

## MENTAL HEALTH ISSUES IN CRIMINAL CASES

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Mental health issues frequently arise in the context of appeals. They may be present in the transcripts. Mental health issues may also be lurking in the background, where you suspect defense counsel could have exploited a defendant's mental health problems but failed to do so. In either event, you will probably need to read psychological or psychiatric records to evaluate potential issues. Few of us are trained in psychology or psychiatry, and it may be difficult to understand the specialized language which appears in the reports. We will attempt to briefly describe common situations where mental health issues arise on appeal, mention some of the issues which may arise in those contexts, and provide some help in understanding the mental health language which may appear in reports relevant to those issues.

### **CONTEXTS IN WHICH MENTAL HEALTH ISSUES ARISE**

Mental health issues come up in several contexts in criminal cases.

#### **Defendant's Competency**

Fundamental to our criminal justice system is the principle that no one can be tried or adjudged to punishment while mentally incompetent. (Pen. Code, § 1367, subd. (a); *Pate v. Robinson* (1966) 383 U.S. 375.) The term "mentally incompetent" means that "as a result of mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner." (Pen. Code, § 1367, subd. (a); *Drope v. Missouri* (1975) 420 U.S. 162, 171; *Dusky v. United States* (1960) 362 U.S. 402.)

The most common potential issue involving competency is whether the trial court abused its discretion in refusing or failing to conduct a competency hearing. "If a defendant presents substantial evidence of his lack of competence and is unable to assist counsel in the conduct of a defense in a rational matter during the legal proceedings, the court must stop the proceedings and order a hearing on the competence issue. (*Pate, supra*, 383 U.S. at pp. 384-386; *People v. Pennington* (1967) 66 Cal.2d 508, 516-517. . . .) In this context, substantial evidence means evidence that raises a reasonable doubt about the defendant's ability to stand trial. (*People v. Frye* (1998) 18 Cal.4th 894, 951-952 . . .) The substantiality of the evidence is determined when the competence issue arises at any point in the proceedings. ([*People v. Welch* [(1999)] 20 Cal.4th [701,] 739.) The court's decision whether to grant a competency hearing is reviewed under an abuse of discretion standard. (§ 1368; *Welch, supra*, 20 Cal.4th at p. 742.)" (*People v. Ramos* (2004) 34 Cal.4th 494,

507.) Expert testimony is not necessary to raise a doubt. (*Pate, supra*, 383 U.S. at p. 385, fn. 7.) “[E]vidence of a defendant’s irrational behavior, his demeanor at trial, and any prior medical opinion on competence to stand trial are all relevant in determining whether further inquiry is required [and] . . . even one of these factors standing alone may, in some circumstances, be sufficient. There are, of course, no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated.” (*Drope, supra*, 420 U.S. at p. 180.)

The classic case in California is *People v. Stankewitz* (1982) 32 Cal.3d 80. In that case a psychiatrist testified the defendant had paranoid delusions his public defender was in collusion with the prosecutor. If a defendant is so delusional or paranoid that he will not trust his attorney or tell him the true facts, then he is incompetent. Note that the mistrust must be delusional, i.e., stemming from a mental disorder. The usual distrust defendants have for their public defenders does not show the defendant is incompetent.

“Under the applicable substantial evidence test, ‘more is required than mere bizarre actions [citation] or bizarre statements [citation] or statements of defense counsel that defendant is incapable of cooperating in his defense [citation] or psychiatric testimony that defendant is immature, dangerous, psychopathic or homicidal or such diagnoses with little reference to defendant’s ability to assist in his own defense. [Citation.]” (*People v. Davis* (1995) 10 Cal.4th 463, 527; *People v. Koontz* (2002) 27 Cal.4th 1041, 1064-1065 [competent despite pro per, untenable defense, harmful witness, rambling close]; *People v. Rodrigues* (1994) 8 Cal.4th 1060, 1109-1112 [insufficient evidence for hearing despite lack of cooperation with counsel, and two experts describing seizures which could have caused brain damage, and possible drug dementia].)

“Thus, while, the California Supreme Court has repeatedly stated that a competency hearing is required whenever there is evidence that ‘raises a reasonable doubt about the defendant’s competence to stand trial’ [citation], in practice, the court has essentially required that the defendant establish his incompetence before a trial court will be required to hold a competency hearing. In our view, the holdings in these cases appear to have lost sight of the fact that, ‘[t]he function of the trial court in applying *Pate*’s substantial evidence test is not to determine the ultimate issue: Is the defendant competent to stand trial? It[s] sole function is to decide whether there is any evidence which, assuming its truth, raises a reasonable doubt about the defendant’s competency.’ [Citation.]” (*People v. Harrison* (2005) 125 Cal.App.4th 725, 735, **DEPUBLISHED**.)

