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Overview of the Relationship between the Law and Mental Health Professionals on the Issue of Competence

A. THE HISTORY OF THE RELATIONSHIP BETWEEN COMPETENCY AND THE LAW

As is discussed in greater detail in Chapter 2, the legal system worldwide has dealt with questions of competency in criminal law for centuries, dating to at least mid-seventeenth century England,[1] perhaps for even 400 years before that.[2] Other questions of competency date to the time of the Code of Hammurabi.[3] Social historians tell us that the relationship between competency and issues related to psychiatric hospitalization was first considered some 2,500 years ago in the Twelve Tables of Rome.[4] The question of the relationship between civil law and competency is similarly venerable: Guardianship has ancient origins in Roman and English common law, for example, as does the law of wills.[5] These, in

1. *See* Bruce Winick & Terry DeMeo, *Competency to Stand Trial in Florida,* 35 U. Miami L. Rev. 31, 32 n.2 (1980).

2. *See* Ronald Roesch & Stephen Golding, Competency to Stand Trial 10 (1980).

3. *See* Thomas R. White, *Oaths in Judicial Proceedings and Their Effect Upon the Competency of Witnesses,* 51 U. Pa. L. Rev. 373, 375, 395 (1903).

4. *See* 1 Michael L. Perlin, Mental Disability Law: Civil and Criminal, § 2A-2.1a, at 46 (2d ed. 1999), citing The Mentally Disabled and the Law 6 (F. Lindman & D. McIntyre eds. 1961).

5. *See, e.g.,* Patricia McManus, *A Therapeutic Jurisprudential Approach to Guardianship of Persons with Mild Cognitive Impairment,* 36 Seton Hall L. Rev. 591 (2006) (guardianship); 3 Sir William Holdsworth, A History of English Law 541–44 (3d ed. 1923) (wills).

short, are inquiries that have concerned lawyers, mental health professionals, and policymakers for centuries.

Yet, in at least two of the three major substantive areas with which this volume is concerned, the most important developments in competency and the law have come within the past 35 years—in the landmark cases of *Jackson v. Indiana*[6] and *Rivers v. Katz*.[7] In *Jackson*—a case nominally involving the competency to stand trial of a criminal defendant who was profoundly mentally retarded, deaf, and mute—the U.S. Supreme Court, for the first time, applied the due process clause to all matters involving the nature and duration of commitment to psychiatric institutions.[8] In *Rivers*—a case nominally about a civil patient's right to refuse the involuntary administration of antipsychotic medications—the N.Y. Court of Appeals seriously considered the relationship between an individual's competency and his right to exercise autonomy in institutionally based decision-making.[9] The impact of both of these cases transcended the circumstances of the narrow legal issues presented, and, in effect, opened the courthouse doors[10] to multiple new inquiries about competency in all relevant aspects of public law.

Simultaneously, researchers and behavioral scholars launched a series of complex, multijurisdictional studies designed to illuminate the multiple layers of competency, to better understand the relationship between competency and mental illness, between competency and decision-making, and between competency and the legal process. These studies—many of which were undertaken under the aegis of the MacArthur Foundation—shone new light on the clinical concepts involved in legal competency decisions and clarified the relationships between competence and mental illness, concluding that mental patients are not always incompetent to make rational decisions and that mental patients are not inherently more incompetent than nonmentally ill patients.[11] In fact, on "any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients and nonpatients."[12] By way of example, the judicial presumption that there is both a de facto and de jure presumption of

6. 406 U.S. 715 (1972).

7. 495 N.E. 2d 337 (N.Y. 1986).

8. *Jackson,* 406 U.S. at 738.

9. *Rivers,* 495 N.E. 2d at 341–42.

10. *Cf.* David Bazelon, *Veils, Values and Social Responsibility,* 37 Am. Psychologist 115, 115 (1982) (courts should "open the courthouse doors" to mental health professionals but "never hand over the keys").

11. Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment: Kendra's Law as Case Study,* 9 Psychol. Pub. Pol'y & L. 183, 193–94 (2003), relying on, inter alia, Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence To Consent to Treatment,* 19 Law & Hum. Behav. 105 (1995); Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence To Consent to Treatment,* 19 Law & Hum. Behav. 127 (1995); Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients To Consent to Psychiatric and Medical Treatments,* 19 Law & Hum. Behav. 149 (1995).

12. Grisso & Appelbaum, *supra* note 11, at 169.

incompetency to be applied to medication decision-making appears to be based on an empirical fallacy[13]; psychiatric patients are not necessarily more incompetent than nonmentally ill persons to engage in such independent medication decision-making.[14]

Also, state legislatures began to consider questions of competency in their efforts to create new solutions to vexing legal-social-clinical problems (e.g., the proliferation of so-called "assisted outpatient treatment" laws, most famously exemplified by New York's Kendra's Law;[15] the creation of so-called "Problem-Solving Courts" such as drug treatment courts or mental health courts, which are conceived as ways of diverting certain individuals from the criminal justice system into more treatment-focused tribunals;[16] and the proliferation of sexually violent predator laws, mandating civil commitment following completion of terms of criminal sentences.[17]

In addition, scholars have increasingly begun to turn their attention to "therapeutic jurisprudence." Therapeutic jurisprudence (TJ) presents a model by which we can assess the ultimate impact of case law and legislation that affects individuals with mental disabilities. Therapeutic jurisprudence studies the role of the law as a therapeutic agent, recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or antitherapeutic consequences, and questions whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential while not subordinating due process principles.[18] Several researchers have focused the therapeutic jurisprudence lens directly on questions of competence in matters related to criminal and institu-

13. *See, e.g.,* Michael L. Perlin, *"You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching,* 9 Clinical L. Rev. 683, 696 (2003) (Perlin, *Lepers*)(discussing literature); Michael L. Perlin, *"Make Promises by the Hour": Sex, Drugs, the ADA, and Psychiatric Hospitalization,* 46 DePaul L. Rev. 947, 973–74 (1997) (same).

