HANDBOOK OF PSYCHIATRY & THE LAW

Ebrahim J. Kermani

Handbook of Psychiatry and the Law

Ebrahim J. Kermani, M.D.
New York University
School of Medicine
New York, New York

YEAR BOOK MEDICAL PUBLISHERS, INC.
CHICAGO • LONDON • BOCA RATON

1 2 3 4 5 6 7 8 9 0 93 92 91 90 89

Kermani, Ebrahim J.
Handbook of psychiatry and the law.

Includes bibliographies and index.
1. Forensic psychiatry—United States. 2. Psychiatrists—Legal status, laws, etc.—United States.
3. Child psychiatry—United States. I. Title.
II. [DNLM: 1. Psychiatry—handbooks. 2. Psychiatry—legislation. WM 33.1 K39h]
KF8922.K47 1989 344.73'041 89-5664
ISBN 0-8151-5087-3 347.30441

FOREWORD

It is difficult to write a foreword to this text which has accepted the challenge of dealing at length with the broad areas of encounter between psychiatry and the legal system. The topics selected range from relatively clear issues such as confidentiality to terribly opaque ones such as surrogate mothers. Even a casual review of the chapter headings will cause the reader to pause at the complexities inherent in the topics this volume bravely engages.

The author uses a method based on the chronologic presentation and explication of actual case law. In this sense, he uses the "data" of the legal profession so as to understand the issues as they have evolved historically. This approach is particularly useful for the student who can see how the attitudes of the courts have evolved and how they have shaped law over time. The method makes the book of greater value to both the beginner and experienced practitioner.

The author makes a very real effort to try to make the evolution of the legal and psychiatric conflicts appear reasonable, notwithstanding the tensions that exist between the legal and psychiatric communities that are not based on "reasonable" differences. There are conflicts that derive from differences in perceived role functions and in the world views that separate these professions and these make a peaceful reconciliation highly improbable.

One can see the biases of the legal profession enter the law in subtle ways. A patient who refuses to participate in a research study is presumed to have the competence to refuse. A patient who agrees to participate in that same study will have his "rights" protected. Apparently, the right to refuse is less in need of protection than the right to participate. This hierarchy is not based on a rational need to protect but represents the values and role functions of the legal profession. Clearly, there can be dangers associated with a research project, but equally clearly there can be benefits to the individual subject as well as to the class of people called patients. The imposition of personal values through the vehicle of the laws can masquerade as the protection—ofttimes selective protection—of rights.

Other examples of this tension can be found in the right to be treated and the right to refuse treatment. It is theoretically possible to hold a psychiatrist liable for withholding a treatment that the patient refused, if it is later ascertained by a court that the psychiatrist failed incorrectly to question the patient's competence to refuse. How much easier it is to reflect with judicial calm and in precise detail on problems long after the problems have occurred. It is unfortunate that clinical decisions cannot be made at the leisurely pace of a legal trial.

To the clinician one of the most confusing situations is that a patient may be committed by the court for involuntary treatment and then still have

the right to refuse medication. It is as if just the experience of being in a mental hospital is inherently therapeutic. Can such a baseless fantasy be really accepted as the explanation? Or, in fact, are we dealing with a prejudice in which the legal profession does not trust the medical profession and wishes to be involved, as if courts reside on some higher moral plane? This is particularly painful to the practitioners of medicine who do not find the ethical standards of the legal profession to be so glorious as to warrant this self-aggrandizing role.

The courts like clarity, but clinical situations are frequently ambiguous. If a clinician believes a patient to be planning to injure another person, the clinician is reponsible to warn that person. This is a clear situation which poses little conflict for most clinicians. The ambiguousness is in the real situation in which there is some risk to another person but where the clinician feels correctly that he or she has a positive relationship with the patient and may be more effective in preventing harm if the patient's revelation is held as a confidence. Violating the confidence will almost certainly destroy the therapeutic relationship, particularly with a paranoid patient. The clinician must judge which action in fact will provide the greatest safety for the potential object of the attack. Can the clinician be infallible? Obviously not. Yet, if the court holds that the duty is to warn whenever there may be a danger, there is little doubt that clinicians will tend to err on the side of protecting themselves rather than their patients' welfare.