If the court has previously considered the competency issue, and has determined a defendant is competent to stand trial, a new competency hearing is only required if there are

“changed circumstances.” If the defendant merely engages in the same bizarre behavior which initially led the court to consider the competency issue, this is not enough to require the court hold another competency hearing. “When, as here, a competency hearing has already been held and the defendant was found to be competent to stand trial, a trial court is not required to conduct a second competency hearing unless ‘it “is presented with substantial change of circumstances or with new evidence” ’ that gives rise to a ‘serious doubt’ about the validity of the competency finding. [Citation.]” (*People v. Marshall* (1997) 15 Cal.4th 1, 33; accord, *People v. Lawley* (2002) 27 Cal.4th 102, 136, 139 [despite defendant being incoherent].)

If the court determines there is a reasonable doubt about competency, the defendant must be examined by experts and the defendant has the right to a jury trial on the issue of competency. However, the trial is not a criminal proceeding. “Although it arises in the context of a criminal trial, a competency hearing is a special proceeding, governed generally by the rules applicable to civil proceedings. (*People v. Skeirik* (1991) 229 Cal.App.3d 444, 455.) The right to a jury determination of competency is statutory, however, not constitutional; thus, counsel may effectively waive it without a personal waiver from the defendant. (*People v. Masterson* (1994) 8 Cal.4th 965, 969, 972; see § 1369.) A defendant is presumed competent unless the contrary is proven by a preponderance of the evidence. (§ 1369, subd. (f); *People v. Medina* (1990) 51 Cal.3d 870, 881-886.) On appeal, the reviewing court determines whether substantial evidence, viewed in the light most favorable to the verdict, supports the trial court's finding. (*People v. Marshall* (1997) 15 Cal.4th 1, 31.) ‘Evidence is substantial if it is reasonable, credible and of solid value.’ (*Ibid.*)” (*People v. Lawley* (2002) 27 Cal.4th 102, 131.)

### **Not guilty by reason of insanity**

“ “If a person under an insane delusion as to existing facts, commits an offense in consequence thereof, is he thereby excused?” To which question the answer must of course depend on the nature of the delusion: but, making the . . . assumption . . . that the labours under . . . partial delusion only, and is not in other respects insane, we think he must be considered in the same situation as to responsibility as if the facts were respect to which the delusion exists were real. For example, if under the influence of his delusion he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment. If his delusion was that the deceased had inflicted a serious bodily injury to his character and fortune, and he killed him in revenge for such supposed injury, he would be liable to punishment.’ [Citations.]” (*People v. Rittger* (1960) 54 Cal.2d 720, 731-732, quoting *M'Naghten's Case* (1843) 10 Clark & Fin. 200, 211 [8 Eng. Rep. 718, 722].)

“ ‘ . . . California courts framed this state's definition of insanity, as a defense in criminal cases, upon the two-pronged test adopted by the House of Lords in *M'Naghten's Case* (1843) 10 Clark & Fin. 200, 210 [8 Eng. Rep. 718, 722]: “[T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.’ [Citations.]” (*People v. Kelly* (1992) 1 Cal.4th 495, 532.)

“ ‘A person is legally insane when, by reason of mental disease or mental defect he was incapable of knowing or understanding the nature and quality of his act or incapable of distinguishing right from wrong at the time of the commission of the offense. The word “wrong” as used in this instruction is not limited to legal wrong, but properly encompasses moral wrong as well. Thus, the defendant who is incapable of distinguishing what is morally right from what is morally wrong is insane, even though he may understand the act is unlawful.’ ” (*People v. Coddington* (2000) 23 Cal.4th 529, 608.)

The “right-wrong” prong is more frequently invoked in cases raising an insanity defense. It is more unusual that a defendant is so delusional he or she does not even understand the nature of the act committed. (E.g., kills someone while in delusional state believing he is killing a Viet Cong enemy who is attacking him.)

In *People v. Skinner* (1985) 39 Cal.3d 765, the defendant was diagnosed as a paranoid schizophrenic. He strangled his wife while on leave from a mental hospital. He believed that the marriage vow "till death do us part" bestowed on him a God-given right to kill his wife if she had violated or was inclined to violate the marital vows, and that because the vows reflect the direct wishes of God, the killing was morally sanctioned.

Another example is found in *People v. Stress* (1988) 205 Cal.App.3d 1259, where a delusional defendant believed he had to kill his wife in order to gain a forum to warn Americans a conspiracy existed between the professional athletic leagues, the television networks, the federal government and others to insure that professional athletes were not drafted for service in the war. In his view, his wife's death was a necessary sacrifice for the greater good.

Insanity cannot be based on a diagnosis of an antisocial personality disorder. (*People v. Fields* (1983) 35 Cal.3d 329, 372.) It cannot be based solely on drug or alcohol use (Pen. Code, § 25.5), but such use can be a partial cause. (*People v. Robinson* (1999) 72 Cal.App.4th 421.)

