

Clinical and Diagnostic Interviewing

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JASON ARONSON INC.

Northvale, New Jersey

London

1989

18 The Forensic Interview

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In 1924, the lord chancellor of England said, "Psychology is a most dangerous science to apply to practical affairs" (Overholser 1953, p. 109). Nowhere is this more apparent than in the forensic arena, through which the psychologist walks an invited, but not necessarily sanctified, guest. The dangers to the professional, moreover, in such an adversarial and public system are legion, yet the opportunities are challenging and exciting; a colleague of mine called forensic psychology the only true "contact sport" in the behavioral sciences.

The heart of forensic psychology is the forensic interview: a clinical interview conducted in the context of a legal process, or pertaining to a psycholegal question. This chapter will present the six distinguishing characteristics of the forensic interview. A focus on the core dimensions of the forensic interview naturally leads to thoughts about specific knowledge, skills, attitudes, approaches, and techniques that the psychologist can apply to the forensic interview to make the final product worthy of his and others' approbation.

THE COERCIVE CONTEXT

The term *forensic* is derived from the Latin *forensis*, meaning "the forum" (Webster 1977). The forum is commonly understood as a public, or legal, forum; hence the application of the term to describe those professionals who practice in a legal context, whether they be psychologists, psychiatrists, or even dentists—so-called forensic odontologists. Inherent in this forensic context is the element of coercion, the first core characteristic that distinguishes forensic interviews from other interviews. Complete voluntariness should never be assumed. Rather, it should be assumed that the interviewee is being either partially or completely forced to do something against his will.

The element of coercion is often obvious. A criminal defendant's attorney recognizes that his client can neither cooperate with him nor understand the nature of the proceedings against him. The attorney therefore enters a motion for his client to be evaluated to determine whether he is competent to stand trial (*Dusky v. United States*). The defendant, by virtue of the case and statutory law surrounding procedures to determine competency to stand trial, can refuse the evaluation

only if he is willing to risk being held in contempt of court (Melton et al. 1987). Yet his Fifth Amendment right against compulsory self-incrimination is also protected if he should give evidence during the competency evaluation that further incriminates him. Even though a competency motion granted by the court usually benefits the defense due to a complete suspension of the criminal proceedings, a seriously mentally disordered defendant, perhaps with a paranoid delusional system, would probably irrationally, but strenuously, resist answering questions in a forthright manner. One defendant who was brought to me for a competency evaluation while in custody angrily accused me of being a "school-worm." Intrigued by his neologism, I asked him what it meant. He replied, "an educated person trying to worm his way into my mind." He was clearly schizophrenic, but he was also right.

A more subtle form of coercion may be present in a civil custody dispute. A mother of a 4-year-old daughter accuses her ex-husband of violating certain visitation terms in the divorce decree. A psychologist is appointed by the court to evaluate the situation and make recommendations to the court. The forensic psychologist, seasoned to the inherent distortions that occur in custody disputes, insists that he evaluate each member of the psychological family, both individually and as a unit, including the individual parents' new live-in companions. The mother, who initiated the new proceedings through her attorney in the hope of reducing her ex-husband's visitation, is now in the uncomfortable position of being interviewed by a psychologist and probably completing certain psychological tests. To her relief, she is initially asked only about her parenting attitudes and beliefs, but she suddenly feels coerced and invaded when the psychologist, with little introduction, presents her with an ambiguous inkblot and asks her, "What might this be?" She consequently produces an invalid Rorschach protocol—too few responses and too many pure F responses.

Coercion may also be an internally perceived process, such as the case of the paranoid schizophrenic who is compelled by his command hallucinations to confess a murder. Such intrapsychic coercion, although recently not recognized by the US Supreme Court as a legal basis for compulsory self-incrimination (*Colorado v. Connelly*), may still be quite clinically salient to the forensic interview.

How should the forensic interviewer respond to this ubiquitous core characteristic? First, this question should be considered prior to the evaluation: What are the legal and clinical factors in this particular interview that could be perceived as coercive? Second, once these factors are identified, the clinician should consider the ways in which coercion will affect the interview. One of the major ways is through malingering or dissembling (concealment) of symptoms, a separate core characteristic which I will consider later. Third, the clinician should tailor the interview to minimize the impact of the coercive factors: (1) Conduct the interview in a neutral setting if at all possible—evaluations in custody settings *must* be done in a private soundproof interview room, although security personnel may insist, for good reason, that they be able to

visually observe the interview; (2) ask that the interviewee not be physically restrained during the interview unless there is an imminent risk to your safety, which there may be; (3) inquire about the reasons for restraints before requesting their removal; and (4) discuss your speculations about the coercive elements of the interview directly and empathically with the interviewee. This brief, but frank, discussion will help establish rapport without misleading the interviewee, and should predict the extent to which the evaluation will be reliable and valid.