The author points out that the courts see electroshock therapy as a hazardous procedure and therefore feel compelled to protect the patient from these putative dangers. Unfortunately, the courts are in total error. The procedure is a safe one. Can we argue that the misperceptions of the court should, nevertheless, lead to regulation and law based on those misperceptions? Should we not argue that when a judge is wrong there must be a process for correcting the misapprehensions underlying the decision? Courts increasingly appear to be sensitive to data that support the decisions they choose to make. Social science data do not tend to be of the hardest sort and therefore lend themselves to judicial abuse.

In many ways, one must recognize that the lawyer and the clinician think differently and make different assumptions. The lawyer looks for preciseness and the clinician lives with ambiguity. The lawyer speaks of conditions such as "beyond a reasonable doubt" while a clinician speaks of behaviors as being present "with some frequency." These very different experiences and the underlying assumptions of the respective disciplines must lead to profound tensions. Finally, lawyers and clinicians fulfill different role functions. The lawyer is an advocate. The lawyer takes the position proposed by the client and argues it as forcefully and effectively as possible. The clinician operates more frequently in locus parentis. The clinician does what he or she believes to be in the patient's best interest. While there is an advocacy element there is an element of playing the role of the healer. Patients abandon some autonomy

when they assume the sick role in order to receive the benefits of that role. The sick or patient role is totally different from the client role that the same person may have with an attorney. These conflicts between role models and disciplinary assumptions cannot be avoided. Nevertheless, a book of this sort has great value because it helps both the clinician and the legal practitioner to understand better the points where conflict must arise and to try to find more effective ways of helping the person in distress, no matter how we may disagree about the definition of helping or distress.

Robert Cancro, MD
Professor and Chairman
Department of Psychiatry
New York University School of Medicine

PREFACE

Just a few decades ago mental health professionals played at most a peripheral role in the judicial process. Today their input is often decisive, and it is pervasive as well, to the extent that nearly every aspect of the process is affected by psychiatric criteria. Of course, during these decades the mental health professions have come to play substantial roles in many facets of daily life such as school and work, whereas once psychiatry was applied only to the profoundly psychotic. Just as psychiatry has rapidly become a vital element in the legal process, the authority of the law over matters once reserved for psychiatrists, such as civil commitment, forced medication, and electroconvulsive therapy, has been greatly expanded. The interface of psychiatry and law today is a fact of life.

This book has been conceived and prepared with the broad goal of serving as a teaching tool. The specific objectives of the book are fourfold: (1) to provide an introduction to the topic of psychiatry and law for mental health professionals; (2) to provide a reference of relevant legal decisions for those interested in the topic; (3) to function as a handbook for those studying for a variety of specialty examinations; and (4) to acquaint mental health practitioners with the legal issues that they are likely to encounter in their practice.

The book's methodology is historical, presenting actual court rulings on each subject chronologically. These landmark cases are analyzed and discussed from the perspectives of psychiatry and law. Presenting the actual cases seemed the only valid technique to this writer, because rulings often depend on how the judges and finders of fact interpret the minutiae, a process which could not be accurately duplicated in a fictional account. In other words, broad principles derive from the details, so idiosyncrasy will always play a part in a system such as ours, which is responsive instead of dictatorial. To see just how that happens is as important as understanding the underlying philosophical framework. Thus, concepts such as "the duty to warn" and "competency to stand trial" are substantiated by actual cases described in narrative and followed by commentary from concerned specialists and the author.

Common medical, psychiatric, and legal vocabulary and Latin phrases have been used in order to preserve the academic value of the book for those scholars and researchers interested in the scholarly aspect of the issues. However, a glossary at the end should prevent these terminologies from being an obstacle to beginners in this field or to a general reader. The subject matter is summarized as follows.

SECTION I: GENERAL PSYCHIATRY

Psychiatry and Tort Law

Mental health professionals, like all other citizens, are expected to act prudently, and take precautions against creating risk or injury to other citizens. Once a professional such as a psychiatrist has agreed to provide services for a patient, a physician-patient relationship is established in which the psychiatrist or other caregiver has a duty to exercise knowledge, skill, and good judgment in taking care of his patients.

