

Group Dynamics in Forensic Pretrial Decision-Making

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This study examines how forensic evaluators' opinions that pertain to diagnosis, competency to stand trial, and criminal responsibility (Maryland's version of the not guilty by reason of insanity plea) are rendered at a state forensic hospital for defendants pleading not criminally responsible. Pretrial evaluations completed independently by a psychiatrist, a psychologist, and a social worker were presented at a forensic staff conference where psychiatrists and psychologists openly "voted" on diagnosis, competency to stand trial, and criminal responsibility. These results were then sent to the court. The purpose of this study was to assess the clinicians' level of agreement and the role that conformity played in the decision-making process. A sample of twenty court-ordered pretrial evaluations of defendants examined at the hospital between March and June 1991, with evaluators' opinions generated by a secret ballot, were compared with a matched control group from an earlier time, when opinions were generated by open ballot. The study was designed to compare the opinions of forensic evaluators in issues of diagnosis, competency to stand trial, and criminal responsibility between the two samples. The defendants in the experimental group and the control group were matched on the basis of age, race, sex, and offense. It was hypothesized that with secret ballot voting there would be greater disparity of agreement regarding diagnosis, competency to stand trial, and criminal responsibility opinions compared with the open method of voting. However, the results of this study did not support that hypothesis. There was little disparity on forensic opinions rated either by secret or open voting.

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The subject of group conformity and its impact on decision-making has been studied extensively by social scientists. Researchers in psychiatry have looked closely at interexaminer reliability and validity of psychiatric diagnoses. Forensic research has explored judges' and psychiatrists' perspectives on dangerousness,¹ prosecution and defense attitudes about criminal responsibility,² disagreements between judges' and forensic psychiatrists' opinions on defendant's competency to stand trial,³ psychiatric versus nonmedical mental health decisions on commitment,⁴ the level of agreement between the clinical evaluation of sanity and subsequent legal disposition,⁵ and interexaminer agreement in concordance with psychiatric opinion on a court verdict.⁶ However, the effect of conformity on pretrial decision-making as it pertains to the determination of diagnosis, competency to stand trial, and criminal responsibility has not been addressed in the literature. As such, we studied the impact of group process on pretrial decision-making in the setting of a forensic hospital.

The characteristics of group behavior include structure, status hierarchy, individual roles, group norms, leadership, and cohesiveness.⁷ A forensic case conference can be described as a formal group, led by a psychiatrist, in which status hierarchy and roles of individual panel members are determined by profession and educational background. The panelists have the common goal of evaluating the patient and presenting medical opinions to the court regarding the defendant's diagnosis, competency to stand trial, and criminal responsibility.

The commonality of motivation, attitude, expectation, and performance among group members is termed cohesiveness. Cohesive forces may or may not be beneficial to the group. It is known that as cohesion increases, conformity increases within the group. This is helpful in terms of productivity of task-directed behavior.⁸ However, highly cohesive forces put groups at risk for "groupthink" activity. "Groupthink" is a term for essentially unhealthy group conformity that occurs when pressures to conform are in the interest of solidarity rather than that of official goals. When excessive pressure to conform is present in a group, opposing views are suppressed. Members with incohesive opinions keep their views to themselves and discussion becomes one-sided. Preserving relations between members and preserving group image as a united front can take priority over making the best decision.⁷ In the instance of a forensic case conference, pressure to present a unanimous opinion to the court could jeopardize appropriate judgment of the data and the value of the forensic opinion itself.

Situations that were characteristic of possible "groupthink" activity were observed by the authors at a 220-bed forensic center where evaluations for competency to stand trial and criminal responsibility are routinely performed. Defendants were initially screened by a psychologist or psychiatrist in the county where the offense had occurred. Defendants identified by the screener as "possibly not competent" or "possibly not responsible" were referred for further and

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more extensive evaluation at the state forensic hospital. The vast majority of evaluations were conducted on an outpatient basis in which law enforcement officers from the respective counties transported the defendant to the hospital on the day of their examination. There were rare occasions when a defendant who had been released on bond presented for an evaluation on their own accord.

At the hospital, defendants underwent a day-long comprehensive evaluation and, unless otherwise indicated (i.e., inpatient hospitalization to clarify questions that persisted about diagnosis, competency, or criminal responsibility), were returned to the detention center later that same day. As part of the evaluation, the defendant would be interviewed by a social worker, a psychologist, and a psychiatrist. Typically, the interviews were conducted individually, although occasional interviews were performed as a team. When all of the data had been collected (including interviews with collateral sources of information, detention center records, psychiatric records, and medical records), the respective evaluators presented their findings at a forensic psychiatric case conference. The conference was chaired by a psychiatrist or psychologist, and at least one panel member had to be a psychiatrist. Most conferences had at least two psychiatrists and one psychologist present. After the evaluators presented their data, the defendant would be brought into the case conference and interviewed by panel members. Following an interview, which lasted an average of 15 minutes, psychologists and psychiatrists were asked to give their opinions

about diagnosis, competence to stand trial, and criminal responsibility. These opinions were recorded by the chairperson, who in turn wrote a brief report to the court and identified the hospital opinion as either unanimous or by majority. The individual opinions of panel members were recorded as well.

