiting. It is at this point that the heroin addict becomes the danger

to society. He will generally go to great lengths to get a supply of heroin. This psychiatric implication of narcotic addiction is probably the most important when viewed from the legal standpoint. The life of the narcotic addict is centered around making enough money to support his habit, making the connection with the person selling to him, and trying to avoid the police and withdrawal. Because of the expense of heroin, most often the narcotic addict will turn to crime to support his habit. Petty theft, major theft, burglary and robbery are common, and the severity of the crime and violence with which it is carried out are generally directly related to the acute need for the narcotic at that particular time. Female addicts often become prostitutes or shoplifters in order to get enough money to support their addiction.

Federal studies indicate that addicts who are sufficiently affluent to buy the narcotics do not generally commit criminal acts. The psychological state of opiate addiction is one of passivity, not one of aggression. Therefore, one might reasonably conclude that a violent crime or any crime committed by a narcotic addict under the influence of narcotics is not based upon the presence of the narcotic itself. On the other hand, crimes committed by the narcotic addict in withdrawal have a reverse connotation. The crime is committed during an absence of the drug and, therefore, is no more defensible than a crime committed to obtain food,

clothing or any other necessity. Opiate addiction, criminologically, is the least offensive and provides the least legal problems for the attorney.

ALCOHOL

Any discussion of organic nervous system impairment must include a discussion of alcohol. Alcohol is basically a central nervous system depressant, that is, it retards the actions of the central nervous system, slowing down reflexes and other body functions. Alcohol's primary effect upon the user is that of a sedative. However, as with many sedatives, there is also a stimulating effect as a byproduct. The sedating effect of alcohol is deeper and more important as a principal effect of alcohol ingestion. However, the stimulating effect of alcohol, while not nearly as profound, appears to be longer acting. Therefore, theoretically, a person taking alcohol as a problem-solving agent or as a sedative may well lose the sedating effects and still have a mild stimulant effect carried over from the same ingestion.

Stanley Gitlow, M.D., indicates that this may be one of the major reasons for the repetitive drinker. The fact that after the sedative effect (which is the generally desired effect) has worn off, the user still suffers from a mild stimulating effect which is not desirable. The repetitive drinker then takes another drink to calm him down, but when this wears off he has even a more stimulating effect from the alcohol. Plainly, this can lead to a pyramid effect. Both Gitlow and L. Wharton, M.D., noted researchers in this

field, feel that at the apex of this pyramid, the repetitive user has built up the longer-lasting stimulative effects to such a peak that the only way he can sedate himself is to consume a very large quantity of alcohol. They feel that when this happens, one sees the syndrome we know as the "alcoholic blackout". Characteristic of the alcoholic blackout syndrome is a lack of judgment, poor control of both emotional and physical processes, distortion of reality, perception and amnesia. The alcoholic blackout syndrome does not preclude the living or acting out of a normal life, nor does it mean that the person who is so involved in a blackout is going to become a raving maniac. Alcoholics who have gone into a blackout state have later found out, after returning to conscious awareness, that they carried out business and life functions as normal yet had no memory of what happened during that period.

As the symptoms of the alcoholic blackout might suggest, this can cause some rather interesting problems from a legal point of view. There are several documented cases of crimes having been committed while a person was in an alcoholic blackout state. The person had no knowledge of having committed the crime, and in several cases could think of no reason why the crimes were committed. Dr. Wharton has documented a case in which a person killed his best friend while apparently in an alcoholic blackout state. The murderer, upon returning to conscious awareness and being

informed of what he had done, could think of no possible reason for the crime, and psychiatric reports later indicated that there was no conscious reason for the violent act. This would lend support to the concept of a distortion of reality while under an alcoholic blackout state.

Penal Code Section 26 indicates that no person shall be held criminally responsible for an act done while unconscious. Medically, the alcoholic blackout state is, in fact, an unconscious state in that while the person is acting out some control over his actions, he has no memory or conscious control over his actions. In fact, many doctors who treat alcoholics indicate that the super ego, that part of the conscience which limits behavior, is the only part of the human body which is soluble in alcohol.

There are, however, compelling reasons for not treating the alcoholic blackout as unconscious behavior. Medically, this would fly in the face of accepted treatment for alcoholism. One of the standard treatment axioms for the alcoholic is that he takes the first drink volitionally; that if he can't control his use of alcohol in himself, no one else can; further, that if he takes the first drink, he is responsible for anything that happens subsequently. This is one of the cases where medical and legal science appear to be operating from the same premise. The courts have followed the leads of their medical colleagues and held in a long succession of cases that self-induced alcoholic states are

not a bar to criminal responsibility. However, in People v. Conley, the court stated that if the defendant by voluntary intoxication renders himself incapable of appreciating his duty to confirm his conduct to the requisites of law, he cannot be found guilty of a crime requiring specific mens rea. The court in the Mosher case stated that anything that would appreciably interfere with the defendant's capacity to harbor malice aforethought, as in the Conley case, would result in reduction of the charge from a crime requiring specific state of mind to a crime requiring only a general mens rea, i.e., first degree murder to manslaughter, with the reasoning that if the unconsciousness results from voluntary intoxication, the defendant is not completely acquitted.