A female superior court judge had been verbally threatened by a defendant, now in custody, and asked me to evaluate him. Supported by civil and case law (*Tarasoff v. Regents of Univ. of California*), I agreed.

The defendant was brought to me while in custody. He sat and glowered at me, remaining mute. I explained to him the nature of my interview and made several empathic statements concerning the obvious coercion he must be feeling. He stared at me. I then asked him that if he understood my statements but was voluntarily choosing not to answer me, he should nod his head. He did. I then told him that if he wanted to end our brief encounter, he should nod his head. He did. The deputy escorted him, at my request, back to his cell.

All criminal defendants should be allowed an opportunity to consult with counsel before they participate in a forensic psychological interview. This protects the defendant's Sixth Amendment right to counsel, it shields the psychologist from inadvertently giving legal "advice" concerning the defendant's choice to participate in the interview, and it may attenuate the felt coercion during the interview. In civil proceedings, such as personal injury and custody cases, a right to consult with counsel is usually a moot issue since no criminal process is involved and both parties have usually retained their own counsel prior to any request for a psychological interview.

THE ABSENCE OF PRIVILEGE

Mental health professionals are ethically trained to value and protect the confidentiality of patient care and its written products. The legal correlate of confidentiality—privileged communication—is also considered an essential right held by the patient. In forensic interviews, however, there is virtually always a partial or complete waiver of privilege. This is often quite unsettling to the clinician first entering the forensic arena because it jostles his heretofore sanctified belief in the inviolate nature of the patient-therapist relationship. It also brings with it a "fishbowl effect": The professional's behavior with patients is no longer as insulated as he would like it to be. Forensic interviewing is no place for narcissistically sensitive clinicians who feel entitled to privacy in their work.

The nature and degree of waivers of privilege are quite variable. Criminal defendants entering a plea of not guilty by reason of insanity (NGRI) automatically waive all privilege since they are introducing

their mental state at the time of the alleged crime as a complete defense. The court forces a partial waiver of privilege when it finds a reasonable doubt that a criminal defendant is competent to stand trial, even if the prosecution enters the motion; yet the forensic examination is limited to evaluation of the defendant's psychological processes relevant only to his competency, and incriminating evidence uncovered during the examination is protected. Depending on the jurisdiction, clinicians retained by the defense in a criminal trial and then subsequently not used as experts may or may not be called as witnesses by the prosecution (*United States ex. rel. Edney v. Smith; United States v. Alvarez*). The judicial rule of thumb in most criminal litigation is a balancing of the individual's rights to privileged communication and the public safety.

In civil litigation, waiver of privilege is often carefully controlled by the court. California, for example, established a constitutional basis for privileged communication between therapist and patient when it wrote, in part,

We believe that a patient's interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. . . . [U]nder a properly limited interpretation, the litigant-patient exception to the psychotherapist-patient privilege . . . does not unconstitutionally infringe the constitutional rights of privacy of either psychotherapists or psychotherapeutic patients. . . . [W]e point out, however, because of the potential invasion of patients' constitutional interests, trial courts should properly and carefully control compelled disclosures in this area in light of accepted principles [*In re Lifschutz*].

How should the forensic interviewer respond to this core characteristic? First, therapists should be thoroughly familiar with their jurisdiction's penal code, civil code, and evidence code concerning privileged communication. There may be contradictions among these codes, and subsequent case law may have been written to clarify or delineate the nature and extent of privilege in certain representative cases.

Second, the clinician should be quite familiar with his profession's code of ethics, and should ponder potential areas of conflict in a particular case between his profession's ethical principles and his jurisdiction's settled law. For example, the American Psychological Association states that psychologists have an ethical responsibility to "avoid undue invasion of privacy" (principle 5, American Psychological Association 1981). However, ethical principles generally carry little weight in court.

Third, the legal context of a particular case, and its impact upon privilege, should be thoroughly assessed and understood before the forensic interview. A legal consultation with an attorney *knowledgeable in this area of law* may be quite propitious.

Fourth, at the beginning of the interview, forensic clinicians should spend as much time as needed to explain to the interviewee *who* they are, *what* they are doing, *why* they are doing it, *how* they are going to do it, *what* will be produced, and *where* the product will be used. The inter-

viewee must be fully informed. I might conduct this portion of the interview as follows:

Hello, Mr. Smith. My name is Doctor Reid Meloy. I am a psychologist hired by your attorney [who] to meet with you this afternoon. I am here to learn as much as I can about you, and the crime you are charged with [what]. As you know, the reason I am here is that you and your attorney are considering an insanity defense. This means that because of a mental disorder at the time of the crime, you were not responsible for your behavior [why]. Any questions?

I will be talking with you and asking you lots of questions. You do not have to answer any of them, and can ask me to repeat or clarify any questions you don't understand. I'll also be asking you to fill out some questionnaires, and I may ask you to respond to certain objects, drawings, or pictures that I'll show you [how]. Any questions?