14. Perlin, *supra* note 11, at 194; *see generally,* Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications,* 2 Psychol., Pub. Pol'y & L. 137 (1996).

15. *See, e.g.,* N.Y. Mental Hyg. Law §9.60(5)–(6) (constitutionality upheld in In re K. L., 806 N.E.2d 480 (N.Y. 2004)).

16. *See, e.g.,* Pamela M. Casey & David B. Rottman, *Problem-solving Courts: Models and Trends,* 26 Just. Sys. J. 35 (2005).

17. *See, e.g.,* 1 Perlin, *supra* note 4, § 2A-3.3, at 75–92.

18. Michael L. Perlin, *"For the Misdemeanor Outlaw": The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities,* 52 Ala. L. Rev. 193, 228 (2000). *See generally,* Therapeutic Jurisprudence: The Law as a Therapeutic Agent (David B. Wexler ed. 1990); Essays in Therapeutic Jurisprudence (David B. Wexler & Bruce J. Winick eds. 1991); Law in a Therapeutic Key: Recent Developments in Therapeutic Jurisprudence (David B. Wexler & Bruce J. Winick eds. 1996); Therapeutic Jurisprudence Applied: Essays on Mental Health Law (Bruce J. Winick ed. 1997).

The scope of therapeutic jurisprudence now goes far beyond questions of mental disability law. *See, e.g.,* 1 Perlin, *supra* note 4, § 2D-3, at 540 nn. 133–43 (discussing applications of TJ to, inter alia, domestic violence law, family law, labor arbitration, workers' compensation law, probate law, and policies about disclosure of sexual orientation).

tional law,[19] and courts are also beginning to consider principles of therapeutic jurisprudence in deciding cases and rewriting court rules.[20]

It is certainly reasonable to anticipate that this confluence of case law, behavioral investigation, legislative action, and scholarly ferment will continue and will expand in the future.[21]

B. FUTURE GROWTH

We can confidently predict that these areas of law and psychology will continue to evolve in future years. As we discuss in the subsequent parts of this book, it is entirely foreseeable that competency-related case law will continue to grow in the areas of criminal procedure (especially in matters involving [a] the pretrial process,[22] [b] post-guilty verdict stages,[23] and [c] the death penalty),[24] sexually violent predator laws,[25] the laws related to psychiatric institutionalization (the relationship between competency and, variously, civil commitment,[26] the right to refuse treatment,[27] and deinstitutionalization, especially as that relates to the Americans with Disabilities Act),[28] correctional law as it relates to questions of inmate discipline and segregation,[29] and those areas of civil law that focus on trusts and estates,[30] contractual obligations,[31] domestic relations,[32] and guardianships.[33] In short, we expect that this will be a growth area for the foreseeable future.

19. *See, e.g.,* Bruce Arrigo, & Jeffrey Tasca, *Right to Refuse Treatment, Competency to be Executed, and Therapeutic Jurisprudence: Toward A Systematic Analysis,* 24 L. & Psychol. Rev. 1, 1–47 (1999); Patricia McManus, *A Therapeutic Jurisprudential Approach to Guardianship of Persons with Mild Cognitive Impairment,* 36 Seton Hall L. Rev. 591 (2006); Richard Barnum & Thomas Grisso, *Competence to Stand Trial in Juvenile Court in Massachusetts: Issues of Therapeutic Jurisprudence,* 20 New Eng. J. on Crim. & Civ. Confinement 321 (1994); Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection,* 28 *Hous. L. Rev.* 15, (1991).

20. *See, e.g.,* Amendment to the Rules of Juvenile Procedure, Fla. R. Juv. P. 8.350, 804 So.2d 1206 (Fla. 2001); In re Mental Health of K.G.F., 29 P.3d 485 (Mont. 2001).

21. *See infra* Chapter 1 B.

22. *See infra* Chapter 2 D 1.

23. *See infra* Chapter 2 D 3.

24. *See infra* Chapter 2 H.

25. *See infra* Chapter 2 G.

26. *See infra* Chapter 3.

27. *See infra* Chapter 3.

28. *See infra* Chapter 3.

29. *See infra* Chapter 3.

30. *See infra* Chapter 4 C.

31. *See infra* Chapter 4 B.

32. *See infra* Chapter 4 D.

33. *See infra* Chapter 4 E.

C. WHY THE QUESTION OF COMPETENCE IS SO IMPORTANT TO MENTAL HEALTH PROFESSIONALS

1. Introduction

Because mental health professionals are often called upon to assist the court in its determination of competency, the way that competency is defined by the law is of great interest. In order to accomplish a forensic assessment of any kind, the first task of the examiner is to understand the legal question. The definitions provided by the law (What is the meaning of "insanity"? What is the standard for involuntary civil commitment? Does a person need to be "competent" to enter into a contractual relationship with another?) may incorporate terms that are ambiguous or concepts that have disparate meanings when used in clinical settings.[34]

To clarify the focus of the examination, the mental health examiner must operationalize the concept or term so that its functional components can be identified for evaluation.[35] For example, the term "reasonable appreciation of available pleas" is ambiguous and must be conceptualized by examining the functional capacities at play. Is it enough to be able to name the pleas, "guilty" and "not guilty?" Or should the accused be expected to know each plea and the nature and quality of the evidence that would justify that plea, along with likely consequences of entering the plea? What constitutes a reasonable appreciation? Is it sufficient to memorize the answers, through participation in a program designed to restore competency, or must the person be able to demonstrate an actual understanding of what each plea means?[36]

2. Legal Implications

When the mental health examiner has operationalized *which* competency is to be assessed and has accomplished the assessment, the resulting opinion may have significant implications that may involve incarceration, court-ordered treatment, or, potentially, the death penalty.[37] The legal concept of competency may embrace values or principles held by society; clearly, the legal implications of a finding of "competent-or-not-competent" are reflections of society's determination about who should and who should not be held responsible for their own behavior.[38]

34. Or terms, such as "insanity," that are no longer used in clinical settings. See, e.g., Richard Lowell Nygaard, *On Responsibility: Or, the Insanity of Mental Defenses and Punishment,* 41 Vill. L. Rev. 951, 955 n.11 (1996) ("the word insanity anachronistically survives in our legal vocabulary, notwithstanding the fact that this construct has no medical counterpart").