Psychiatrists have a duty to act nonnegligently. If their conduct falls below the level of professional standards, a lawsuit can be brought against them by their patients, and the triers of fact may find that they breached their duty.

The plaintiff-patient in a negligence suit must prove to the triers of fact that the alleged injury would not have occurred or rarely occurs in the absence of negligence, that the psychiatrist had exclusive control over the instrumentality that caused the injury, that the patient did not contribute to the injury, and finally that the psychiatrist and plaintiff-patient were the only ones with access to the actual occurrence.

Underlying these expectations and duties is the concept of tort, derived from the Latin *tortus*, or "twisted." In law, tort signifies a wrong; specifically a private or civil wrong or injury resulting from a breach of the legal duty originating in society's expectations of responsibility in interpersonal conduct.

Under this doctrine, a psychiatrist or other mental health professional may be found negligent in a variety of categories. The five major pillars of tort law in psychiatry that confront the practitioner are (1) confidentiality, (2) informed consent, (3) sexual encounters, (4) suicide, and (5) duty to warn and protect and prediction of dangerousness.

Confidentiality in a psychotherapeutic relationship is not only an ethical issue, but a legal one. Psychiatrists or other mental health professionals cannot publish their patients' life histories for self-serving purposes. The confidential relationship between therapist and patient creates a fiduciary duty from the therapist to the patient, and unauthorized release of said information breaches fiduciary duty, leading to lawsuits. The doctor-patient privilege is a legal concept designed to protect the patient, and only the patient can waive the privilege. In certain circumstances, however, courts may order psychiatrists to release and reveal specific information in the interest of justice. If psychiatrists refuse to do so, they can be held in contempt of court and sent to prison. The doctor-patient privilege remains in force after the patient's death. In cases of suspected fraud perpetrated by clinicians, the court is sensitive to the competing interests of confidentiality and justice, and requires disclosure of information limited to facts bearing on the possible fraud.

All persons, competent or incompetent, have the right to determine what shall be done with their own bodies. The law makes it clear that patients

should receive adequate information from their physicians and after they comprehend it, they should voluntarily consent before any procedure is commenced. Patients have a right to know of all possible side effects, complications, and what may ensue after a certain procedure. If a patient is mentally incompetent to make a decision and give informed consent, the court might utilize substitute judgment, in which case the judge decides what the incompetent person would want if he or she were not incompetent. The judge, acknowledged to be a reasonable person, receives the necessary information and then gives consent with the presumption that that was what the patient, if competent, would have decided.

In emergency situations, the law permits the physician to start treatment without a patient's consent, abiding by the assumption that rational persons would want treatment.

Professionals have a duty to exercise reasonable care to safeguard their patients from suicide. This duty is more restrictive when a patient is voluntarily or involuntarily confined to a psychiatric ward, and specifically if the patient was admitted to the hospital because of suicidal tendencies. The court does not accept arguments that volitional or negligent acts by a patient contributed to the suicide. In suicide allegations, the court wants to learn whether the caretaker exercised reasonable care and precautions as measured by the degree of care, skill, and diligence customarily exercised by other psychiatrists or hospitals in the community.

Sexual encounters between therapists and their patients are not only unethical but grounds for malpractice as well. The court will try to find out whether the transference and the countertransference were mishandled. The court will determine therapists to be liable if they have acted in a seductive, suggestive manner. Also, the court has extended the scope of malpractice to situations where the therapist was sexually involved with the patient's spouse.

In landmark cases covering "duty to warn and protect," two trends emerged in court rulings. The first indicates that the confidential character of patient-psychotherapist communications must yield to the extent that disclosure is essential to avert danger to others, and communication privileges end where the public peril begins. The second trend indicates that the existence of a special relationship between psychotherapists and patients does not mean that the duties stemming from that relationship are owed to others at large. The author argues that the original Tarasoff doctrine is sound from both the perspective of public policy and psychotherapeutic practice, but that its extension, which has occurred in several other cases, is problematic for psychotherapists.