When we're finished, I will be thinking about everything you've told me and studying all the other information I've received from your attorney. Then I will write a report [what]. This report, which I expect to have finished one week from today, will be sent only to your attorney. But if you do plead insanity, my report will go to the court, the judge, and the district attorney, the prosecutor [where]. I can then be forced to testify truthfully and completely about anything you've told me or any opinions that I've formed. Any questions? Do you understand? Can you tell me briefly what I've told you so I know you understand?

The disclosure of such information, although it appears tedious, is generally expected behavior in forensic interviews. It is consonant with ethical principle 6, wherein psychologists must "fully inform consumers as to the purpose and nature of an evaluative . . . procedure" (American Psychological Association 1981), and with recent case law (*Estelle v. Smith*).

The doctrine of informed consent is not as germane to a forensic interview as it is to treatment, since most forensic evaluations are court-ordered. However, the clinician should be sensitive to the possible need for informed consent prior to a forensic interview, and should seek it in writing if necessary. Three elements are considered to determine whether informed consent has been obtained: (1) the adequacy of disclosure from both the clinician's and the patient's perspective, (2) the patient's competency to give consent, and (3) the voluntariness of the consent (*Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees; Grisso 1986*). Informed consent is more likely to be a requirement in civil work (personal injury, family, and custody cases) than in criminal work.

A LAY COMMUNICATION TOOL

Unlike other mental health interviews, the forensic interview is essentially a means to gather information that can then be communicated to non-mental health professionals. The product of the forensic interview, whether it be a written report or an oral testimony, is only valuable if it is understandable to educated lay professionals, usually attorneys and

by the general presence of external factors that would be considered "secondary gain" in most forensic settings, such as monetary settlements, movement to a less restrictive level of care (prison to hospital), or mitigation of a criminal offense.

Although there are a wide variety of forms of distortion, I will limit this discussion to conscious, willful distortion by the interviewee. Other forms of distortion that have more symbolic and unconscious meanings, such as factitious disorder, must be clinically ruled out in forensic evaluations, but they are not as prevalent as intentional distortion. This core characteristic *must be assumed to exist* in all forensic interviews until it is disproven.

Distortion in the interview usually takes one of two forms: *simulation* (malingering), which is the feigning of symptoms that do not exist; and *dissimulation* (dissembling), which is the concealment or minimization of symptoms that actually do exist. Other combinations are possible. Garner (1965) defined pure malingering as the feigning of disease where none exists; partial malingering as the conscious exaggeration of symptoms that do exist; and false imputation as the ascribing of actual symptoms to a cause consciously recognized as having no relationship to the symptoms.

Although dissimulation is not mentioned in DSM-III-R, simulation is termed *malingering*, and is defined as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives . . ." (p. 360). It should be strongly suspected in any medicolegal setting if any combination of the following are noted: marked discrepancy between claimed symptoms and objective findings, lack of cooperation during the diagnostic evaluation, and a diagnosis of antisocial personality disorder. This "suspicion index" would also apply to dissimulation.

How should the forensic clinician respond to the core characteristic of distortion? Prior to any forensic evaluation, whether civil or criminal, one should construct the hypothesis that *distortion will be present in this evaluation*. Once this particular perspective is taken, *disproving* this hypothesis then becomes the clinical task. In order to accomplish this task, the clinician must be familiar with the research literature on simulation and dissimulation (Adelman and Howard 1984, Gorman 1984, Resnick 1984, Rogers 1984a). Rogers (1984a) constructed both heuristic and empirical models of malingering and deception, and I have adapted and combined them in Table 18-1.

All indicators have heuristic support among a group of experienced forensic clinicians that Rogers (1984a) surveyed. This table also covers the three data sources for the clinician to consider in determining whether an interviewee is distorting: the clinical interview, psychological testing, and independent corroborative information. A judgment of distortion should not be made without consideration of all three data sources, if available.

The clinical interview's contribution to the distortion hypothesis can be viewed from the dual perspective of observation and intervention.

TABLE 18-1. Clinical Indicators of Distortion

Indicators	Response styles		
	Reliable	Simulated	Dissimulated
1. Severity of symptoms	variable	severe	minimal
2. Selectivity of reporting symptoms	selective	overendorsement	underendorsement
3. Consistency of self-report	consistent	consistent	consistent
4. Contradictory symptoms	unlikely	likely	unlikely
5. Rare symptoms	unlikely	likely	unlikely
6. Sequence of symptoms	consistent with diagnosis	inconsistent	inconsistent
7. Obvious v. subtle symptoms	balanced	more obvious	more subtle
8. Appearance of symptoms	gradual onset and resolution	sudden onset	sudden resolution
9. Memory of past psychological problems	normal memory	heightened memory of impairment	heightened memory of adjustment
10. Potentially self-damaging statements	likely	unlikely	unlikely
11. Random response pattern	no	unlikely	no
12. Self-report inconsistent with clinical observation	no	unlikely	likely
13. Endorsement of highly specified symptoms	unlikely	likely	unlikely

Adapted by permission of Van Nostrand Reinhold, from Rogers, 1984a. Underlines denote indicators that are empirically supported in the literature (a five-year search of Psych Abstracts, PsycInfo, and NCMHI databases).