35. *See* Thomas Grisso, Evaluating Competencies 22, 52–54 (2d ed. 2003).

36. *See generally infra* Chapter 2.

37. *See infra* Chapter 2 H.

38. See, for example, Grisso, *supra* note 35, at 477: "An expert opinion that answers the ultimate legal question is not an 'expert' opinion, but a personal value judgment. No amount or type of empirical and scientific information alone can answer the question of legal competence, because the degree of ability required for legal competence is not definitive, absolute, or

These value determinations are beyond the expertise of mental health professionals and are best left to the law. The mental health professional can offer an opinion about whether the individual possesses the capacities identified as operational definitions of the legal construction of competency, and can explain the basis of the opinion, but the mental health professional must then stop short of making the final step—whether the individual is, as a matter of fact, competent. That is a determination to made by the law. Put simply, an opinion regarding competency is not a finding of competency—the ultimate issue is the determination of the court.

3. Clinical Implications

Clinical implications of an individual's competency to stand trial are irrelevant when they are unmoored from the legal context. That is, incompetence to stand trial is not a clinical condition that requires treatment or for which there is an established intervention regimen.[39] An infinite number of clinical conditions may contribute to incompetence to stand trial, including cognitive impairment such as mental retardation or brain disorders that may have an impact on a person's reasoning ability or memory, as well as those conditions of psychosis that may distort the individual's reasoning ability or capacity for interpersonal communication or impair contact with reality to such an extent that the person cannot properly assist counsel's efforts to mount a defense.[40]

Those conditions, in and of themselves, each have clinical implications apart from the competency question. There may be a need for ongoing medication management, inpatient or outpatient treatment, or special support and assistance for independent living. A clinical condition—the nature of which contributes to a judicial finding of incompetence—is not, standing alone, the basis for the finding.[41] Competence assessment hinges on specific functional deficits, which *may* be

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consistent across cases; *see also,* Gary Melton et al., Psychological Evaluations for the Courts , §1.04 (2d ed. 1997), and *id.* at 17 :

> [A]lthough the range of opinions with which mental health professionals provide the courts should be narrowed to exclude opinions of a purely moral or legal nature, the door should be left open to professional opinions, including formulations of legally relevant behavior, that might assist (as opposed to overwhelm) the trier of fact. At the same time, mental health professionals should be careful to indicate the level of scientific validity or certainty attached to their opinions.

The use of the word *responsible* in this context is used in a far broader sense than simply whether a defendant is to be held *criminally* responsible for an act because of his or her mental state.

39. On the confusion that persists in this specific area of the law and policy, *see* Perlin, *supra* note 18.

40. On the question of the ability of the defendant to assist counsel, *see* 4 Perlin, *supra* note 4, § 8A-2.3, at 23–24 (2d ed. 2002).

41. *See* Perlin, *supra* note 18, at 202–08 (on how findings of incompetence to stand trial—regardless of severity of crime or defendant's clinical condition—leads to lengthy institutionalization in maximum security facilities, often ones inappropriate and countertherapeutic for the defendant).

present along with each of a number of clinical conditions, but which also *may* be absent in the cases of other individuals suffering from the same clinical conditions. For example, one person who suffers from paranoid schizophrenia may be so affected by delusions that she believes her attorney has entered into a conspiracy with the prosecutor to bring about her imprisonment. This suspiciousness may cause her to withhold critical information from her attorney, information that would clearly assist in her defense. By contrast, another person suffering from paranoid schizophrenia may have periods of lucidity that allow for active participation in the defense effort, or delusions focusing on a specific group of feared persecutors, excluding defense counsel who are—instead—trusted. The diagnosis of a psychiatric condition is, itself, insufficient to establish incompetence.[42]

4. Constraints Potentially Limiting Adequacy of Assessment

A forensic mental health assessment is a snapshot of the examinee's functioning at a specific time and with regard to whatever functional capacities are at issue. The clarity of the image depends on the tools available—the snapshot may be a fuzzy image when the functional capacities are ill defined or difficult to measure. The sources of data may also limit the examiner—a defendant may be unwilling to cooperate by answering questions, may try to control the outcome by faking incapacity, or may be so disturbed or cognitively impaired that it is not possible to reasonably assess understanding. Medication may affect performance in the examination.[43]

Conditions of the assessment may be less than optimal in other ways—examinations conducted in noisy visiting areas of jails, or in attorney consultation areas with glass separating examiner and defendant, may constrain assessment.[44] Language barriers, cultural differences, or mistrust bred of mental illness may interfere with communication.[45] There are sometimes pressures to complete an assessment in a short time, or access to the examinee may be limited so that the

42. *See* 4 Perlin, *supra* note 4, § 8A-2.3, at 20–22 (discussing levels of mental disability that, in and of themselves, have, in certain cases, not been seen as a sufficient basis for an incompetency finding).

43. On the question of whether a currently incompetent defendant may be involuntarily medicated so as to make him or her competent to stand trial, *see infra* Chapter 2 A 1 d.

44. The *Standards for Educational and Psychological Testing* (1999), authored by the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education notes that psychologists are obligated to create a testing environment relatively free of distractions. Standard 5.4 states, "The testing environment should furnish reasonable comfort and minimal distractions." *Id.* at. 83. Many test manuals also include a statement to this effect in the instructions for administration. For example, the *WAIS-III Manual* states, "As a rule, no one other than you and the examinee should be in the room during the testing." *See* David Wechsler, Weschsler Adult Intelligence Scale-III 29 (1997).

45. Mark D. Cunningham, *The Role of the Forensic Psychologist in Death Penalty Litigation,* presented January 19, 2007, at the American Academy of Forensic Psychology Continuing Education Workshop Series, in San Diego, CA (PowerPoint slides of paper on file with authors).

assessment must be accomplished in one or two visits when several would have been ideal. Third-party information, a staple of forensic assessment, may be limited. Records of previous functioning, earlier evaluations, school and medical records, and other objective sources of data are generally consulted, and this time-consuming process, in the absence of adequate consent to access information, requires a court order, further protracting the process.