As new members of the panel, the first two authors were uncomfortable participating in a process that required them to render an opinion about such weighty issues in such a brief period of time. Furthermore, the first two authors were struck by the unanimity of opinions. There was little, if any, discussion about diagnosis, and panel members seldom, if ever, disagreed about the ultimate issues of competence to stand trial and criminal responsibility. The authors were troubled by panel member's complacency when it came to exploring the fine points of a diagnosis, the issue of competency, or the defendant's version of the instant offense. It appeared that peer pressure was omnipresent and weighed heavily on how individual committee members arrived at their opinions. Statements such as "Well, I didn't quite see it that way, but you can put me down for that [diagnosis and/or forensic opinion]," or "Put me down for that one so the hospital doesn't give a split opinion," or "I'll go along with that so that I don't end up in court" were the norm and not the exception. While the authors were distressed by the aforementioned remarks, a significant majority of these statements were made in reference to the issue of diagnosis and not when discussing the ultimate issues of criminal

responsibility or competency to stand trial. For example, if two panel members believed a defendant most closely met the DSM-III-R criteria for suffering from a schizoaffective disorder and the third member believed that the defendant suffered from a bipolar disorder, the third member might agree and go along with the diagnosis of schizoaffective disorder. Similarly, if there was disagreement about the extent of a defendant's history of illicit substance use (i.e., abuse versus dependence) or what personality traits most closely fit a given individual, it appeared that the minority opinion usually was changed to conform to the majority opinion.

After observing this behavior, the authors elected to study whether peer pressure and conformity were dictating examiners' opinions and conclusions. An hypothesis was developed that with secret ballot voting as compared to open voting there would be a greater disparity in agreement with regard to diagnosis, competence to stand trial, and criminal responsibility. The study was designed as a pilot study for descriptive purposes as well as a review of the hospital's traditional method of formulating forensic opinions.

Methods

A sample of cases was obtained from the 56 defendants seen in forensic staff conference between March and June 1991. The cases were chosen depending on whether one of the authors was available to sit on the panel and administer the study. Twenty-three such cases were

identified. Because of incomplete data, the forensic conference panel deferred rendering an opinion on 3 of the 23 cases. These 3 cases were dropped, leaving a final sample of 20 evaluations that were studied for interexaminer agreement as it pertained to diagnosis and forensic issues.

Panel members were aware that they would be participating in a study involving secret and open balloting in forensic decision-making. However, in order to minimize experimental bias, they were not informed of the study hypothesis.

During the study period, and prior to each case presentation, panel members were provided with an anonymous questionnaire that was divided into three sections: diagnosis, competency to stand trial, and criminal responsibility (see Fig. 1). The case was presented in the usual manner by the assigned evaluators, after which time the defendant was interviewed. Following the interview, panel members were asked to complete the questionnaire.

The diagnosis section was divided in to Axes I, II, and III. In determining the Axis I and Axis II diagnoses, panel members were asked to refer to an eight-page list, attached to the questionnaire, which identified all of the Axis I and Axis II diagnoses in the DSM-III-R. Based on the data presented and the clinical interview, they were instructed to circle what they believed were the appropriate diagnoses at the time of the instant offense. In addition, the psychiatrists were asked to enter the appropriate Axis III diagnoses, if applicable.

Under the competency to stand trial and criminal responsibility sections of the

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CASE NUMBER _____

DIAGNOSIS:

AXIS I: CIRCLE DIAGNOSIS ON ATTACHED PAGE (YOU MAY CIRCLE MORE THAN ONE DIAGNOSIS).

AXIS II: CIRCLE DIAGNOSIS ON ATTACHED PAGE (YOU MAY CIRCLE MORE THAN ONE DIAGNOSIS).

AXIS III: _____

COMPETENT TO STAND TRIAL?

"Incompetent to stand trial" means not able: (1) To understand the nature or object of the proceeding; or (2) To assist in one's defense. (HG §12-101)

YES _____

NO _____

DEFERRED _____

RESPONSIBLE?