Observations of an individual attempting to distort or deceive find direction in the following research conclusions: Increased body movements and postural shifts are more indicative of deception than is facial expression (Ekman and Friesen 1969, McClintock and Hunt 1975, Rogers 1984a); visual clues serve more as a distraction than as a facilitation in the detection of deception (Littlepage and Pineault 1978, Rogers 1984a); verbal content is a primary determinant in the detection of deception (Maier and Thurber 1968, Rogers 1984a); intuitive assumptions concerning an individual's veracity may lead to misjudgments in the face of actual honesty or dishonesty (Zuckerman et al. 1979); and clinical research of distortion in psychiatric populations is extremely important, but very limited (Rogers 1984a).

Interventions during the clinical interview to ferret out distortion include: purposeful lengthening of the interview to induce fatigue; varying the pace and speed of questioning; confrontation of the interviewee with the suspicion that he is distorting; repeat questioning with sufficient time and interference to increase the difficulty of remembering prior deceptions; suggesting the need for 24-hour hospitalization to thoroughly assess the clinical situation (and sometimes carrying out the suggestion); in criminal settings, evaluating the defendant as soon as possible after the crime was committed; avoidance of leading or suggestible questions about symptoms; using open-ended questions to inquire about symptoms (for example, "Can you describe to me what it's like to be depressed?"); intentionally mixing symptoms from various diagnostic categories that are usually mutually excludable (for example, "Do you ever have auditory or visual hallucinations right after you've had a drink of alcohol?"); linking preposterous or fantastic symptoms to complaints ("Have you noticed a change in your hat or glove size since you started hearing the voices?"); purposefully inducing stress ("I don't want you to be anxious about what I'm going to ask next"); and expanding on details at random without following a detectable order or sequence. I always try to present myself as an "ambiguous stimulus" to the interviewee, especially at the beginning of the evaluation, after the initial legal and ethical introductions. This minimizes clues to which the interviewee can consciously adapt if he is planning a distortion strategy. If he is not planning to distort, his initial presentation should be quite reliable and valid without needing me to provide the antecedents for his behavior.

Thorough knowledge of the nature and expression of certain commonly feigned symptoms is also very important. Hallucinations, for instance, are a troublesome symptom in a forensic setting because they cannot be absolutely disproved or objectively measured. Yet clinical research has given the clinician a wealth of information about hallucinations, particularly in schizophrenia: Command hallucinations are experienced by only a small proportion (less than 20 percent of schizophrenic patients (Hellerstein et al. 1987) and are successfully resisted by most patients who hear them (Goodwin et al. 1971). Command hallucinations do not significantly increase the risk of inpatient violence (Hellerstein et al. 1987). Hallucinations are usually accompanied by delusions, and

are usually related to some psychic purpose (Resnick 1984). Voices speaking directly to the patient or commenting on his behavior are characteristic of schizophrenia, but are less easily discussed than alcohol-induced hallucinations (Alpert and Silvers 1970, Resnick 1984). Schizophrenic hallucinations are usually intermittent, and rarely continuous (Goodwin et al. 1971). The majority of schizophrenic patients, when asked if their hallucinations could be a product of their imagination, will say yes (Goodwin et al. 1971). Most auditory hallucinations will be heard "outside" the head and will contain both male and female voices (Goodwin et al. 1971). The message is usually clear, and is accusatory about one-third of the time (Goodwin et al. 1971). Hallucinating patients should also be asked what they do to make the voices go away. Common coping strategies include specific activities, changes in posture, seeking out others, or taking medication (Resnick 1984).

Patient A complained of continuous auditory hallucinations telling him to kill his sister. He was absolutely sure that the voices were a product of his schizophrenia, which he gladly talked about with any clinician. He said that they were always "inside" his head, especially when one of the clinicians suggested that this location of hallucinations was "much more serious" than if they occurred "outside" his head. He had not thought of any strategies to alleviate the "voices." The clinical staff concluded that he was malingering (simulating) the symptom of auditory hallucinations, and his motivation to deceive became a focus of treatment.

The use of psychological tests to ferret out distortions in a forensic setting is the second source of data to be considered by the clinician. It is beyond the scope of this chapter to review all of the psychological tests commonly used to detect distortion, so instead I will briefly comment on two of the most widely used tests: the Minnesota Multiphasic Personality Inventory (MMPI) and the Rorschach.