Finally, the rate of reimbursement for competency assessment may be insufficient to encourage some skilled practitioners to participate in them, and may drive those who do the assessments to give them less than their due. When a 10-hour assessment might be barely adequate, for example, the established rate of reimbursement may be more nearly the hourly rate for 2 hours of the clinician's time. While it is assumed that a clinician who agrees to do a competency evaluation will provide the time and attention required to do an adequate job, it is naïve to assume that the rate of reimbursement will not have an impact, directly or indirectly, on the quality of examinations available to the court. Court clinics employ forensically trained evaluators who provide these assessments in many urban communities, potentially resolving this tension. The advantage of having trained and experienced examiners available to do the assessments may be somewhat compromised, however if caseloads are unreasonable. Additionally, there is the risk that clinic staff may become enmeshed with the process of prosecution and lose their neutrality.[46]

5. Informed Consent on the Part of the Examinee[47]

The process of gaining informed consent—a knowing and voluntary decision to participate in a proposed treatment—raises several considerations when competence is being assessed. First, the examinee whose competency is at question cannot be assumed to have the capacity to knowingly evaluate the proposed treatment. In some cases, the examinee may have limitations that could exert an impact on the capacity of the examiner to understand some aspects of the informed consent discussion. Even cognitively unimpaired litigants may not be able to anticipate the consequences of refusing to participate in the assessment, of discussing uncharged offenses, or of admitting to or denying a juvenile adjudication record that is understood to have been sealed. It is with counsel that this informed consent discussion must first occur, so that counsel can carefully evaluate the potential impact of each prong on the defendant's position and make the informed decision about whether to go forward with the assessment as it is being described. Second, voluntariness, in the true sense of the concept, is not

46. On the futility of demanding authentic "neutrality" in many such settings, *see* Michael L. Perlin, "*They're An Illusion To Me Now": Forensic Ethics, Sanism and Pretextuality,* in Psychology, Crime and Law: New Horizons and International Perspectives (David Canter & Rita Zukauskien eds. 2007) (in press).

47. *See infra* Chapter 4 A 1.

totally possible when the assessment is court ordered; generally, it the rare examinee who voluntarily decides to undergo an assessment of competency. Whether the examiner is legally obligated to obtain informed consent or the examinee is legally capable of giving it, the examiner may be ethically obligated to ensure that the examinee or the legal representative of the examinee has had the opportunity to contemplate the nature and potential consequences of the examination and has had time to raise any objections.[48] Prof. Kirk Heilbrun has wisely used the term "Notification of Purpose" to describe the process by which an involuntary examinee is notified of the elements that would normally be included in informed consent.[49]

6. The Difference between Expert as Forensic Witness and Expert as Therapist

Forensic examination and *clinical* examination and treatment are two distinctly different kinds of mental health services. Historically, the courts have often relied on testimony from medical and mental health treatment providers to assist in making determinations of matters important to the administration of justice. As it became increasingly common to invoke expert testimony in a wide variety of court cases, the profession of forensic examination began to take shape. Mental health professionals—whose data include the patient's self-report—became increasingly aware that an assessment for a court matter differed significantly from an assessment for clinical purposes.[50] In the clinically driven examination, the examinee or the examinee's guardian (if one has been appointed) often initiates the examination and treatment to relieve suffering. The examinee is often, but not always, cooperative, and may stand to benefit from the treatment, specifically by gaining relief from some debilitating condition.[51] The examination and treatment generally occur in the context of a trusting relationship and some assurance of confidentiality. The cost may be borne by the examinee or a third party with whom the examinee has an established relationship, such as a guardian, employer, or insurance provider. Participation in the service generally remains voluntary and the examinee or service recipient can expect to benefit or to leave the treatment relationship if no benefit accrues, if trust falters, or for any reason.

48. APA Ethics Code, 3.10 Informed Consent (c), "When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding."

49. Kirk Heilbrun, Principles of Forensic Mental Health Assessment 141–153 (2001).

50. *See generally,* Stuart Greenberg & Daniel Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles,* 28 Prof'l Psychol: Res. & Prac. 30 (1997); Michael L. Perlin, *Power Imbalances in Therapeutic and Forensic Relationships,* 9 Behav. Sci. & L. 111 (1991).

51. Or, paradoxically, he may wish to exercise his right to personal autonomy by *refusing* certain treatment that his treating mental health professional may recommend. *See infra* Chapter 3.

By contrast, the forensic mental health assessment is generally initiated by someone other than the examinee. The court, the attorney, or an agency may cause the assessment to occur. The examinee's wishes about the assessment may be of little concern. The assessment is intended to provide information that will assist a court or administrative body in answering a legal question or establishing some competency or fitness. The results may specifically thwart the aims of the examinee. Data collected as part of the assessment will necessarily be shared with others, and the examinee generally has no control over how they are distributed or utilized. The cost of the assessment may be borne by the examinee, as in parenting assessments or lifetime assessment of testamentary competency, or may be paid by a party with an opposing interest.

With these differences driving the forensic assessment, special considerations are warranted to ensure that the examinee's rights are not violated and that the resulting opinions are sufficiently reliable and relevant to the court or administrative body to warrant their consideration. The forensic assessment is ideally conducted in an objective, dispassionate way by a neutral examiner who actively seeks data to confirm or disconfirm each reasonable hypothesis.[52] The examiner will not be preserving a traditional treatment relationship in providing courtroom testimony, her courtroom presentation, and traditional concepts of treater confidentiality are not typically betrayed by the examiner's presentation,[53] a subtle but powerful

52. *See, e.g.,* Heilbrun, *supra* note 49; and see Greenberg & Shuman, *supra* note 51, at 56:

> Therapists do not ordinarily have the requisite database to testify appropriately about psycholegal issues of causation (i.e., the relationship of a specific act to claimant's current condition) or capacity (i.e., the relationship of diagnosis or mental status to legally defined standards of functional capacity).
>
> These matters raise problems of judgment, foundation, and historical truth that are problematic for treating experts.