## **Lack of specific intent or other requires mental state**

There is no longer a defense of diminished capacity, but the defendant can argue a lack of specific intent or malice aforethought. (*People v. Saille* (1991) 54 Cal.3d 1103, 1116-1117.)

Penal Code “Sections 28 and 29 permit introduction of evidence of mental illness when relevant to whether a defendant actually formed a mental state that is an element of a charged offense, but do not permit an expert to offer an opinion on whether a defendant had the mental capacity to form a specific mental state or whether the defendant actually harbored such a mental state.” (*People v. Coddington* (2000) 23 Cal.4th 529, 582.)

For example, an expert cannot say she or he believes the defendant, due to mental illness, lacked the capacity to premeditate or deliberate. Nor can an expert say she or he believes the defendant did not premeditate or deliberate. But the expert can say the defendant had a mental illness which would cause the defendant to act impulsively, without thinking or considering the consequences of his conduct.

## **Forced medication at trial**

The court can force medication in order to make defendant competent only if (1) an important government interest at stake which is diminished if the defendant will be hospitalized for a while, (2) involuntary medication will significantly further the state interests in a timely prosecution and fair trial, (3) involuntary medication is necessary to further those interests as opposed to contempt or other remedies; and (4) administration of the medication is medically appropriate. (*Sell v. United States* (2003) 539 U.S. 166, 180-183; *People v. O'Dell* (2005) 126 Cal.App.4th 518, 569-572.) The unjustified forced administration of medication could violate the due process right to a fair trial under the Fourteenth Amendment. (*Riggins v. Nevada* (1992) 504 U.S. 127, 137.) [“In extreme cases, the sedationlike effect [of antipsychotic medication] may be severe enough (akinesia) to affect thought processes. It is clearly possible that such side effects had an impact upon not just Riggins' outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel.” (internal quotation marks omitted)]

## **Sentencing**

“ [E]vidence about the defendant’s background and character is relevant because of the belief, long held by this society, that defendants who commit criminal acts that are attributable to a disadvantaged background, or to emotional and mental problems, may be

less culpable than defendants who have no such excuse.’ ” (*Penry v. Lynbaugh* (1989) 492 U.S. 302, 319, quoting *California v. Brown* (1987) 479 U.S. 538, 545 (conc. opn. of O’Connor, J.) see also *Wiggins v. Smith* (2003) 539 U.S. 510, 535; see also *Atkins v. Virginia* (2002) 536 U.S. 304 [retardation].) “More than any other single factor, mental defect have been respected as a reason for leniency in our criminal justice system.” (*Caro v. Woodford* (9th Cir. 2002) 280 F.3d 1247, 1258, citing 4 William Blackstone, Commentaries \*24-\*25.)

### **Conditions of probation**

There is little case law in California concerning when the court can order a defendant to take medication as a condition of probation. Arguably, the factors in *Sell* would apply. (See *United States v. Williams* (9th Cir. 2004) 356 F.3d 1045, 1056; cf. Welf. & Inst. Code, § 5345 et seq.)

### **Mentally Disordered Offenders**

The elements to an MDO commitment are as follows. “First, the prisoner must have ‘a severe mental disorder that is not in remission or cannot be kept in remission without treatment.’ (§ 2962, subd. (a).) Second, the disorder must have been ‘one of the causes of or was an aggravating factor in the commission of a crime for which the prisoner was sentenced to prison.’ (§ 2962, subd. (b).) Third, the prisoner must have been ‘in treatment for the severe mental disorder for 90 days or more within the year prior to the prisoner’s parole or release.’ (§ 2962, subd. (c).) Fourth, before the prisoner’s parole or release, the treating physician and other specified medical authorities must certify that each of the noted conditions exists, and that by reason of the disorder, the prisoner ‘represents a substantial danger of physical harm to others.’ (§ 2962, subd. (d)(1).) [¶] The final criterion for treatment as an MDO under section 2962 is set forth in subdivision (e), [the defendant must be in prison after being convicted of a listed offense].” (*People v. Anzalone* (1999) 19 Cal.4th 1074, 1077.)

### **Sexually Violent Predatory Offenders**

To commit someone under the Act, the state must prove “[1] a person who has been convicted of a sexually violent offense against two or more victims and [2] who has a diagnosed mental disorder that [3] makes the person a danger to the health and safety of others in that it is likely that he or she will engage in [predatory] sexually violent criminal behavior.” (*Cooley v. Superior Court (Martinez)* (2002) 29 Cal.4th 228, 246, quoting Welf. & Inst. Code, § 6600, subd. (a)(1).)