Self-report measures in criminal populations are inherently unreliable (Hare 1985a). Yet the MMPI should be considered the clinician's "workhorse" in adult forensic interviews due to the enormous amount of research available concerning its clinical use, and the sensitivity of its various indicators of distortion.

The most commonly used indicator of distortion, whether simulation (fake bad) or dissimulation (fake good) is the configuration of the validity scales L, F, and K. Since the early work of Hunt (1948) and Gough (1950), the F-K index has been confirmed as a reliable indicator of distortion (Greene 1980, Osborne et al. 1986, Rogers 1984a).

The Wiener (1948) Subtle-Obvious items on five scales of the MMPI also appear to be especially useful in forensic settings. A difference of greater than 1 standard deviation between the subtle and obvious items on any one of the scales should alert the clinician to the possibility of simulation or dissimulation around the particular symptom complex measured by the scale, depending on the direction of the difference (subtle items greater than obvious items suggests dissimulation; obvious

items greater than subtle items suggests simulation). Rogers (1983) noted, however, that specific indicators of randomness should be measured before distortion conclusions are drawn from the Wiener-Harmon subscales. He suggested the use of the Carelessness Scale (Greene 1978) and the Test-Retest Scale (Buechley and Ball 1952) to rule out random responding.

The Rorschach remains the second most widely used psychological test (Piotrowski et al. 1985) by members of the Society for Personality Assessment (SPA), and it is popular with other clinicians as well (Lubin et al. 1984). The Comprehensive Scoring System (Exner 1986) is gaining in use and was preferred by more than one-third of the SPA members who responded to Piotrowski and colleagues' (1985) survey.

Controversy surrounds the vulnerability of the Rorschach to distortion. Albert and co-workers (1980) found that a group of untrained subjects could successfully simulate paranoid schizophrenia and fool a group of expert clinicians who were given their Rorschachs. This study has been critiqued, however, for its small sample size (six subjects in each group), blind analyses, and unknown methods of scoring (Exner 1978, Ziskin 1984). Exner (1978) and others (Seamons et al. 1981) found that standardized administration and scoring of Rorschach protocols did allow for respectable discrimination between faked and genuinely psychotic Rorschach protocols. Albert and colleagues' (1980) study has yet to be replicated using Exner's (1986) Comprehensive System of scoring.

The heart of Rorschach distortion appears to lie in the difference between content and structural analysis. Both Exner (1978) and Seamons and associates (1981) noted that the layperson's idea of "faking psychosis" is to give dramatic and fantastic content responses. Blind content analysis of such data would be misleading in the absence of other behavioral data. Structural analysis of the same protocol would probably yield nonpsychotic indices, however, since these would be much more difficult to compute and distort, even with prior knowledge of their meaning. In the Exner (1986) system, such indices as X+%, X-%, and Special Scores, as indicators of reality convergence, reality distortion, and cognitive slippage, respectively, would be very difficult to intentionally distort.

I would suggest that interpretation of the Rorschach in a forensic setting begin with the Comprehensive System (Exner 1986) to determine whether the protocol is valid, with a particular focus upon number of responses and lambda (see Meloy 1988 for Rorschach criteria with psychopathic individuals). The Exner (1986) scoring is also the most defensible in court due to the extensive empirical studies that have been done. Once validity has been established, content analysis of the Rorschach can then proceed so that certain object relational and psychodynamic patterns are fully apprehended. I think this multidimensional analysis of the Rorschach is most revealing and useful in forensic settings (Meloy 1988). My clinical experience suggests that the best way to "beat" the Rorschach is to refuse to take the test, but this behavior is also diagnostically and behaviorally revealing.

The third source of data to be considered in distortion is collaborative information on the individual. This source is crucial to disproving the distortion hypothesis and should be aggressively pursued by the forensic examiner. One very useful forensic instrument, the Hare Psychopathy Checklist (Hare 1980), a trait measure of psychopathic disturbance completed by the forensic clinician, has *greater* reliability and validity when based upon only corroborative information than when based upon only the clinical interview (Hare 1985b).

The following behaviors are useful in increasing the amount of available corroborative information: Obtain all records on the patient (school, medical, psychiatric, psychological, criminal history, arrest, prosecution, defense, archival court, and so on) and read them before the examination; meet with the patient at least twice, and consider administering some tests twice, to measure temporal reliability; audio- or videotape the evaluation, always with the patient's permission, and review it later; conduct collateral interviews, using the efficiency of the telephone to do so; and gather data on the patient in as "naturalistic" a manner as possible. The latter method might include observing the patient approaching and leaving the office; observing the patient's interactions with others; asking the secretary about the individual's behavior in the waiting room; or visiting the individual's home (or jail module) for a portion of the evaluation. It can also be useful at the end of the evaluation for the clinician to lay paper and pencil down, sit back, and ask the patient, "Now, is there anything else you'd like to tell me?" The obvious nonverbal clues here suggest to the patient that the clinician may be receptive to some "off the record" comments, without his actually saying so. It is a misleading, and some would consider deceptive, gesture, but it may yield important new information.