Alcoholism and Drug Addiction

This chapter discusses whether alcoholism and drug addiction are considered diseases in a medical context, or manifestations of abnormal personality. The

relationship between these two conditions and psychiatric disorders is also explored.

According to law, alcoholism is a handicapping condition and therefore discrimination in the form of job termination due to alcoholism is illegal. Nevertheless alcoholics, even when intoxicated, are legally liable for their behavior and its effects. If they commit a crime they can be prosecuted as a competent person, and may not claim as a defense their alcoholic condition.

Drug addiction itself is not criminal behavior. As with alcoholics, however, drug addicts cannot escape legal responsibility for their actions, unless they can prove that the drugs have made physiologic changes in their brain, and even then they must meet the criteria of the insanity defense.

Right to Treatment and Right to Refuse Treatment

The legally recognized purpose of psychiatric hospitalization is to offer treatment to mentally ill persons. The law requires that states provide adequate care to institutionalized patients, and if the state fails in this, the Department of Justice has the obligation to compel the state to comply with its responsibilities. The patients have a right to receive such treatment as will help them recover or improve their mental condition. Furthermore, a state may not confine an individual to a mental hospital unless it offers some sort of treatment, training, or habilitation to help that individual improve or be cured of illness.

While patients have the right to receive treatment, they also have the right to refuse treatment in nonemergency situations. In such cases, patients must be given a judicial hearing and the state, which has the burden of proof, must show with clear and convincing evidence that the patients lack the capacity to make their own treatment decisions, that is, medicating mentally ill persons against their will is a judicial function and is not to be relegated to medical authorities.

The courts have found that psychiatric patients, like any other citizens, have a right to the protection of the due process clause of the Fourteenth Amendment and to be free from unjustified intrusions such as forced medications.

Intrusive Modalities

Electroconvulsive therapy (ECT) is a treatment of choice for severe depression. The complication rate is very minimal. Nevertheless, society and the legal establishment view ECT with skepticism. Legislatures and courts have greatly curtailed this form of treatment, seeing ECT as a form of hazardous and unusual treatment. Therefore, the courts have imposed various requirements to be fulfilled prior to the administration of ECT.

Seclusion and restraint is a form of treatment useful for assaultive, ag-

gressive patients for the purpose of maintaining a patient's safety and the safety of others. It is not illegal to place a patient in restraint so long as the mental health professional has exercised sound judgment.

Psychosurgery is surgical intervention to sever fibers connecting one part of the brain to another or to destroy certain tissue in the brain in order to alter behavior. The number of these procedures has been declining. However, a few operations are still being performed on violent epileptic patients. The court is mainly interested in whether such patients are able to give true informed consent or not.

Hypnosis, although an unreliable procedure, may be used in order to enhance the memory of a witness, plaintiff, or defendant. However, the state should adopt certain procedural safeguards as prerequisites to admitting testimony containing hypnotically refreshed recollection.

Traumatic Neurosis

Experiencing trauma can trigger an affliction called "traumatic neurosis." Its many psychiatric symptoms range from impaired memory to depression. Organic problems can also arise from traumatic neurosis. There are two categories of legal claims based on traumatic neurosis: tort actions and workers' compensation.

Witnessing stressful events can cause psychological harm, and a witness may bring a lawsuit for liability against the responsible party. Being a victim of sexual harassment on the job is a trauma-producing phenomenon likely to cause traumatic neurosis.

Under the Workers' Compensation Act, compensation is awarded for the incapacity to work because of injuries arising from and during employment. Benefits are allowed only for the inability to work, and negligence is not an issue. Claimants must demonstrate, at the very least, that their employment contributed to if not caused their disability. Some courts accept purely mental stimuli as a causal basis if these can be connected specifically with employment. Others courts require that a physical injury be the catalyst for the neurosis. The prevailing view is that mental disability should be treated no differently from physical injury. Courts generally have not considered a claimant's preexisting mental condition as an essential criterion, focusing instead on whether or not the work contributed to the disability. The "preliminary link theory," which requires a presumption of compensability, has been adopted by some courts. If an emotional injury stems from stress and not trauma, to justify a compensation award it must arise from stressors of greater dimension than the quotidian tensions most work entails. Thus the countless stresses and strains experienced daily during employment do not constitute grounds for award of compensation.