Mental disorder includes paraphilia (*People v. Butler* (1998) 68 Cal.App.4th 421,

441-442), pedophilia (*People v. Mercer* (1999) 70 Cal.App.4th 463, 466), antisocial personality disorder. (*People v. Burris* (2002) 102 Cal.App.4th 1096, 1098-1110; see *Kansas v. Crane* (2002) 534 U.S. 407, 412 [40-60 percent of prison population so diagnosed].)

## **Habeas Corpus**

Be alert to hints in the record the defendant is mentally ill and the possibility defense counsel failed to properly investigate the issue by obtaining medical records and consulting with experts. An attorney who fails to investigate possible mental health issues, either at trial or sentencing, “deprive[s] himself of the reasonable bases upon which to reach informed tactical and strategic trial decisions.” (*People v. Frierson* (1979) 25 Cal.3d 142, 163.)

For example, in *People v. Mozingo* (1983) 34 Cal.3d 926 the Supreme Court held trial counsel provided ineffective assistance in failing to investigate an insanity defense even though defendant refused to enter an insanity plea and refused to cooperate with any psychiatrists. Counsel did not bother to investigate mental health issues because the defendant refused to enter a plea of insanity. The Supreme Court held counsel should have “undertak[en] sufficient investigation of possible defenses to enable counsel to present an informed report and recommendation to his client.” (*Id.*, at p. 934.)

If you think trial counsel may have failed to adequately investigate mental health issues at trial or at sentencing, you will have to do the investigation to show counsel’s omission was prejudicial. Obtain releases from the client (sample included with the materials) and get the client’s medical records from prison’s, jails, and any hospitals where he received treatment. If you think there is a possible claim of ineffective assistance of counsel, you should consider applying for funds to hire a mental health expert who can help you decipher the records and render an opinion how they could have helped your client. A sample application for expert funds is included in these materials.

## **Case Law on the Side-Effects of Antipsychotics**

“Psychotropic (or antipsychotic) drugs have become a primary tool of public mental health professionals for treating serious mental disorders, replacing such earlier measures as lobotomy, insulin shock, and electroshock. In many patients they minimize or eliminate psychotic symptoms. They ‘also possess a remarkable potential for undermining individual will and self-direction, thereby producing a psychological state of unusual receptiveness to the directions of custodians.’ (*Keyhea v. Rushen* (1986) 178 Cal.App.3d 526, 531, fn. and citations omitted.) “These include thiorazine, prolixin, stelazine, serentil, quide, tindal, compazine, trilafon, reposit, mellaril, tractan, navane, haldol, moban, and vesprin.” (*Id.* at

p. 531, fn. 1.) “The drugs also, however, have many serious side effects. Reversible side effects include akathisia (a distressing urge to move), akinesia (a reduced capacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait), and various other complications such as muscle spasms, blurred vision, dry mouth, sexual dysfunction, drug-induced mental disorders, and, on rare occasions, sudden death. A potentially permanent side effect of long-term exposure, for which there is no cure, is tardive dyskinesia, a neurological disorder manifested by involuntary, rhythmic, and grotesque movements of the face, mouth, tongue, jaw, and extremities.” (*Id.* at p. 531; see also *Riese v. St. Mary’s Hosp. and Med. Ctr.* (1987) 209 Cal.App.3d 1303, 1311-1312.)

“Antipsychotic drugs, sometimes called ‘neuroleptics’ or ‘psychotropic drugs,’ are medications commonly used in treating mental disorders such as schizophrenia.” (*Washington v. Harper* (1990) 494 U.S. 210, 214.) “The drugs administered to respondent included Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane.” (*Id.* at p. 214, fn. 1.) The Supreme Court held:

The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect identified by the trial court is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. The trial court found that it may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akathisia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); and tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face. The State, respondent, and amici sharply disagree about the frequency with which tardive dyskinesia occurs, its severity, and the medical profession's ability to treat, arrest, or reverse the condition. A fair reading of the evidence, however, suggests that the proportion of patients treated with antipsychotic drugs who exhibit the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that 60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe.

(*Id.* at pp. 229-230, citations omitted.)

The California Supreme Court has made similar observations about mental health medication:

No doubt such commonly used drugs, the phenothiazines, have been of considerable benefit to many mentally ill patients. Use of these drugs has greatly reduced the number of mentally ill individuals requiring hospitalization, and the frequency and length of hospitalizations. But they also have been the cause of considerable side effects. Reversible side effects include akathisia (a distressing urge to move), akinesia (a reduced capacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait), and various other complications such as muscle spasms, blurred vision, dry mouth, sexual dysfunction, and drug-induced mental disorders. A potentially permanent side effect of long-term exposure to phenothiazines is tardive dyskinesia, a neurological disorder manifested by involuntary, rhythmic, and grotesque movements of the face, mouth, tongue, jaw, and extremities, for which there is no cure. On rare occasions, use of these drugs has caused sudden death.