When evaluating for criminal responsibility, it is especially important to talk to individuals who observed the defendant just prior to, during, or right after the offense. The reconstruction of an offense is central to the task of inferring the defendant's state of mind, and therefore criminal responsibility, in all insanity evaluations (Rogers 1986).

DISAGREEMENT AND SCRUTINY

Regardless of the clarity, simplicity, and thoroughness of the work product of the forensic interview (oral testimony or written report), it will usually be disliked and disparaged by half of the individuals privy to it. This is the nature of the adversarial system wherein the two sides of any legal question advocate as strongly as possible for their opposite positions. The judicial hope is that the trier of fact, whether judge or jury, will then be better able to discern the truth.

The forensic clinician must steel herself to this adversarial reality, being careful not to personalize and feel narcissistically insulted by disagreements from "the other side." It is less usual to have both legal counsels stipulate to (accept) the forensic "work product," and this most

commonly happens when the forensic psychologist is appointed as *amicus curiae* (friend of the court) to conduct the evaluation. Such consensual gifts are the exception, not the rule.

Disagreement by opposing counsel is therefore accompanied by careful scrutiny of the work product to ferret out mistakes; such errors of omission or commission during the forensic interview then serve as points of attack during cross-examination if the case goes to trial.

Such disagreement and scrutiny is the fifth distinguishing core characteristic of the forensic interview. How should the forensic clinician prepare for this core characteristic? *Most fundamentally, forensic clinicians should advocate for their data and interpretations based only upon sound scientific reasoning.* This should take precedence over all personal philosophy, political views, social reformist ideals, and therapeutic goals for the patient. The forensic interview is not the place to develop a social advocacy or psychotherapy treatment plan for the interviewee. This principle is most easily followed when the clinician is appointed by the court, but it presents major difficulties when he is retained by counsel and the forensic interview findings are not what counsel wants. He will likely seek another examiner, reluctantly pay the clinician's bill, and not call him again. This may be quite economically damaging in the short run, but in the long run will build the clinician's reputation among attorneys and judges as a professional that *cannot be bought*. It takes great integrity and resolve to maintain a neutral, behaviorally scientific position in an adversarial system that is continuously attempting to distort the facts and findings of every scientific investigator and may initially punish by not referring more cases.

Moreover, the ability to successfully advocate for a forensic database depends upon the reliability and validity of the content of the database. Certain steps can be taken to ensure that the forensic interview is both reliable and valid.

First, attorneys should be excluded from observing or participating in most forensic interviews. The one exception may be during an evaluation for competency to stand trial, when the interactions between the attorney and his client are crucial behavioral samples to correctly answer the legal question. This exclusionary position finds case law support at both the federal and state level for both criminal and civil evaluations. Despite the opposing Sixth Amendment right to counsel, most courts have deferred to the request of the clinician that attorneys be excluded in both civil and criminal proceedings when the examiner is court appointed (*United States v. Byers*, *Durst v. Superior Court*, *Tarantino v. Superior Court*, *In re Spencer*, *Rollerson v. United States*, *Edwards v. Superior Court*, *Vinson v. Superior Court*). The American Bar Association (1984) also supports the exclusion of counsel from clinical interviews in most cases. However, attorneys do not like to be excluded from anything. Such a clinical position may raise the ire of counsel, particularly opposing counsel, but when faced with such a demand it is very important not to capitulate. The clinician should allow the attorney to take his demand to

court in the form of a motion and let the court rule on the appropriateness of his presence.

Second, it is most wise to use structured interview formats when conducting forensic interviews. Such formats demonstrate to anyone who scrutinizes clinicians' work that they do have a "standard of care" and are interested in their own clinical reliability. It also ensures that crucial areas to be probed will not be overlooked because of momentary anxiety or distraction.

Structured interview formats may range from the clinician's own list of questions that he repeatedly uses when he addresses a certain psycholegal question, to much more formalized structured interviews that have both reliability and validity in the larger scientific community.

One such instrument, the Rogers Criminal Responsibility Assessment Scales (R-CRAS), is an excellent example of a structured interview for evaluating insanity at the time of the criminal offense (Rogers 1984b). The R-CRAS is a systematic and criterion-based instrument modeled after the Schedule of Affective Disorders and Schizophrenia. It consists of a 15-page examination booklet that is organized into two parts. Part 1 consists of 25 assessment criteria that are each quantified into four to six gradations of increasing severity. They address patient reliability, organicity, psychopathology, cognitive control, and behavioral control. Part 2 consists of three decision models that operationalize the American Law Institute (ALI), Guilty But Mentally Ill (GBMI), and McNaghten standards of criminal responsibility. The structured instrument has a moderate degree of internal consistency and a high degree of interjudge reliability (Meloy 1986).