Contractual and Testamentary Capacity

A person who executes a will must possess mental capacity at the time of execution for that will to be legally valid. The testator or testatrix must have a sound mind, understand the nature of his or her acts, and know the natural objects of his or her bounty and the extent of property. Such a person must be acting voluntarily, free of the undue influence of others.

Civil Commitment

Civil commitment is a last-resort option of involuntary placement in a mental institution for the purpose of treatment. State police powers and the doctrine of parens patriae are both vehicles for initiating commitment. Law enforcement agencies or family and friends of mentally ill persons can request their commitment, and patients should be apprised at all times of their rights. The court has ruled that patients must be examined by the psychiatrists signing papers in favor of their commitment. Patients are appointed counsel by the court to represent their point of view and articulate their wishes in a legal forum.

Clinical findings show that committed mental patients are less likely than voluntary ones to have prior hospitalization, and are no more likely to suffer psychosis. Furthermore, civil commitment has been used as a social policy tool to rid the public of violence-prone persons.

The standard of proof for civil commitment is clear and convincing evidence, and proof of incapacity must be thoroughly documented and properly presented.

Civil commitment has no specific duration, but procedures allow petitioners hearings to contest their hospitalization. Hospitalization is not to be seen as punishment for insanity defendants. For transferees from prisons to mental institutions, due process must be adhered to. The guidelines of due process established by law for all involuntary patients create an unfortunate adversary relationship between patient and psychiatrist.

Outpatient commitment is a new and controversial phenomenon. Criteria are more lenient, but the effectiveness of outpatient commitment is questionable. Finally, the issue of civil commitment of homeless persons is explored.

Competency to Stand Trial

The doctrine that a mentally ill person cannot be put on trial has an ancient history, but its modern form developed in the United States starting in 1960 when the US Supreme Court ruled that defendants must have the ability to understand the proceeding against them and be able to consult with and assist their attorneys. Lack of these abilities constitutes incompetency to stand trial.

In succeeding years the Supreme Court extended its first decision and ruled that indefinite commitment of criminal defendants solely on account of

their lack of capacity to stand trial violates due process. The Supreme Court justices have warned both sides in the trial courts to be alert, before and during the course of the trial, to evidence suggesting possible incompetency of a defendant, and that they have the responsibility to report such evidence.

Clinicians have a complicated job in assessing competency. They must approach the task with clinical thinking, keeping in mind that their role is to provide factual clinical material for the courts. A variety of tests have been introduced to aid this process.

Judging the competency to stand trial of a defendant who is on medication or has what is called "synthetic sanity" has brought a new dilemma for mental health professionals. Many courts bar the trial of a defendant taking antipsychotic drugs because the defendant's unmedicated demeanor is very important for the jury to see.

In spite of the extensiveness of the doctrine prohibiting the trial of incompetent persons, courts in areas far from the intellectual centers of the country may remain unaware of, feel unaffected by, or be uncertain of how to implement the doctrine, and defendants in those jurisdictions may therefore be denied its protections.

Insanity Defense

The history of the insanity defense goes back over 2000 years, with the state of insanity being compared to a child's innocence. Modern formulations of the insanity defense have sprung from the M'Naghten ruling in mid-nineteenth century England. Recent examples are the doctrine of criminal behavior as the result of mental illness, and the implementation of standards set forth in the American Law Institute tests.

The content of expert psychiatric testimony has been restricted to medical issues and how certain states can affect behavior, and psychiatric labels and broad speculation have been prohibited.

According to some studies, crime is more prevalent among mentally ill people, while other studies negate that finding or remain inconclusive. One study of death row inmates strongly suggests that the incidence of mental illness in criminals is much higher than generally thought, and that their mental illness often goes unrecognized.

It has been determined that defendants have a right to psychiatric assistance when their mental state at the time of the offense is an issue in a trial, and also to mitigate a capital sentence. In both cases the scope of this assistance has been defined.