Although a new generation of antipsychotic drugs, the so-called atypicals, have been regarded as being more benign and effective, considerable controversy remains over both their efficacy and the extent and nature of their side effects. Moreover, most atypical antipsychotics are difficult to administer without a patient's cooperation, because unlike the older generation of medications, the newer drugs are generally not available in forms that can be injected. Also, phenothiazines are cheaper than atypicals and are still the most widely used class of drugs to treat psychosis. The basic constitutional and common law right to privacy and bodily integrity is therefore especially implicated by the forced administration of medications with such potential adverse consequences

(*In re Qawi* (2004) 32 Cal.4th 1, 14-15, citations omitted.)

## COMMON DIAGNOSES

### Axis I

Clinical disorder = Problems with perceptions, feelings, or relationships which causes stress or impairment in everyday functioning.

### SCHIZOPHRENIA

- 295.xx Schizophrenia: delusions, hallucinations, or disorganized speech or behavior
- 295.40 Schizophreniform: two such episodes in less than six months
- 295.70 Schizoaffective: schizophrenia with depression or bipolar
- 297.1 Delusional disorder: suffering from a plausible delusion for more than a month
- 298.8 Brief Psychotic Episode: suffering from a delusion for less than a month

### MOOD DISORDERS

depression = at least five of the following: feels depressed, loss of interest, weight loss or gain, insomnia or hypersomnia, increased or decreased activity, fatigue, guilt or sense of worthlessness, unable to concentrate or make decisions.

mania = inflated self-esteem or grandiose, decreased sleep, more talkative or pressured speech, flight of ideas or racing thoughts, distractability, increased activity, increased activities with risks.

- 296.xx Bipolar I: manic and depressed at least four times within a year
- 296.89 Bipolar II: manic and depressed at least once within a year
- 301.13 Cyclothymic: generally less severe manic phases
- 300.4 Dysthymic: long-term low-grade depression
- 311 Depressive NOS (not otherwise specified)

### ANXIETY DISORDERS

- 300.01 Panic attacks
- 300.02 General anxiety: for at least six months
- 300.21 Panic attacks with agoraphobia
- 300.22 Agoraphobia = fear of crowds
- 300.23 Social phobia = social anxiety settings
- 300.29 Specific phobia = an object triggers panic
- 300.3 Obsessive-compulsive = recurrent thought or activity
- 308.3 Acute stress: for less than a month
- 309.81 Post-Traumatic Stress Syndrome: (A) witnesses or experienced an event concerning (a threat of) great injury or death and with fear, helplessness, or horror; and (B) the traumatic event is re-experienced by recurrent recollection or dreams, acting or feeling as if it is recurring, distressed from cues symbolizing the event or trauma; and (C) avoid stimuli of the

trauma; and (D) arousal with insomnia, irritability, hypervigilance, or easily startled.

IMPULSE DISORDERS = failure to resist temptation or impulse which is harmful

312.30 Impulse Control NOS

312.32 Kleptomania

312.33 Pyromania

V71.01 Antisocial behavior

#### SUBSTANCE ABUSE

Dependence, abuse, intoxication, or withdrawal

Dual diagnosis: substance abuse and another disorder, usually schizophrenia or mood

291, 303 Alcohol

292.xx Amphetamine, cannabis, cocaine, hallucinogen, nicotine, opioid, PCP, sedative.

304.80 Polysubstance dependence

#### SEXUAL DISORDERS

302.9 Paraphilia NOS = recurrent and intense fantasies, urges, or behaviors for more than six months involving nonconsensual sex

302.2 Pedophilia

#### ADJUSTMENT DISORDER

309.9 Adjustment disorder NOS: stressors cause distress or functional impairment

309.0 with depressed mood

309.24 with anxiety

309.28 with anxiety and depressed mood

309.3 with conduct disturbance = violates rules

#### FACTITIOUS, SOMATOFORM DISORDERS

300.xx Somatization, conversion, hypochondria: psychosomatic symptoms causing significant impairment with no apparent advantage to the patient

300.16 Factitious disorder: feigned psychosomatic symptoms with no apparent advantage to the patient

V65.2 Malingering: feigned psychosomatic symptoms to gain an apparent advantage

V15.81 Noncompliance with treatment

#### ATTENTION DEFICIT DISORDER

Symptoms arise before the age of 7, symptoms exist at school and at home, and they impair functioning.

314.00 Attention deficit disorder. At least six of the following for more than six months: not devote close attention to detail, frequent difficulty sustaining attention, does not

seems to listen when spoken to, does not follow instructions or finish tasks, difficulty organizing tasks, avoids or dislikes tasks involving sustained effort, loses things necessary to complete tasks, easily distracted, forgetful.