A second example of a structured interview, this time used to assess competency to stand trial, is the Interdisciplinary Fitness Interview (IFI) by Golding and colleagues (1984). Ideally used in a joint interview by both a mental health professional and an attorney, the IFI covers the joint domains of psychopathology and law from an explicitly functional perspective. It consists of three sections: legal items (for example, "quality of relationship with one's current attorney"); psychopathological items (for example, "delusional processes"); and overall evaluation ("overall fitness judgment").

Interjudge agreement yielded a kappa coefficient of 0.93 in one study (Golding et al. 1984). It appears to have both a low false positive and a low false negative rate, and many fewer false positive errors than the older Competency Screening Test (McGarry et al. 1973). Further validity studies are needed, however (Meloy 1985).

A third example of structured interviewing, although not standardized, is the "structural interview" developed by Kernberg. In Kernberg's (1984) own words,

The structural diagnostic interview . . . combines a psychoanalytic focus on the patient-interviewer interaction with a psychoanalytic technique for interpreting conflictual issues and defensive operations in this interaction in

order to highlight simultaneously the classical anchoring symptoms of descriptive psychopathology and the underlying personality structure. [p. 30]

Kernberg's interview begins in a traditional manner with a history taking and mental status examination, but then probes more deeply into the patient's personality by focusing on questions that are bound to elicit certain transference and countertransference reactions: emotions perceived by the examiner that may be crucial to identifying underlying Axis II disorders that are endemic in forensic settings. Kernberg begins his investigation of pathological character traits with the following questions: "You have told me about your difficulties, and I would now like to hear more about you as a person. Could you describe yourself, your personality, what you think is important for me to know so that I can get a real feeling for you as a person?" (p. 33). Such a structured interview that combines both descriptive-symptomatic and object relational areas of inquiry can be particularly useful in assessing psychopathically disturbed individuals (Meloy 1988).

A third method to ensure the reliability and validity of the forensic interview is always to address the psycholegal question—nothing more and nothing less. The design of the forensic interview should be a logical outgrowth of the psycholegal question to be answered, and the database produced by the interview should build inferences that logically answer the psycholegal question. Anyone scrutinizing the forensic clinician's work should not be surprised by the interview methods or tests chosen to address a particular question, and subsequently should not be taken aback by the conclusions drawn from the accrued database.

I am always amazed at the frequency with which this seemingly simple and direct proposition is not followed by forensic clinicians. One way this commonly occurs is by what I call the "Oh, no!" technique (rather than the "Ah ha!" experience). One is carefully reading a forensic evaluation that appears to be accumulating more and more information supporting a particular legal opinion (for example, the individual did not know the difference between right and wrong at the time of the offense). Suddenly, on the last page, the evaluator renders the *exact opposite* opinion, and the reader is left feeling surprised and confused. Reasons for such Aristotelean failures abound, but the essential problem is that the logical progression has been negated and reversed.

Another common way this occurs is by what I call the "leap-before-you-look" technique. One begins reading a forensic evaluation that is supposedly addressing a psycholegal question. As the report proceeds, the reader waits expectantly, and more impatiently, for the forensic interviewer to *do* something or *say* something that is relevant to the psycholegal question. Then the report is finished with an opinion and a recommendation.

Something has been lost; the structure of the interview, the questions asked, the tests administered, the database collected, and the resultant conclusions *had nothing to do with the psycholegal question*. I have read

reports that addressed competency to stand trial when the psycholegal question was insanity at the time of the offense. I have seen clinicians attempt to diagnose organic brain syndrome using the Rorschach. I have seen psychiatrists render opinions of dangerousness based solely upon a diagnosis of schizophrenia. Absolute reliability may occur in the face of absolutely zero validity. The forensic interview must be scientifically relevant and therefore a valid measure of the psycholegal question.

The courts have long recognized the importance of reliability and validity in expert testimony, and the admonition set forth in *Frye v. United States* (D.C. Circuit 1923) is also applicable to the structuring of the forensic interview:

Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made *must be sufficiently established to have gained general acceptance in the particular field in which it belongs*. [italics mine, 293 F. 1013]

This admonition, known as the "Frye test," is usually understood to mean that the particular scientific technique in question must be accepted by a majority of the profession, usually through authoritative scientific writings and other judicial citations.