Brain damage from either acute or prolonged alcohol ingestion is common and well documented. Alcohol is metabolized by the cells of the nervous system. Therefore, alcohol has a direct effect on the nervous system. Researchers indicate that the ingestion of alcohol causes a greatly increased rate of loss in the neurons or cells of the nervous system. It is from this progressive and increased ingestion that we derive the so-called burned out alcoholic with his mind gone. This syndrome is, of course, quite common in the chronic alcoholic and several studies have been done on it. However, we are now learning more about acute organic symptoms of alcohol ingestion,

specifically as they relate to the person's inability to control himself.

Some organic problems encountered in acute alcohol ingestion are delirium tremens, also known as "DT's" of which the symptoms are increased mental confusion often to the point of loss of memory and judgment, increased psychomotor activity, hallucinations and/or delusions and, in some cases, seizures much like grand mal epileptic seizures. In some cases cerebral degeneration has been seen from the acute usage of alcohol. This is more commonly described in the long-term alcoholic. This is characterized by impaired motor function and movement.

Peripheral neuritis or a degeneration of peripheral nerves has been described in acute and chronic alcoholics. Unlike the destruction of the central nervous system, however, the peripheral neurons will regenerate, and this deterioration is usually reversible with medical treatment. Alcoholic hallucinations are an acute organic problem ascribed to the overuse of alcohol. This state appears much the same as an hallucinating psychotic. However, the impairment most generally will resolve itself in thirty days.

Of most interest to the legal mind would be the Korsakoff Syndrome, which is a psychotic-like state ascribed directly to brain damage caused by prolonged use of alcohol. In this state, extensive and prolonged alcoholic intake has

caused irreparable damage to those areas of the brain concerned with mental functions and motor activity. The patient may well appear as a burned out alcoholic with severe emotional problems. However, the emotional problems are due to physical impairment. The nature of this state is much the same as a paranoid psychosis. Judgment is poor. There is a distortion of reality and control. Legally, this person comes under the insanity rules rather than brain damage, but they are more readily identifiable because of more pronounced brain damage as seen on clinical evaluations.

In trying a case in which the voluntary intoxication or possible irrational behavior of a person under the influence of alcohol is an issue, one must make the differentiation as to whether the act is from a present ingestion of alcohol or whether past use has created an ongoing deterioration due to organic impairment. A further problem may be presented in the person who has a toxic reaction to alcohol. This is an allergic reaction that may cause a psychotic-like state from a minimal contact with alcohol. The courts, as previously discussed, will not generally exonerate the person who voluntarily ingests alcohol and then, under its influence, commits a crime. However, a serious difference arises where the person suffers from chronic brain disfunction due to extensive alcohol ingestion. This person generally will meet the test of legal insanity, based on the reasoning

that the condition he is operating under is pre-existing and permanent, and, while initially at some time in the far distant past, probably stemmed from a voluntary act of intoxication, is, at this point, an ongoing disease of mind.

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APPENDIX

The following is the Department of Corrections Exclusionary Criteria for the Civil Addict Program as of June 1, 1972. The Exclusionary Criteria are periodically updated and changed. Therefore, it is advisable to contact a representative from CRC to determine the latest Exclusionary Criteria. In Los Angeles County the CRC representative is: Miss Angela Idoux, 107 South Broadway, Los Angeles, California 90012; telephone: 620-2247.

I. SUITABLE FOR CIVIL ADDICT PROGRAM

A. Primary Problem - Opiate Addiction

The case history reveals that the person has a primary problem of addiction to narcotics, or is in imminent danger of becoming addicted, rather than criminal or delinquent patterns of behavior of which the addiction is only a part.

B. Manageable Within Program Resources

The person can be controlled, treated, programmed and managed in a minimum security, open-dormitory facility.

C. Trafficking in Narcotics Minimal

Any trafficking in narcotics, marijuana, or dangerous drugs has been of a relatively minor extent and only to provide for subject's need for narcotics.

D. Over Age 18

This civil program is specifically designed for adult offenders.

E. Previous Commitments

The person is deemed to be a tractable, non-violent, nonaggressive individual, and previous commitments have been mainly to county jail facilities.

II. UNSUITABLE FOR CIVIL ADDICT PROGRAM

A. Excessive Criminality

Persons whose histories include criminality of any nature which is evaluated as chronic and/or extensive are considered unsuitable for the civil addict program.