See also, Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists,* 16 Law & Hum. Behav. 655, 658 (1991) (Guideline IV §A, "Relationships") (*Specialty Guidelines*):

> During initial consultation with the legal representative of the party seeking services, forensic psychologists have an obligation to inform the party of factors that might reasonably affect the decision to contract with the forensic psychologist. These factors include, but are not limited to . . . (2) prior and current personal or professional activities, obligations, and relationships that might produce a conflict of interests.

We use the word "ideally" as a recognition that this goal is not always met. *See, e.g.,* Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law,* 20 N. Eng. J. Crim. & Civ. Confinement 369, 380–81 (1994) (discussing matter of Dr. James Grigson, "who testified [in multiple death penalty cases] in defiance of all existing professional ethical guidelines").

53. *See* Kirk Heilbrun et al., *Pragmatic Psychology, Forensic Mental Health Assessment, and the Case of Thomas Johnson,* 10 Psychol. Pub. Pol'y & L. 31, 37 (2004):

> For example, when performing a court-ordered evaluation, the forensic clinician must provide the individual being evaluated with basic information regarding (a) the nature and purpose of the evaluation, (b) who authorized the evaluation, and (c) the associated

consideration in the treating professional's provision of courtroom testimony.[54] Matters disclosed in a treatment relationship with no anticipation of litigation were, undoubtedly, shared without the forewarning that they might be disclosed in court in a way that could be harmful. Where the treatment professional may rightly be concerned that the "patient" will feel betrayed when private matters disclosed in treatment are now revealed during cross-examination, the forensic examiner has, from the outset, clearly conveyed an absence of confidentiality in the process of assessment and the potential that anything disclosed could be used in court in a way that would compromise the aims of the examinee.[55]

The fact finder may believe that treatment providers can offer useful clinical information about someone who is well known to them and that this information, derived for treatment purposes rather than litigation, is more reliable. The forensic expert may be viewed as a hired gun, and the treating clinician viewed as a helping professional whose motives are altruistic. However, the treating clinician has generally not conducted an assessment of the capacities or competencies at question in the legal matter. The careful assessment of relevant capacities, derived from multiple data sources selected for their objectivity and reliability, is quite different from clinical assessment. Clinical assessment, conducted in anticipation of providing remedial intervention, relies principally on the presentation of the patient, which is assumed to be driven by a wish to get help with symptoms. The clinician,

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limits on confidentiality, including how the individual's information might be used. In this context, however, the individual's participation in the evaluation is not voluntary, and it would therefore be inappropriate for the forensic clinician to seek informed consent. By contrast, when an attorney retains a forensic clinician to conduct an evaluation of that attorney's client, the evaluation is voluntary, and informed consent should therefore be obtained from the individual before proceeding.

54. When a forensic witness takes the stand, there can be no blanket assurances of confidentiality, and, in anticipation of this testimony, the witness cannot promise to an examinee that she or he will not disclose certain information. This, of course, is a separate matter from attorney-client confidentiality, a topic beyond the scope of this volume.

55. There is a significant difference between the empathetic skills used in therapeutic relationships and the interviews used in forensic encounters, where the employment of such empathy may be highly inappropriate. *See, e.g.,* Donald Judges, *The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement,* 41 Hous. L. Rev. 515, 589 n.411 (2004), quoting Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles,* 28 Prof. Psychol.: Res. & Prac. 50, 53 (1997) (explaining that while "[t]he therapist is a care provider and usually supportive, accepting, and empathic; the forensic evaluator is an assessor and usually neutral, objective, and detached as to the forensic issues"), and Alan M. Goldstein, *Overview of Forensic Psychology,* in 11 Handbook of Psychology: Forensic Psychology 3, 5 (Alan M. Goldstein ed., 2003) (observing that "in forensic assessments, the motivation [of the client] to consciously distort, deceive, or respond defensively is readily apparent" compared to nonforensic clinical evaluations).

While clinicians should be professionally skilled at drawing people out and invoking dependency and trust, in the forensic examination, it may be disingenuous for forensic examiners to use that posture. *See generally,* Daniel W. Shuman, *The Use of Empathy in Forensic Examinations,* 3 Ethics & Behav. 289 (1993).

wanting to be helpful to the patient and to the court and unschooled in evidentiary standards, may stretch to try to answer the question before the court.

Treating clinicians may have information that illuminates some aspect of the question before the court. Taken for what it is, appropriately limited by the clinician and given the weight it merits by the fact finder, this information may be salient. The difficulty is that clinicians routinely fail to articulate those limits, either because they are not asked the relevant questions or because they do not appreciate the difference between a forensically driven and a clinically driven assessment. Just as routinely, the legal setting calls for the clinician to offer opinions on matters beyond those that the clinical examination addressed. For these reasons, mental health testimony is sometimes viewed as "junk science."[56] The thoughtfully conducted forensic mental health examination and resultant carefully limited testimony, by contrast, can form reliable and relevant evidence of direct assistance to the court.

7. Absence of Confidentiality

There is little confidentiality afforded the forensic examinee. The data collected in the forensic examination forms the basis for expert opinion that is to be offered, and the parties involved have the expectation that they can probe it for completeness and accuracy. Thus, with limited exceptions, the examinee should be led to understand that there will be no confidentiality afforded in the assessment process.[57] This runs counter to the expectations generally held about mental health practitioners—not only examinees, but even counsel, may assume that psychologists, psychiatrists, or counselors *always* keep the confidences of people to whom they provide services. When services are provided in the anticipation of litigation, this is almost never the case.

8. Potential for Outcome to Be Unhelpful or Harmful to the Examinee's Interests

Clinicians generally are trained to do no harm. The forensic assessment may, however, result in failure to have one's property distributed as one wished, incarceration, involuntary commitment, or, ultimately, even death—consequences that might logically be seen by the examinee as quite harmful. How does the forensic mental health examiner reconcile this potential harm with principles of nonmalfeasance and beneficence?