314.01 Attention deficit and hyperactivity disorder. In addition, at least six of the following: fidgets or squirms in a seat, leaves desk inappropriately in class, runs and climbs excessively and when inappropriate, difficulty playing quietly, always moving, talks excessively, blurts out answers before questions are completed, difficulty waiting turns, interrupts.

#### CONDUCT DISORDER

312.8x Conduct disorder: aggressive, harmful, damaging, deceitful or thieving, or serious violation of rules.

313.81 Oppositional defiant

#### MENTAL RETARDATION

318.2 Profound retardation: IQ < 25

318.1 Severe retardation: IQ 20-40

318.0 Moderate retardation: IQ 35-55

317 Mild retardation: IQ 50-70

#### ABUSE OR NEGLECT

995.52 victim of child neglect

995.53 victim of molestation

995.54 victim of child abuse

#### **Axis II**

Personality disorder = A stable, inflexible behavior pattern deviating from cultural expectations causing a distorted perception of self or others, abnormal range of emotion, impaired and distressed interpersonal functioning, or poor impulse control. They are enduring, inflexible and pervasive, starting in early adulthood.

#### ECCENTRIC FEATURES (related to schizophrenia or mood disorders)

301.00 Paranoid PD = Pervasive distrust and suspicion, and at least four of the following: feels exploited, doubts others' loyalties, will not confide in others, reads hidden meanings into benign remarks, holds grudges, perceives attacks on reputation, doubts others' fidelity.

301.20 Schizoid PD = Detached and restricted emotion, and at least four of the following: no desire for close relationships, solitary, no sexual interest, no pleasure from activities, no close friends, indifferent to praise or criticism.

301.22 Schizotypal PD = Poor interpersonal skills, distorted perception, eccentric behavior, no close relationships, and at least five of the following: non-delusional ideas of reference, odd or magical beliefs, unusual perception, odd thinking and speech, paranoid, constricted affect, odd behavior or appearance, no close friends, social anxiety.

#### DRAMATIC OR EMOTIONAL FEATURES (related to depression or anxiety)

301.7 Antisocial PD\* = Violates other's rights when at least 15 years old, and at least three of the following: nonconformity to laws or social norms, deceitful, impulsive, irritable and aggressive, disregard of safety, irresponsible at work or with money, lack of remorse.

301.81 Narcissistic PD\* = Needs admiration and lacks empathy, and at least five of the following: grandiose or sense of superiority, fantasies of power or beauty or ideal love, believes he or she is special and should associate only with high-status people, requires excessive admiration, a sense of entitlement, exploitive, lacks empathy, envious of others and a belief that others are envious, arrogant.

301.83 Borderline PD (borderline depressed or bipolar) = Unstable relationships or self-image, and at least five of the following: frantic avoidance of abandonment, unstable and intense relationships with idealization and depersonalization of the other person, unstable self-image, impulsive, suicidal and self-mutilating behavior, reactive mood or unstable affect, chronic feeling of emptiness, inappropriate anger, paranoid.

301.50 Histrionic PD = Emotional and attention seeking, and at least five of the following: a need to be the center of attention, seductive or provocative behavior, shifting and shallow emotions, physical appearance made to draw attention, impressionistic, theatrical, suggestible, views relationships as more intimate than is realistic.

\*Psychopathic in SVP cases (Hare) is a combination of antisocial and narcissistic personality traits.

#### ANXIOUS OR FEARFUL FEATURES (related to anxiety disorders)

301.82 Avoidant PD = Inhibited or hypersensitive, and at least four of the following: avoids interpersonal activity, does not risk being disliked, restraint in intimate relationships, preoccupied with potential criticism, inhibited in new situations, views self as socially inept, reluctance to take risks.

301.6 Dependent PD = Submissive, clingy, in need of being taken care of, and at least five of the following: indecisive, lets others assume responsibility for major areas one's life, not disagreeable, lacks initiative, helpless when alone, excessive effort to receive nurture, constant need for relationships, excessive fear of being left to care for oneself alone.

301.4 Obsessive-compulsive PD = Preoccupied with orderliness, perfection, control, or inflexible and closed, and at least four of the following: irrational preoccupation with details or organization, perfectionism thwarts completion of tasks, excessive devotion to work, overly moral, difficulty throwing things out, reluctant to delegate, miserly spending,

rigid and stubborn.

#### MISCELLANEOUS

301.9 Personality Disorder NOS

301.9 Depressive PD

301.9 Passive-aggressive PD

V62.89 Borderline retardation: IQ 71-84

#### **Axis III**

General medical conditions (GMC) = Medical problems of the patient. Can include medication-induced ailments, such as the following:

332.1 Neuroleptic-induced Parkinsonism

333.xx other medication induced problems with muscle tone

995.2 adverse reaction to medication

#### **Axis IV**

Psychosocial and environmental problems (PEP) = The sources of the patient's psychological stressors or the absence of expected support. Generally, the doctor focuses on the following:

primary support group (family)

social environment

education

occupation or vocation

housing

economic

health care access

legal

other stressors

#### **Axis V**

Global Assessment of Functioning (GAF) scale = A scale from 1 to 100 on how well the patient is functioning.