A defendant is not criminally responsible for criminal conduct if, at the time of that conduct, the defendant, because of a mental disorder or mental retardation, lacks substantial capacity: (1) To appreciate the criminality of that conduct; or (2) To conform that conduct to the requirements of law. (HG §12-108)

YES _____

NO _____

DEFERRED _____

PLEASE MAKE SURE YOU HAVE ENTERED THE CASE NUMBER IN THE SPACE PROVIDED AT THE TOP OF THE PAGE.

Figure 1. Questionnaire.

questionnaire, the respective statutes were defined according to Maryland law. Specifically, "Incompetent to stand trial" means that a defendant is not able (1) "to understand the nature or object of the proceeding;" or (2) "to assist in one's

defense."⁹ Maryland's statute for insanity, which follows the American Law Institute standard, is stated as follows:

A defendant is not criminally responsible for criminal conduct if, at the time of that conduct, the defendant, because of a mental disorder or

mental retardation, lacks substantial capacity: (1) To appreciate the criminality of that conduct; or (2) To conform that conduct to the requirements of law.

For purposes of this section [of the statute] "mental disorder" does not include an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct.¹⁰

Furthermore, Maryland case law does not recognize mental disorders that result from voluntary intoxication of alcohol or illicit drugs as a viable insanity defense.¹¹

As was done for the diagnosis portion of the questionnaire, after all of the data were presented and the interview was completed, panel members were asked to render opinions about whether the defendant was competent to stand trial and was criminally responsible for the instant offense. They were instructed to check the opinion blank on the questionnaire (Yes, No, or Deferred) that best corresponded to their personal opinions.

To ensure that extraneous comments would not influence participants' secret ballot opinions, members of the study group were instructed to keep all opinions or remarks about the case to themselves until after everyone had completed filling out their questionnaire. Thus, comments such as "Oh! This is a straightforward one," or "This case is a mess," were eliminated.

After the participants completed the questionnaire, they were asked to place it into an envelope marked with the corresponding case number. After the envelope was sealed, panel members were able to continue and provide the chairperson with their opinions about diagnosis, competence to stand trial, and criminal

responsibility. Participants' "secret" opinions were used only for the purpose of this study, and their "open" opinions were the ones that were recorded by the chairperson and sent to the court.

When the data had been collected, the secret ballot opinions on diagnosis, competency, and criminal responsibility were compared with those from the open voting. In addition, to account for the bias of the experiment on the evaluators' opinions, we compared the results from the secret ballots with the results of defendant's from a matched control group. This group was selected from evaluations conducted at the hospital over a period of several years prior to the study when open voting was the means by which opinions were recorded. Matching to earlier cases was done for the following criteria: age at the time of the offense, race, sex, inpatient/outpatient status, and criminal offense (principal charge). The cases were able to be 80 percent matched for age within six years. The remaining criteria were matched in all the cases.

Results

Sample As previously noted, the sample consisted of 20 cases presented at a weekly forensic conference. Eighteen of the cases were evaluated for both competency and criminal responsibility, and two of the cases were for competency only. The sample consisted of 14 outpatients and 6 inpatients ranging in age from 18 to 76 with 18 males and 2 females. Eleven of the defendants were black and 9 were white. There was also a wide range of offenses represented including murder,

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		<u>OUTCOME</u>	
		<u>COMPETENCY</u>	
		Open Voting	
		Unanimous	Split
Secret Ballot	Unanimous	18	0
	Split	1	1

Figure 2. Outcome: competency.

		<u>OUTCOME</u>	
		<u>CRIMINAL RESPONSIBILITY</u>	
		Open Voting	
		Unanimous	Split
Secret Ballot	Unanimous	15	0
	Split	1	2

Figure 3. Outcome: criminal responsibility.

arson, assault, forgery, child abuse, and sex offenses.

Study Outcome A comparison of the results of the secret ballot and open voting in regard to the issue of competency to stand trial is shown in Figure 2 in a cross-tabulation diagram. In 18 of the 20 cases, there was no difference between the opinions expressed in the secret and open voting. Of the remaining two cases, one had a split (not unanimous) opinion in both voting sessions, and the other had a split opinion in the secret ballot voting and unanimous opinion in the open voting.

With respect to the issue of criminal responsibility, comparison of the results showed that 15 of the 18 cases had unanimous opinions in both secret and open voting. There were two cases in which there was a split opinion in both voting sessions. One other case had a split opinion in the secret ballot voting and a unanimous opinion in the open voting (see Fig. 3).

The unanimity of the principal Axis I diagnoses for both the secret and open voting is compared in Figure 4. Eleven of 20 cases had unanimous opinions in both

secret and open voting. Eight of 20 opinions were split in the secret and open voting. There was only one case in which the opinion about an Axis I diagnosis was split in the secret voting and unanimous in the open voting.