Examples would be patterns of burglaries, robberies, forgeries; grand theft. Cases which fall within this category are often those with:

1. A long history of criminal behavior.
2. Criminal behavior which precedes their addiction history and continues after their addiction.
3. Those who have served multiple periods of incarceration.

4. Persons whose histories indicate criminal activity unrelated to immediate need for narcotics.

B. Sales of Narcotics, Dangerous Drugs or Marijuana

Our primary concern is to distinguish those individuals who sell on a limited basis for their own needs from those who are more extensively and seriously involved in trafficking. This would include:

1. Those who appear to be involved in a large-scale trafficking operation.
2. Persons found to be trafficking or in possession of narcotics, marijuana, or dangerous drugs beyond that which might be reasonably necessary to support their own immediate need for narcotics.

C. Assaultive Behavior

Not suitable for civil commitment would be cases in which a history of assaults, battery and other offenses against the person indicated. Examples would be:

1. Those with a pattern of aggressive and assaultive behavior. This pattern may be developed

either by acts committed over several years with periods of nonviolent adjustment in between, or it may demonstrate itself in a series of acts preceding the instant arrest.

2. Those who have a pattern of aggression which precedes their narcotic addiction and continues after their addiction.

3. Those for whom it is adjudged that long-term institutionalization is indicated because of the seriousness of their behavior.

4. Single acts of aggression may warrant exclusion when:

   a. The act was of such nature that it demonstrates aggression which was aggravated or vicious.

   b. When the individual was involved in using dangerous or deadly weapons in the commission of the instant or prior offenses.

D. Other Relevant Reasons

1. Extreme Recalcitrance: Case history shows subject can reasonably be classified as an escape risk or is recalcitrant to the extent that he unduly threatens the good order and security of the open dormitory and minimum security facilities of the civil addict program.

2. Unresponsive to Program: Case history shows that while the person is a narcotic addict, or in imminent danger thereof, he has been previously exposed to therapy and rehabilitation programs without significant gains (either within the California Youth Authority, Department of Corrections, Department of Mental Hygiene, federal or other programs).

3. Other Medical or Psychiatric Disorders: Those who, while they be addicted to narcotics, have major behavior or medical disorders distinguishable from narcotics addiction, and which would need treatment (in addition to treatment for addiction) which the civil program is not able to provide.

a. Sex deviates -- Case history or diagnosis shows person to be a sex deviate who needs treatment for this pathology in order that he may be controlled and that he becomes less of a threat or menace to society.

b. Chronic psychotics -- Persons who would require treatment for their psychosis before the addiction problem could be approached. Treatment for serious mental illness is not available in the civil addict program.

c. Serious medical disorders --

   1. Persons with such serious medical problems that treatment for their narcotic addiction is secondary.

   2. Persons whose medical problems are severe and may be deemed irreversible.

3. Persons diagnosed as senile and unable or unwilling to become involved in our programming.

4. Nonamenable to Civil Addict Program: These are individuals who cannot or will not participate in phases of our programs, those who we are neither treating nor controlling; repeated failures who are simply containment cases. Examples would be:

   a. Those who have been released several times and who rapidly and repeatedly abscond from supervision.

   b. Those who repeatedly relapse to narcotic use with little or no progress demonstrated when they are released from the institution.

5. Arson History: A person whose case history indicates that he/she has committed arson, or arson-like acts (i.e., set fires, set off explosions, fire bombs, etc.).

6. Extreme Protective Custody Cases:

   a. Those who for various reasons have to be kept in protective custody status and who thus are unable to become involved in any meaningful program.

   b. Those who will be released to the custody of another jurisdiction and who will be required to serve a subsequent period of institutionalization (minor offenses, such as traffic warrants or failure to provide, will not warrant exclusion).

   c. Persons who are confirmed, overt or provocative homosexuals cannot be adequately controlled or protected in the open dormitory setting.

III. CASES REQUIRING SPECIAL CONSIDERATION PRIOR TO CIVIL ADDICT PROGRAM COMMITMENT

The Department of Corrections recommends that very careful consideration for alternative dispositions be given before the below-listed categories are committed to the civil addict program:

A. Other Confinement Pending

Persons with unresolved probation where the ultimate outcome would be a period of confinement in county or federal facilities upon release from the civil addict program. If probation supervision can run concurrent with civil commitment, these persons may be considered.

B. Deportation Warrant Outstanding

Persons where a warrant for deportation has been issued.

C. Parolees

Persons already under felony parole supervision of the Department of Corrections. In consideration of such referrals, the court is invited to ascertain the views of the Superintendent of the California Rehabilitation Center and of the Adult Authority or Women's Board of Terms and Paroles before arriving at its decision (In re Rascon on Habeas Corpus, Crim. 9601, May, 1966). Such referrals should include:

1. Only those persons whose major problems appear to be the result of addiction rather than

disposition to serious criminality.

2. Those cases in which the restrictions of Section 3052 of the Welfare and Institutions Code have been waived.