90+ superior functioning, no psychological symptoms

80 good functioning in all areas, does not require counseling

70	no more than slight impairment, transient and expected impairment from stressors
60	some difficulty but generally functions well, occasional counseling helpful
50	moderate difficulty and interference with functioning, needs counseling
40	serious impairment and avoidance or panic
30	major impairment, poor judgment, needs constant supervision, inpatient treatment
20	unable to function, delusional or impaired reality
10	unable to function, sometimes a danger to self or others, must commit
1	persistently nonfunctional, requires long-term commitment
0	inadequate information

### **Observations/Mental Status Evaluations**

Observations of certain features concerning the patient are frequently recorded in psychological reports because they might indicate certain disorders.

Inappropriate dress or demeanor might reveal anxiety or disorganized thought.

Posture, facial reaction, and grooming can indicate the patient's motivation and self-perception.

Eye contact: wandering eyes might suggest distractibility, hallucinations, cognitive deficits or mania; avoiding eye contact might suggest anxiety, constant eye contact might suggest suspicion or paranoia

Orientation (time, place, and purpose) and whether memory is distorted can indicate schizophrenia or hallucinations

Speech: subdued tone can indicate depression or anxiety; hoarse or pressured speech can indicate mania; monotone can indicate schizophrenia; rising pitch can indicate anxiety; drop in pitch can indicate sadness or depression; excessive modulation can indicate mania or somatoform disorder.

Thinking: long pauses can indicate depression; short pauses can indicate mania; varied pauses can indicate schizophrenia; fragmented speech or the use of special terms can indicate schizophrenia.

Insight: full (describes symptoms as a result from a disorder), partial (knows there are problems but lacks awareness of the disorder), none (denies suffering from mental problems).

Judgment = the ability to choose appropriate goals and select socially acceptable objectives in order to reach the goals.

## Scores Based on the Bell Curve

CUMULATIVE PERCENTAGE	STANDARD DEVIATION	WECHSLER IQ TEST	WECHSLER SUBSETS	T-SCORES
0.1	-3	55	1	20
2.3	-2	70	4	30
15.9	-1	85	7	40
50	0	100	10	50
84.1	+1	115	13	60
97.7	+2	130	16	70
99.9	+3	145	19	80

## MEDICATIONS

### Antipsychotics/Neuroleptics/Psychotropics

Treats schizophrenia (psychosis, delusions); sometimes treats depression, mania, bipolar, anxiety, nausea.

Side-effects: extrapyramidal effects (spasms, tardive dyskinesia, stiffness), endocrine effects (weight gain, diabetes, impotence in men, menstrual irregularities in women), sedation, mental dullness ("Thorazine haze"), muscarinic effects (dry mouth, constipation, blurred vision).

### PHENOTHIAZINES (includes TRICYCLICS)

chlorpromazine (Thorazine)

promazine (Sparine)

triflupromazine (Vesprin)

acetophenazine (Tindal)

fluphenazine (Prolixin, Decanoate, Permitil, Modecate)

perphenazine (Trilafon)

prochlorperazine (Compazine)

trifluoperazine (Stelazine)

mesoridazine (Serentil)

thioridazine (Mellaril)

butoperazine (Repoise)

### PHENYLBUTYLPIPERADINES

Less sedative but harsher extrapyramidal effects.

haloperidol (Haldol)

pimozide (Orap)

## THIOXANTHENES

Less sedative but harsher extrapyramidal effects.

thioxanthene (Navane)

flupenthixol (Fluanxol)

## DIHYDROINDOLONES

molindone (Moban)

## ATYPICALS (includes DIBENZEPINES)

Newer drugs generally with less severe side effects.

clozapine (Clozaril) [can reduce the white blood cell count]

loxapine (Loxitane, Daxoline)

olanzapine (Zyprexa)

quetiapine (Seroquel)

risperidone (Risperdal) [generally less severe side-effects than other atypicals]

ziprasidone (Geodon)

aripiprazole (Abilify)

## **Antidepressants**

Treats depression, bipolar, dysthymia, anxiety, small doses of tricyclics for migraines.

Side effects: tricyclics and tetracyclics have the same effects as antipsychotics.