Axis II diagnoses were reviewed for the presence or absence of a personality disorder. In the secret ballot voting, 78 percent of the evaluators noted the presence of a personality disorder. In the open voting, 81 percent diagnosed a personality disorder. Seven evaluators changed their opinions about the existence of a personality disorder in the defendant in the time between the voting sessions.

A sample of cases from previous years was matched, as noted above, to identify the effect that the study itself had on the

		<u>OUTCOME</u>	
		<u>AXIS I DIAGNOSIS</u>	
		Open Voting	
		Unanimous	Split
Secret Ballot	Unanimous	11	0
	Split	1	8

Figure 4. Outcome: Axis I diagnosis.

results. In the matched cases, 18 of the 20 opinions were unanimous for competency to stand trial, criminal responsibility, and Axis I diagnosis. Also noted was the fact that 15 (75%) of the defendants in the matched cases were believed to have a personality disorder.

Discussion and Conclusion

The results of the study did not support the hypothesis that evaluators changed their opinions on diagnosis, competency, and criminal responsibility due to peer influence in the open voting as compared with the secret ballot. There was little disparity in the forensic opinions in either voting session. However, the study did yield some interesting results pertaining to diagnosis. The interevaluator reliability (percentage of unanimous decisions) for Axis I diagnoses in the study cases was virtually the same (55 to 60%) in both the secret and open voting. In comparison, the interevaluator reliability in the matched cases for Axis I diagnoses, was much higher at 90 percent. These results suggest that group process had influenced the evaluators in the staff conferences held prior to the initiation of the study (matched cases) by leading them to conform their opinions to those of the other group members. The results also suggest the possibility that the evaluators present at the conferences held during the study were more likely to be committed to the opinions they had written down on the secret ballots in regard to diagnosis.

It appears that the study itself generated disagreement and increased thinking about diagnostic opinions. The authors

noted that the interviews of the defendants and the subsequent case discussions increased in duration during the study, although this effect was not formally measured. Additionally, the presence of the questionnaire, with a comprehensive listing of all the diagnoses found in the DSM-III-R, as well as the availability of the DSM-III-R (brought by the authors and placed on the conference table), may have influenced the outcome.

An interesting finding revealed by the study was the difference of clinical agreement between evaluators regarding opinions of Axis I diagnoses and opinions pertaining to competency and criminal responsibility. Unanimous opinions on Axis I diagnoses were relatively low (55 to 65%) in both secret and open voting. However, unanimous opinions on competency and criminal responsibility were relatively high (90 to 95% and 83 to 88%, respectively) for the two types of voting. The increased disparity of agreement in opinions of diagnoses may be due to the fact that many more choices were available to the evaluator for Axis I diagnoses. As previously noted, choices of diagnostic opinions were based on the DSM-III-R, in which many diagnoses have similar features (i.e., bipolar disorder versus schizoaffective disorder versus major depressive disorder). In contrast, decisions of competency and criminal responsibility were voted as either competent or not competent and criminally responsible or not criminally responsible, respectively. Whether this finding is simply the result of the evaluators having more choices from which to choose an Axis I diagnosis or represents a true divergence in thinking

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has yet to be determined. This is an area that needs further research for proper evaluation.

Another interesting result noted in the study cases, as well as in the matched cases, was the high level of personality disorder diagnoses. It is not known whether this is an accurate reflection of the population seen at this forensic hospital, an anomaly peculiar to the cases in the study, or simply diagnostic error. In any case, the issue should be studied further before conclusions are made.

In summary, the results of the study did not suggest that peer pressure influenced the final opinions of evaluators making decisions about forensic issues in a group setting. The study did suggest that the group process and/or the effect of the study itself may have affected the diagnostic opinions rendered in these conferences. The study also revealed a high percentage of personality disorder diagnoses in the sample.

The study was limited by the small sample size and the fact that a finding of insanity is a relatively rare event. Again, this study was considered a pilot as well as a review of the hospital's traditional method of formulating forensic opinions. This study was not designed and did not claim to be a statistical evaluation of forensic opinions. The study was a descriptive analysis of forensic case conference activity following observations by the authors of possible "groupthink" situations. Further research involving larger samples, double-blind studies, and statistical analysis is needed to verify these findings.

In light of the results to date, the hospital has reorganized the pretrial evaluation procedure. Cases are evaluated by individual psychiatrists, psychologists, and social workers as was done previously. However, the conference at which "voting" on the diagnostic and forensic issues took place is no longer held. The forensic conference is now convened for educational purposes only. A vote is no longer taken for unanimous or majority opinions by staff. Only the original evaluators' opinions are sent to the court. Subsequent research should investigate whether this change has an effect on the formulation of diagnostic and forensic opinions.

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