56. *See, e.g.,* Paul C. Giannelli, *The Abuse of Scientific Evidence in Criminal Cases: The Need for Independent Crime Laboratories,* 4 Va. J. Soc. Pol'y & L. 439 (1997); Mike Redmayne, *Expert Evidence and Scientific Disagreement,* 30 U.C. Davis L. Rev. 1027 (1997).

57. Melton et al., *supra* note 38, § 3.04, at 46: "In the purely evaluative relationship, however [contrasted to the typical *therapetuic* relationship], confidentiality is close to nonexistent. The clinician-patient privilege does not apply when the clinician-'patient' relationship is the creature of the court, as is the case with court-ordered evalutions."

The task of the mental health professional who undertakes examinations that will be relied upon by a court is to conduct the examination in a way that respects the examinee's autonomy, the system of justice, and the principle of fairness.[58] The examiner has an obligation to carefully assess the relevant capacities, explore all rival hypotheses, actively seek data that would test each hypothesis, and arrive at an objective assessment of the matter.[59] The examiner can then forcefully present that finding, disclosing all data underlying the opinion and data that argued for a different opinion. What happens beyond that is out of the control of the examiner, but is in the hands of the fact finder. The outcome, presumably, is a reflection of how society has construed the issue, rather than how the mental health professions construe it or how the particular evaluator sees it.

In order to perform forensic mental health assessments, the clinician must accept this dichotomy and achieve some comfort with it. The examiner cannot attempt to thwart justice as the law styles it by offering opinion testimony in order to achieve a certain outcome for the examinee.[60] The evaluation must be done with neutrality and objectivity rather than from an advocacy stance.

9. The Special Circumstances of Mandated Reporting

In most jurisdictions, mandated-reporter status requires the examiner to make a report to authorities when there is a reason to believe abuse or neglect of an elder or a child has occurred.[61] There are generally no exceptions for mental health professionals. The attorney may assume that the retained examiner is working under the work-product shield and instruct the examiner not to disclose anything about the assessment to anyone without the attorney's express permission, but this instruction may run counter to the mental health professional's legal

58. American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct,* 57 Am. Psychologist 1060 (2002) ("Principle E: Respect for People's Rights and Dignity").

59. *Specialty Guidelines, supra* note 52, Guideline VII, Public and Professional Communications, (D) "When testifying, forensic psychologists have an obligation to all parties to a legal proceeding to present their findings, conclusions, evidence, or other professional products in a fair manner. This principle does not preclude forceful representation of the data and reasoning upon which a conclusion or professional product is based. It does, however, preclude an attempt, whether active or passive, to engage in partisan distortion or misrepresentation. Forensic psychologists do not, by either commission or omission, participate in a misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position."

60. *Id.*

61. Mary Connell, et al., *Expert Opinion—Does Mandatory Reporting Trump Attorney-Client Opinion?* 24 American Psychology–Law Society News, 10, 15 (2005), accessible at http://www.ap-ls.org/publications/newsletters/fall2004.pdf and at http://home.comcast.net/~slgolding/publications/Mandated_reporting.htm (both last accessed June 20, 2007). See generally, Maryann Zavez, *The Ethical and Moral Considerations Presented by Lawyer/Social Worker Interdisciplinary Collaborations,* 5 Whittier J. Child & Fam. Advoc. 191, 203 (2005) (on the question of whether mandatory reporting obligations "might still trump" what otherwise would be protected attorney-client communications).

and ethical obligation to report. The case of *Tarasoff v. Regents of the University of California*[62] raises a further potential mandated-reporting requirement in many jurisdictions. The mental health professional may have a duty to take preventative measures when it would appear, to a reasonable and competent clinician, that an examinee is likely to harm another person in the near future. There is generally no duty unless the potential victim is specifically identifiable.[63] It may be acceptable to provide the warning by notifying authorities or committing the examinee, or, in examining an already incarcerated individual, by providing the warning in the report to be submitted to the court.[64]

What, then, must counsel do in securing expertise when there is risk that the examiner may discover an uncharged offense? And in fact, even details of the charged offense must, according to the mandated-reporter statute, generally be reported when they come to the attention of the mandated reporter. In most states, the statutes do not excuse the mandated reporter from the obligation to report on the basis that the case is already being investigated by a protective service or public service agency. The statutes are ordinarily construed very simply, requiring anyone who becomes aware of or has reason to believe a child or adult is in danger of being abused or neglected, or has been abused or neglected, to report to the appropriate agency within a specified period of time.[65]

62. Tarasoff v. Board of Regents of University of California, 551 P.2d 334 (Cal. 1976).

63. Thompson v. County of Alemeda, 614 P.2d 728 (Cal. 1980).

64. *See generally,* Michael L. Perlin, Tarasoff, *and the Dilemma of the Dangerous Patient: New Directions for the 1990's,* 16 Law & Psychol. Rev. 29 (1992); Michael L. Perlin, "*You Got No Secrets to Conceal": Considering the Application of the Tarasoff Doctrine Abroad,* 75 U. Cin. L. Rev. 611 (2006).

65. In Texas, by way of example, state family law provides that "[a] person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter." Tex. Fam. Code Ann. § 261.101(a) (Vernon 2002); see White v. State, 50 S.W.3d 31, 47 (Tex. App.-Waco 2001, pet. ref'd) ("cause" means "sufficient reason"). The same law "imposes a mandatory requirement upon any person, not merely law enforcement officers, to report child abuse, whether it is physical abuse, sexual abuse, or other conduct included in the definition of 'abuse.'" Tex. Fam. Code Ann. § 261.101(a); see State v. Harrod, 81 S.W.3d 904, 908 (Tex. App.-Dallas 2002, pet. ref'd) (prosecution for failure to immediately report child sexual abuse), Rodriguez v. State, 47 S.W.3d 86 (Tex. App.-Houston [14th Dist.] 2001, pet. ref'd) (conviction for failure to immediately report child abuse); Tex. Att'y Gen. Op. No. DM-458 (1997) at 3 (section 261.101(a) does not allow sex offender treatment providers to decide whether or not to report "incomplete or dated" information received from client).