## TRICYCLICS

amitriptyline (Elavil, Endep)

clomipramine (Anafranil)

doxepin (Sinequan, Adapin)

imipramine (Tofranil, Janimine)

trimipramine (Surmontil, Rhotrimine)

amoxapine (Asendin)

desipramine (Norpramin, Pertofrane)

notriptyline (Aventyl, Pulvules, Pamelor)

protriptyline (Vivactil, Triptil)

## TETRACYCLICS

maprotroline (Ludiomil)

mirtazapine (Remeron)

## PHENETHYLAMINES

venlafaxine (Effexor)

## TRIAZOLOPYRIDINES

trazodone (Desyrel)

## AMINOKETONES

Also treats nicotine addiction

Side effect: greater risk of seizures

bupropion (Wellbutrin, Zyban)

## SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)

Newer drugs with less side-effects but can increase suicidal and homicidal tendencies when the medication is started or ended.

fluoxetine (Prozac)

paroxetine (Paxil)

sertraline (Zoloft)

fluvoxamine (Luvox)

citalopram (Celexa)

## MONOAMINE OXIDASE INHIBITORS (MAOI)

A wide range of side effects including high blood pressure, reduced performance of the kidneys, lower blood flow to the brain and sometimes coma. The drug interacts with a wide variety of medications and foods.

isocarboxazid (Marplan)

phenelzine (Nardil)

tranylcypromine (Parnate)

## MISCELLANEOUS

nefazodone (Serzone)

## **Antianxiety/Anxiolytics/Depressants**

Treats anxiety, panic disorders, phobias, insomnia.

Side effects: sedation, poor sleeping habits, addiction. Buspirone is not sedating.

## BENZODIAZEPINES

diazepam (Valium)

clonazepam (Klonopin)

others (Librium, Ativan, Xanax, Dalmane, Restoril, Halcion)

BUSPIRONE (BuSpar)

## TRICYCLIC ANTIDEPRESSANTS

See above.

amitriptyline (Elavil, Endep)

others

## BETA-BLOCKERS

Beta blockers inhibit the effects of adrenaline (also known as epinephrine).

Treats hypertension, angina, arrhythmia, migraines, insomnia, extrapyramidal disorders, anxiety and panic attacks.

Side-effects: potential heart problems, asthma, hypotension, temporary sterility.

propranolol (Inderal)

nadolol (Corgard)

others

## **Anticonvulsants/Antiepileptics**

Treats severe anxiety, seizures, Parkinson's, extrapyramidal disorders, mania.

## BENZODIAZEPINES

Side effects: see above.

diazepam (Valium)

clonazepam (Klonopin)

## BARBITURATES

amobarbital (Amytal)

pentobarbital (Nembutal)

phenobarbital (Sulfoton)

secobarbital (Seconal)

## HYDANTOINS

Side effects: interferes with a wide range of drugs.

phenytoin (Dilantin)

mephenytoin (Mesantoin)

ethotoin (Peganone)

fosphenytoin (Cerebyx)

## MISCELLANEOUS

valporic acid (Depakote, Valproate)

Side effect: see above. Its benefit is that it is not sedating.

carbamazepine (Tegretol, Eptol)

Side effect: higher risk of anemia, bone marrow deficiency.  
primidone (Mysoline, Myidone)  
Metabolizes into phenobarbital.

### ANTICHOLINERGICS

Side effect: fast heart beat and arrhythmia, ulcers, glaucoma, psychosis in elderly.  
trihexphenidyl (Artane)  
benztropine mesylate (Cogentin)

### ANTI-HISTAMINES

In addition to allergies, older antihistamines treat nausea, motion sickness, anxiety, extrapyramidal effects and insomnia because of the side-effect of causing drowsiness.  
diphenhydramine (Benadryl, Excedrin PM, Nytol)  
promethazine (Phenegran)  
hydroxyzine (Atarax, Vistaril)

### **Antimania**

Treats mania, bipolar.

lithium (Carbolith, Cibalith, Lithane)

Side effect: Can impair kidney function, high blood pressure, diabetes. In rare cases, it causes irreversible brain damage. The patient needs constant monitoring because the therapeutic dose is close to a toxic level. The concentration of lithium changes broadly with normal changes in body chemistry throughout the day. Signs of toxicity include drowsiness and confusion.

valproic acid (Depakote, Valproate)

Side effects: Higher risk of liver failure, pancreas failure, ovarian cysts, spina bifida in children.

carbamazepine (Tegretol, Epitol)

Side effect: higher risk of anemia, bone marrow deficiency.

### **Stimulants**

Treats attention deficit disorder/ hyperactivity, narcolepsy, obesity, dementia, fatigue, depression, psychosis.

Side effects: hyperactivity, hypertension, insomnia, addiction, psychosis, depression, thinning of the bone, anxiety, addiction.

### AMPHETAMINES

amphetamine (Adderall, Benzadrine, Biphphetamine)  
dextroamphetamine (Dexadrine)  
methamphetamine (Desoxyn)  
methylphenidate (Ritalin)