The use of a new concept "guilty but mentally ill," as an alternative verdict has caused controversy. Almost no legal or medical professional groups have favored implementation of this verdict, which is supposedly another option, but more often becomes a compromise. Some states have abolished the insanity defense altogether, in the belief that individuals who act with a

proven criminal state of mind are accountable for their acts regardless of motivation or mental condition.

The US Supreme Court has struggled with the insanity issue on several occasions, although the insanity defense is technically an issue of state law rather than the US Constitution. The Court decided that if a defendant keeps silent after receiving a Miranda warning, that silence may not be construed as evidence that he or she comprehended the warning. Spontaneous confession, even if attributable to mental illness, is not to be construed as a forced confession and may be used in a court of law, in the view of the Supreme Court.

The positions of professional organizations directly involved in the insanity defense issue are discussed. These groups include the American Psychiatric Association, the American Bar Association, the American Medical Association, and the American Civil Liberties Union.

A variety of issues affect the parameters, procedures, and utilization of the insanity defense, including posttraumatic stress disorder, heat of passion, pathologic gambling, and multiple personality. These issues along with relevant court rulings are covered.

Psychiatry in the Sentencing Process and the Death Penalty

The arguments for and against mental health professionals participating in death penalty proceedings are both compelling. Both appear in Supreme Court decisions addressing this issue and in the work of researchers studying it. One conclusion is that permitting the presentation of psychiatric testimony mitigating the death sentence necessitates allowing the presentation of exacerbating evidence as well, in which case the psychiatrist testifying for the prosecution does not violate the Hippocratic oath. Certain safeguards should be instituted for such testimony, however.

While mental health professionals joined others in the trend to abolish the death penalty in the early 1960s, actually a majority of these professionals believe it is an effective deterrent.

The ethics and ramifications of mental health professionals predicting the future dangerousness of capital defendants have sparked debate, and the way was cleared by the Supreme Court for these professionals to contribute in that regard. The Supreme Court asserted that although predicting future dangerousness is difficult, it should not therefore be avoided.

Defendants cannot be compelled to incriminate themselves in examinations by prosecution psychiatrists without the protections of the Miranda doctrine.

After continuing controversy, it is argued that mental health professionals may have a moral rationale for treating death row prisoners even if doing so makes the prisoners competent for execution.

SECTION II: CHILD AND ADOLESCENT PSYCHIATRY

The Rights of Children Under the U.S. Constitution

Children's rights under the Constitution have been consistently upheld, but with limitations. The degree of limitations usually depends on two factors: (1) the general political climate in the country, and (2) the specific issue. Minors under a defined state age are entitled to First Amendment rights which can be curtailed under given circumstances. The right to personal expression is guaranteed for everyone by the Constitution including school-age children. However, offensive, vulgar language can be punished by the school authorities if they deem it unsuitable. Discussion of controversial subjects in school can be silenced, and school authorities can act on behalf of parents to protect children from exposure to unsuitable material.

Minors retain a right to privacy when it involves very private affairs such as pregnancy and abortion. They need no parental permission or judiciary approval to obtain an abortion or contraceptives. However, they do not have the right to purchase pornographic reading matter.

The law is sensitive to children who need psychiatric treatment, but parental decision has a substantial role in providing that care and treatment. The parents may commit their child to an institution without a judicial hearing, and an objective party affiliated with the institution will review the case. When a conflict arises between the parents and the state regarding psychiatric treatment of the child, the parental authority supersedes that of the government.

In criminal proceedings children have the right to many aspects of due process of law. However, juveniles do not have the constitutional right to trial by jury, and the state can use preventive detention far more readily than it can for adult defendants to serve legitimate state interests. Corporal punishment in public school is not in violation of the Constitution, and it is not considered a violation of the Eighth Amendment.

The Rights of Handicapped Children

The Congress enacted several statutes in the 1970s which were intended to ensure that handicapped children receive an appropriate education. Recent cases have further defined, and in some instances expanded, the level of services required under the law.

The Education for All Handicapped Children Act (EAHCA) was designed to provide the funds necessary for states to implement programs and services for the handicapped in fulfillment of equal education. The possible need of handicapped children for psychological counseling (psychotherapy) in order for them to benefit from an educational program was recognized. Handicapped children may not be expelled from school for bad behavior if the behavior in any way resulted from their handicap.