Section 261.101(b) of the family law act establishes a specific reporting requirement for "a professional," defined as "an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children," including "teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers." (3) Tex. Fam. Code Ann. § 261.101(b) (Vernon 2002). If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the

From the examiner's perspective, there is arguably an obligation to introduce this issue during the informed consent process with counsel, before the examination begins, so that the attorney can take whatever steps are required in contemplation that the statute may be triggered. Finally, the examiner, in discussing the contours of the examination with the examinee, is duty bound to notify the examinee of what will be done with any information obtained in the examination, including that covered under mandated-reporter status.[66]

10. "Door-Opening Considerations" and the Instant Case

In criminal cases in some jurisdictions, the defendant's examination by a defense-retained mental health expert may "open the door" to a prosecution-retained expert examination. Within this issue, however, is a secondary one. Acting anticipatorily, counsel may instruct the defendant not to discuss the instant offense with the defense expert because to do so would open the door to the examination of it by the prosecution expert. This matter raises both legal and ethical considerations for the forensic examiner. It is imperative that counsel make the decision about whether to allow the defendant to discuss the alleged offense—this is a legal matter and may invoke the defendant's constitutional rights against self-incrimination.[67]

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professional has cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code.

See http://www.oag.state.tx.us/opinions/op50abbott/ga-0106.htm (last accessed June 20, 2007).

66. APA Ethics Code, 3.10, Informed Consent:

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

67. *See* 4 Perlin, *supra,* §§ 10-2 to 2.4a.

There may be costs to the perceived credibility of the defense retained expert, however, in not discussing the alleged offense—the fact finder may perceive the expert as partisan for having failed to do so because of the door-opening potential.[68] This should be counsel's carefully considered determination.[69] When counsel makes the decision, the expert must then determine whether the examination can be done at all, under the terms decided by retaining counsel. If the examiner believes there is some prohibition to doing an assessment under constrained conditions, this should be revealed as early as possible in the process to allow counsel time to seek another expert.[70]

11. Dilemma of the Uncooperative Examinee

The mental health examiner faced with an unwilling or uncooperative examinee must take a number of steps to protect the rights of the examinee and to ensure that the examination produces useful results. First, no examination should proceed before counsel is available to the examinee,[71] and if the court orders an examination to go forth before counsel has had an opportunity to consult with the examiner and examinee, the examiner should make known to the court the ethical obligation to delay the assessment until this has been accomplished.[72] Assuming that appropriate consideration has been given to the individual's right to consult with counsel and counsel has supported the examination effort and instructed the examinee to submit to the examination, but the examinee nevertheless fails to cooperate, the examiner carefully considers the next course of action. The examinee

68. See, for example, Specialty Guidelines, supra note 52, Guideline VI, Methods and Procedures, (C), "In providing forensic psychological services, forensic psychologists take special care to avoid undue influence upon their methods, procedures and products. . . . As an expert conducting an evaluation, treatment, consultation or scholarly/empirical investigation, the forensic psychologist maintains professional integrity by examining the issue at hand from all reasonable perspectives, actively seeking information which will differentially test plausible rival hypotheses."

69. Mark D. Cunningham, *Informed Consent in Capital Sentencing Evaluations: Targets and Content,* 37 Prof'l Psychol.: Res. & Prac., 452, 457–458 (2006).

70. Mark D. Cunningham and Thomas J. Reidy, *A Matter of Life or Death: Special Considerations and Heightened Practice Standards in Capital Sentencing Evaluations.* 19 Behav. Sci. & L. 473, 485, 486 (2001).

71. Specialty Guidelines for Forensic Psychology, *supra* note 52, Methods and Procedures, § D, at 661:

> Forensic psychologists do not provide professional forensic services to a defendant or to any party in, or in contemplation of, a legal proceeding prior to that individual's representation by counsel, except for persons judicially determined, where appropriate, to be handling their representation pro se. When the forensic services are pursuant to court order and the client is not represented by counsel, the forensic psychologist makes reasonable efforts to inform the court prior to providing the services.

(See http://www.ap-ls.org/links/currentforensicguidelines.pdf)

72. APA Ethics Code, *Principle E: Respect for People's Rights and Dignity* (2002).

may need further consultation with counsel to be apprised of the potential consequences of not cooperating with the examination.[73] Mental health professionals are not in a position to alert examinees to the potential legal consequences of not cooperating with an examination and should not attempt to do so.

If the examinee remains uncooperative, the examiner has next to decide what to do with the information that has been obtained, including the examinee's resistant behavior and communications. A lack of cooperation often so constricts available data that no opinion can be offered about the examinee. Sometimes, however, this is not the case. If, for example, an examinee refuses to cooperate in a court-ordered examination of competency, but in so doing lays forth a coherent and logical set of reasons and demonstrates capacities that bear relevance to an assessment of competency, the examiner may be in a position to offer opinion about those specific capacities. There remains the question whether the examinee is *sufficiently* competent to assist counsel in planning his or her own defense, however, if counsel has advised the examinee to cooperate and the examinee has not done so. Thus, the opinion may be attenuated by further explanation of the limits in apparent functional capacities making up competency to stand trial, and the fact finder can then determine whether sufficient information is available to make a finding.

Thus far, we have explored explicit uncooperativeness. The examinee may, however, give overt signs of cooperating with the examination but covertly withhold relevant information or present a skewed picture of functioning. This covert uncooperativeness is anticipated in most forensic assessments. That is, the examinee has a significant stake in the outcome of the assessment and might naturally be expected to attempt to control that outcome by feeding the examiner the necessary impression. *Impression management* is anticipated, and forensic assessment always includes evaluation of how forthcoming or cooperative the examinee has been in providing an accurate representation of functioning.[74] The assessment of response style may occur through testing that specifically addresses response style, through examination of the individual's internal consistency across interviews and other indicia of statements, and through comparison of data obtained from third-party sources.

