THE EXPERT WITNESS MANUAL

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The Expert Witness Manual©

by

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I. SCOPE OF ARTICLE

This article relates to the work being done by the Family Law Section's Expert Witness Committee, to draft a manual relating to all aspects of expert witness testimony in family law litigation. The book will be ready for distribution at the Advanced Family Law Course in August of 1999.

II. INTRODUCTION

In November of 1997, the Chair of the State Bar's Family Law Section, Ann Crawford McClure, appointed a committee of the Family Law Council to explore issues relating to the admissibility of expert witness testimony in family law cases. The principal concern in the formation of the committee was the growing importance of the line of cases developing new law on legal reliability of expert witness testimony. The Family Law Council was concerned that case law developed in personal injury litigation (particularly products liability litigation) might have unintended consequences that would adversely affect family law litigation.

The Committee, chaired by Richard R. Orsinger, first met on November 15, 1997. Through that meeting and subsequent meetings on the average of twice per month, the Committee formulated a strategy to deal with the concept of "legal reliability" of expert testimony in family law litigation. The Committee determined to find out what standards existed that governed the activities of expert witnesses, to collect them together, and to present them in a book for the Bench and the Bar.

III. THE IMMEDIATE PROBLEM

The immediate problem was the list of factors to be used to determine legal reliability, stated in the Texas Supreme Court case of *E.I. duPont de Nemours v. Robinson*, 923 S.W.2d 549 (Tex. 1995). In *Robinson*, the Texas Supreme Court held that scientific expert testimony is admissible only if it is "reliable." According to *Robinson*, the "legal reliability" of an expert's theory or technique can be determined by considering factors such as the following:

(1) the extent to which the theory has been or can be tested;
(2) the extent to which the technique relies upon the subjective interpretation of the expert;
(3) whether the theory has been subjected to peer review and/or publication;
(4) the technique's potential rate of error;
(5) whether the underlying theory or technique has been generally accepted as valid by the relevant scientific community; and
(6) the non-judicial uses which have been made of the theory or technique.

The Texas Supreme Court noted that:

> the factors mentioned above are non-exclusive. Trial courts may consider other factors which are helpful to determining the reliability of the scientific evidence. The factors a trial court will find helpful in determining whether the underlying theories and techniques of the proffered evidence are scientifically reliable will differ with each particular case.

Id. at 566-567. Although the *Robinson* factors were said to be non-exclusive, courts seemed to be using the *Robinson* factors as checklist for determining admissi bility of expert testimony, even in areas outside of the physical sciences, where the *Robinson* factors had less or no application.

Robinson was patterned after the U.S. Supreme Court case of, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 593-94 (1993), which required scientific expert testimony to be critically evaluated by federal trial judges for soundness in methodology before it is admitted into evidence. The Texas Court of Criminal Appeals had taken an analogous step in state court criminal proceedings, in the case of *Kelly v. State*, 824 S.W.2d 568 (Tex. Crim. App. 1992) (applying TRE 702 requirement of legal reliability to the then-novel scientific DNA "fingerprint" evidence). However, none of those three cases articulated legal reliability issue in the same terms. Thus, as the Family Law Council committee was doing its work, courts in Texas state civil proceedings, Texas state criminal proceedings, and federal court proceedings all around the county, were attempting to wrestle with legal

reliability issues, with uncertain and non-uniform results.

IV. LEGAL RELIABILITY EXTENDED TO ALL EXPERTS

While the Committee was moving ahead with the application of *Robinson* factors to family law litigation, the Texas Supreme Court handed down its decision in *Gammill v. Jack Williams Chevrolet, Inc.*, 972 S.W.2d 713, 718 (Tex. 1998). Although *Gammill* involved the question of whether *Robinson* factors apply to the testimony of engineers, the Texas Supreme Court considered whether the legal reliability standards of *Robinson* extend to all experts. The Supreme Court recognized that the specific factors listed in *Robinson* did not readily apply to all experts, but went on to note:

> If one views Daubert in a broader context, the Daubert Court is giving strong advice to district courts: in ruling on admissibility, trial judges are the gatekeepers and should pay particular attention to the reliability of the expert and his or her testimony.

The Court went on to say: "[T]rial judges have a heightened responsibility to ensure that expert testimony show some indicia of reliability."

In *Gammill*, the Texas Supreme Court announced the following important rule of law for civil litigation in Texas courts:

> We conclude that whether an expert's testimony is based on "scientific, technical or other specialized knowledge," Daubert and Rule 702 demand that the district court evaluate the methods, analysis, and principles relied upon in reaching the opinion. The court should ensure that the opinion comports with applicable professional standards outside the courtroom and that it "will have a reliable basis in the knowledge and experience of [the] discipline."

Given the diversity of experts who testify in state court on a wide range of topics, it was not possible for the Supreme Court to specify "applicable professional standards outside the courtroom," or when an expert opinion will have "a reliable basis in the knowledge and experience of [a] discipline." The Supreme Court turned this responsibility over to the trial judges, saying: "The court in discharging its duty as gatekeeper must determine how the reliability of particular testimony is to be assessed."