The mental status examination, for example, would successfully pass the Frye test because it is used by most clinicians in conducting diagnostic evaluations. In fact, the *absence* of a mental status examination during a diagnostic evaluation could call into question the interviewer's competence. On the other hand, forensic clinicians using the Piotrowski method for interpreting the Rorschach could be seriously challenged using the Frye test since only 5 percent of survey respondents espouse this method of Rorschach interpretation (Piotrowski et al. 1985). The Exner Comprehensive System is rapidly gaining acceptance among clinicians (35 percent of survey respondents espoused this method) and may soon be the only Rorschach interpretive method that will pass the Frye test.

In California, *People v. Kelly* established a two-prong test for admissibility of new scientific technique: The reliability of the method must be established, usually by expert testimony; and the witness so testifying must be properly qualified as an expert to give an opinion on the subject. The court also noted, however, that this "Kelly-Frye rule" applied to novel devices or processes, not to expert medical testimony: "Such a diagnosis need not be based on certainty, but may be based on probability; the lack of absolute scientific certainty does not deprive the opinion of evidentiary value . . ." (*People v. Mendibles* at 557).

One can therefore conclude that the forensic interview should be conducted in a manner and with certain assessment techniques that would be accepted by a majority of the forensic psychology community.

The opinion rendered on the basis of the forensic interview would not have to be accepted by a majority of the professional community to have evidentiary value, however. Such planning should ensure the reliability and validity of the forensic interview and should protect the forensic clinician, who continually faces scrutiny and disagreement.

FORENSIC PSYCHOLOGICAL INVESTIGATION

The final distinguishing core characteristic of the forensic interview is the attitude and expectation of the interviewer. Forensic interviews compel the forensic clinician to assume the role of a *forensic psychological investigator*. The attitude is one of impartiality and objectivity. The expectation is that data will accumulate that will eventually answer the psycholegal question that prompted the evaluation. The "client" may be a government agency, a private attorney, a referring professional, or the judiciary. It is rarely the interviewee. Monahan (1980) has edited an excellent compilation of papers about the ethics of psychological intervention in the criminal justice system.

The role of the forensic psychological investigator precludes certain other expectations that are often deeply embedded in the clinician's professional training; the role of healer, therapist, "helper," and patient advocate *must be abdicated* if forensic psychological investigation is to occur in a reliable and valid manner. This does *not* mean, however, that respect for the dignity and worth of the individual, protection of his civil rights, protection of his welfare, or awareness of his legal rights should be ignored. In fact, these ethical imperatives must be vigilantly pursued, since forensic investigation, by its nature, may tempt the clinician to violate or compromise them.

The role of the forensic psychological investigator is fully consonant with the psychologist's ethics. Nothing in the ethical principles implies that all professional interactions must be "therapeutic" or "helping." There are limits, however, to psychological investigation:

While demanding for themselves freedom of inquiry and communication, psychologists accept the responsibility this freedom requires: competence, objectivity in the application of skills, and concern for the best interests of clients, colleagues, students, research participants, and society. [Preamble, American Psychological Association 1981]

I have occasionally seen such role confusion lead to contrived ethical conflicts for the clinician and, in some cases, defensive and angry posturing under cross-examination. When this happens, the clinician's credibility as an expert witness is usually lost, and the courtroom experience becomes an unpleasant, if not painful, emotional memory.

How does the clinician prepare to assume the role of a forensic psychological investigator? First, the clinician must be comfortable with the goal of understanding, rather than changing, human behavior. If this is not the case, and the clinician's primary identification is with the role of

therapist or "healer," he should not undertake the role of forensic psychological investigator.

Second, careful thought must be given to potential ethical problems that may arise with each forensic case. The ethical caveat concerning dual relationships (American Psychological Association 1981) is most germane to this consideration. For instance, if at all possible, a clinician should avoid conducting a forensic psychological investigation of a patient he has seen in psychotherapy, regardless of whether the treatment has ended. Sometimes a court order will make this virtually impossible, but the clinician is ethically obligated to inform the court of his professional imperative to avoid such dual relationships (principle 6, American Psychological Association 1981). Clinicians should avoid serving as experts for attorneys who are also friends or social acquaintances. This can be particularly difficult in small communities, but would be considered a violation of the dual-relationship clause if ethically challenged. The assessment of competency for execution is another area of professional concern that raises profound ethical problems for clinicians who believe in the primacy of individual life (Heilbrun 1987). Such an evaluation may violate the preamble, principle 3, and principle 6 of the psychologist's ethical principles (American Psychological Association 1981).

And third, clinicians should be knowledgeable about the other core characteristics that I have outlined and should prepare themselves with the requisite skills, attitudes, approaches, and techniques that I have suggested accompany each characteristic: the coercive context, the absence of privilege, a lay communication tool, the presence of distortion, and disagreement and scrutiny.

Such preparation for the forensic interview should foreshadow success in the forensic arena. After all, it would be a shame if the forensic clinician suddenly realized that his self-perceived "good reputation" was only a symptom of *pronoia*: the delusional belief that others are saying nice things about him behind his back.

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