Impression management may include attempting to feign mental illness or mental retardation, or other impairment of cognition or behavior. *Malingering*

73. *Specialty Guidelines for Forensic Psychologists, supra* note 52, IV Relationships, (E)(1), 1.

> Unless court ordered, forensic psychologists obtain the informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures. If the client appears unwilling to proceed after receiving a thorough notification of the purposes, methods, and intended uses of the forensic evaluation, the evaluation should be postponed and the psychologist should take steps to place the client in contact with his/her attorney for the purpose of legal advice on the issue of participation.

74. Heilbrun, *supra* note 49, at 165.

refers to conscious fabrication or gross exaggeration of symptoms for secondary gain, such as to obtain medication, to avoid responsibility for one's actions, or to invoke sympathy and nurturing.[75] Conversely, impression management may be aimed at appearing to have competencies or positive attributes one does not actually possess. An individual undergoing assessment for parenting competency in a child protection proceeding, or in a battle over parenting time and responsibility at marital dissolution, for example, may "fake good," claiming virtues or qualities that might favorably affect the outcome of the assessment.

Impression management may be conscious or unconscious. The individual may be acutely aware of the potential importance of the outcome of the assessment and deliberately present a distorted impression, or may habitually attempt to portray an exaggeratedly positive image. Consider the person who has difficulty acknowledging any weakness and swaggers self-confidently, with pseudo-bravado, or the person who simply covers over anxieties and fears. Conversely, picture the perpetual victim, who routinely focuses on assumed injuries others have perpetrated, or aches and pains, seeking the attention that comes from the sympathetic listener. Neither person is consciously attempting to fool the listener, and yet each presents a distorted picture, exaggerating certain traits while camouflaging others.

The examiner makes a routine assessment of this impression management, or what may at times be covert uncooperativeness, and incorporates this data into the overall assessment. Generally, mental health examiners refrain from concluding that someone is deliberately lying, or is deceitful, but rather attempt to explicate any apparent distortions and offer hypotheses about possible bases for the distortion.[76]

12. Conclusion

In summary, the courts rely upon mental health expertise in competence determination, and this contribution is enhanced by adherence to general ethical principles of beneficience or nonmalfeasance, respect for the rights and dignity of the examinee, and regard for the system of justice within which the examination occurs. Forensic examinations represent a unique kind of mental health service, posing challenges to the examiner and raising concerns not always an-

75. Richard Rogers, *Introduction,* in Clinical Assessment of Malingering and Deception, 1, 11 (Richard Rogers ed., 2d ed. 1997). On the "ease" with which skilled clinicians can detect malingerers, *see* Perlin, *supra* note 18, at 236–37; Michael L. Perlin, *"There's No Success Like Failure/and Failure's No Success at All" : Exposing the Pretextuality of* Kansas v. Hendricks, 92 Nw. U. L. Rev. 1247, 1259 (1998).

76. Rogers, *supra* note 75, at 11 (hypotheses could include a range of possible response styles including malingering, defensiveness, irrelevant responding, random responding, honest responding, and hybrid responding).

ticipated by the court or counsel. The defendant, whose capacity to make informed and voluntary decisions may be limited, requires the protection of early notification to counsel of elements of the examination process that invoke special consideration. The examination that follows is ideally an objective, neutral, and thorough consideration of relevant and, where possible, reliable data that is synthesized or integrated to address functional capacities at issue in the court's consideration of competence. The examiner distinguishes between the beliefs or opinions that flow from that data to form expert opinion and the personally held beliefs or values that are irrelevant to the court. For that reason, the examiner may describe the elements of an individual's competence without formulating an opinion on whether the person is, by the law's reckoning, competent.

D. AN INTRODUCTION TO SANISM AND PRETEXTUALITY

Sanism is an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry. It permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, and expert and lay witnesses. Its corrosive effects have warped mental disability law jurisprudence in involuntary civil commitment law, institutional law, tort law, and all aspects of the criminal process (pretrial, trial, and sentencing). It reflects what civil rights lawyer Florynce Kennedy has characterized as the "pathology of oppression."[77]

Pretextuality means that courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decisionmaking, specifically when witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends."[78] This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasè judging, and, at times, perjurious and/or corrupt testifying.[79]

One of the authors of this volume (MLP) has explored the relationships be-

77. *See, e.g.,* Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did,* 10 J. Contemp. Legal Issues 3 (1999); Michael L. Perlin, The Hidden Prejudice: Mental Disability on Trial (2000);Perlin, *Lepers, supra* note 14; Michael L. Perlin, *On "Sanism,"* 46 S.M.U L. Rev. 373 (1992).

78. Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance,* 19 Bull. Am. Acad. Psychiatry & L. 131, 135 (1991).

79. *See generally,* Perlin, *supra* note 77.

tween sanism and pretextuality in matters involving, inter alia, competency to stand trial,[80] sexual autonomy,[81] the right to refuse treatment,[82] autonomous decision-making,[83] and competency to plead guilty or waive counsel.[84] In this volume, we will demonstrate how these factors are relevant to—and, in some instances, control—virtually all jurisprudential developments.

80. *E.g.,* Michael L. Perlin,*"Everything's a Little Upside Down, As a Matter of Fact the Wheels Have Stopped": The Fraudulence of the Incompetency Evaluation Process,* 4 Houston J. Health L. & Pol'y 239 (2004); Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency,* 47 U. Miami L. Rev. 625 (1993).

81. *E.g.,* Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?* 20 N.Y.U. Rev. L. & Soc'l Change 302 (1993–94).

82. *E.g.,* Michael L. Perlin, *"And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases*," 42 San Diego L. Rev. 735 (2005); Michael L. Perlin & Deborah A. Dorfman, *"Is It More Than Dodging Lions and Wastin' Time?" Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases,* 2 Psychology, Pub. Pol'y & L.114 (1996).

83. *E.g.,* Perlin, *Lepers, supra* note 13.

84. *E.g.,* Michael L. Perlin, *"Dignity Was the First to Leave":* Godinez v. Moran, *Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants,* 14 Behav. Sci. & L. 61 (1996).