Handicapped and retarded children are entitled to special protection under

the Constitution, and city ordinance zoning laws cannot discriminate against them with housing restrictions. Critically ill infants have been the subject of regulations, but a lawsuit has recently limited the scope of the effect of the regulations. Children with acquired immunodeficiency syndrome (AIDS) have also been determined by the courts to be entitled to rights under statutes protecting the handicapped. Psychiatrists and mental health professionals who work with handicapped children are required to be aware of the developments in law and the promulgation of legislation, in order to give adequate and appropriate guidance to those who consult them.

Victimized Children

Millions of reports of child abuse are filed each year with governmental agencies. Mental health professionals have a special responsibility to report suspected abuse because they have a greater opportunity to observe potential cases. Failure to report suspected child abuse is a misdemeanor punishable by a fine and/or imprisonment. Psychiatrists are also vulnerable to negligence lawsuits for failure to report.

Risk factors for child sexual abuse have been clarified. Clinical manifestations of child sexual abuse are numerous and may continue into adulthood.

When allegations of sexual abuse arrive at the court of law, it is inevitable that the child will take the witness stand. This is likely to be traumatic for the child. Defendants have the constitutional right to cross-examine the witness, even when the witness is a child. They do not have the right to examine the records of protective agencies freely; however, a trial court may determine that some information in a file is material to the defense and release that information only.

The ability to tell a truth from a lie and know the importance of truth-telling, and not any specific age limit, are the criteria for a child's competency to be a witness. The child must have a memory sufficient to recollect events and the ability to communicate them. It is the task of the trial judge to decide whether or not a child is competent to testify, but mental health professionals can determine the credibility of a child as witness, and make recommendations to the court. Defendants have the right to be present during the trial, especially in all critical phases, and to exercise the Sixth Amendment right to cross-examine the child. However, during competency hearings, defendants may be excluded from the hearing since the matters under discussion are not directly related to their defense.

The practice of play therapy, in which children-victims demonstrate how they were abused by using anatomically correct dolls, has been limited by some courts and has caused controversy.

Child Custody

The doctrine of "the best interest of the child" is the principle by which the courts select the custodial parent. Often, courts impose the judges' personal

moral values on the determination of which parent is the best choice for custody. Therefore, homosexuals have suffered denials of their fitness for custody based on their sexual orientation.

Courts can terminate the parental right if a parent is found to endanger the well-being of the child by abuse or neglect. But termination must be based on the standard of clear and convincing evidence. Mentally disabled parents cannot have their parental rights terminated solely because of their illness. Instead, it must be proved that their mental problems render them incapable of properly caring for their children, and that there is little hope for timely improvement of their condition.

Although the right of biological parents supersedes that of psychological parents, under certain circumstances the court will give custody to the latter if it is deemed in the child's best interest.

Joint custody is considered to facilitate communication between divorced parents, and help children thrive in spite of their situation. More than half of the states have laws providing for joint custody. A role for the mental health professionals in custody disputes is generally seen as inevitable to some degree, although therapeutic relationships should be kept as separate as possible from legal processes.

Finally, surrogate motherhood has caused controversy as well as social, legal, and psychological drama. The prevailing legal view is that surrogacy by itself is not against the law but that surrogacy contracts are unenforceable, and financial remuneration to the natural mother for allowing the adoption of the child by the infertile wife goes against the most fundamental ethics of this society.

The society that is seen through this psychiatric-legal lens is one in which philosophical values are actively employed as guides in resolving conflicts. Many of our most vexatious social ills are major elements in these conflicts. Mental health and legal professionals, more than almost any other groups, confront these problems daily and serve to eradicate them by aiding the mentally ill persons under their care to the best of their abilities. Considering the thicket of suffering in which the legal and mental health professions often function together, it is not surprising that their relationship itself sometimes needs healing. It is hoped that this book will facilitate mutual understanding between these two professions.

In the preparation of such a book, I am indebted to many; I should like to express my gratitude to many authors from whom I learned and borrowed. I would also like to acknowledge my appreciation to my editor, Cynthia Tokumitsu, who edited the text.

Ebrahim J. Kermani, MD