As a consequence of the holdings in *Robinson* and *Gammill*, legal reliability challenges can now be brought against therapists, counselors, psychologist, psychiatrists, social workers and similar witnesses who testify in Texas civil proceedings. Challenges can also be brought against accountants and business evaluators giving expert testimony. Litigants and courts can no longer take it for granted that experts with credentials or experience can freely opine about matters at issue in the case. As a result of *Gammill*, in civil litigation in Texas courts litigants and judges must engage in a slow process of building a consensus, judge-by-judge and case-by-case, regarding the professional standards to be used, or adapted for use, in determining the admissibility of various types of expert evidence, and the kinds of opinions that have a reliable basis in the knowledge and experience of a particular discipline.

V. THE EXPERT WITNESS MANUAL

The Expert Witness Manual is designed to speed that process along, and to give lawyers and judges a place to look to find the "applicable professional standards outside the courtroom" that will be incorporated by reference into court proceedings as the measure of legal reliability of expert testimony.

The Expert Witness Manual will also include a comprehensive review of the rules of procedure and evidence that govern the use of expert witness in litigation, and the cases ruling on those subjects.

VI. TENTATIVE SCHEDULE

The State Bar Family Law Section is cosponsoring telephone CLE for the next year, on different aspects of expert witness issues. Here is the tentative schedule. Speakers are not yet confirmed except where indicated.

THIRD THURSDAY CLE (4-23-99 draft)

Sponsored by the Family Law Section and
the Professional Development Department
of the State Bar of Texas

Thur 7/15/99 Noon-2:00pm Expert Witness telephone CLE

J-6 The Expert Witness Manual

Topic: The New Legal Reliability Standards Under *Daubert*, *Kuhmo*, *Robinson*, *Gammill*, *Kelly v. State*, & *Nenno v. State* (Toto... I have a feeling we're not in Kansas anymore")

Panelists: Moderator, Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Professor Dan Shuman, SMU School of Law, Dallas (confirmed)
Judge Paul Womack, Texas Court of Criminal Appeals
Justice Deborah Hankinson, Texas Supreme Court

Thur 8/19/99 Noon-2:00pm Expert Witness telephone CLE

Topic: Can Psychological Evaluations Meet *Robinson*/*Gammill* Reliability Standards?

Panelists: Moderator, Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Professor Dan Shuman, SMU School of Law, Dallas (confirmed)
Jan Marie DeLipsey, Ph.D., Dallas (confirmed)
John Zervopoulos, Ph.D., J.D., Dallas
Hon. John Specia, 225th Dist. Ct., Bexar County

Thur 9/16/99 Noon-2:00pm Expert Witness telephone CLE

Topic: Business Valuation: Assets & Liabilities Approach Compared to the Capitalization of Income Approach and Discounted Future Cash Flows Approach

Panelists: Moderator, Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Patrice Ferguson, CPA, JD, Houston
Scott Turner, CPA, Corpus Christi
Hon. Tom Stansbury, 328th Dist. Ct., Fort Bend County

Thur 10/21/99 Noon-2:00pm Expert Witness telephone CLE

Topic: Psychological Syndromes: Substance or Smoke Screen? Discussing Battered Woman Syndrome, Child Sexual Abuse Accomodation Syndrome; Repressed Memory Syndrome; False Memory Syndrome

Panelists: Moderator, Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Jan Marie DeLipsey, Ph.D., Dallas
Georganna Simpson, Attorney at Law, Dallas
Hon. Bonnie Hellums, 247th Dist. Ct., Harris County

Thur 11/18/99 Noon-2:00pm Expert Witness telephone CLE

Topic: Tracing Commingled Property:

Panelists: Moderator, Stewart Gagnon, Attorney at Law, Houston (confirmed)
Doug Fejer, CPA, Dallas
Robert Cocanower, CPA, Fort Worth
Hon. Frank Sullivan, 322nd Dist. Ct., Tarrant County

Thur 12/16/99 Noon-2:00pm Expert Witness telephone CLE

Topic: The Child as Witness: Competency, Custody Cases, Sex Abuse Cases

Panelists: Moderator: Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Duke Hooten, TDPRS, Boerne
Jan Marie DeLipsey, PhD, Dallas
Ed Silverman, PhD, Houston
Michael Lamb, Or Other Celebrity

Thur 1/20/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Business Valuation: Adjustments for Control Premium, Minority Discount, Marketability Discount, and Blockage Discount; Restricted Stock; Classes of Stock; Buy-Sell Restrictions

Panelists: Moderator: Cheryl Wilson, Attorney at Law, San Antonio (confirmed)
Dan Hanke, CPA, San Antonio
Robert Cocanower, CPA, Fort Worth
Hon. Susan Rankin, 301st Dist. Ct., Dallas County

Thur 2/17/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Recovered Memory/False Memory: Valid or Voodoo?

Panelists: Moderator, Richard R. Orsinger, Attorney at Law, San Antonio (confirmed)
Jan Marie DeLipsey, PhD, JD, Dallas
Elizabeth Loftus, PhD, Seattle (Or Other Celebrity)
Hon. Dean Rucker, 318th Dist. Ct., Midland County

Thur 3/16/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Character and Value of Employment Benefits

Panelists: Moderator: Joan Jenkins, Attorney at Law, Houston (confirmed)
Bill Clifton, Attorney at Law, Dallas
Mary Jo McCurley, Attorney at Law, Dallas
Hon. Jim Squire, 312th Dist. Ct., Harris County

Thur 4/20/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Relocation of Children: Legal Issues and Mental Health Evidence

Panelists: Moderator: Hon. Ann Crawford McClure, 8th Court of Appeals, El Paso (confirmed)
Jo Jenkins, Attorney at Law, Houston
Richard Warshak, PhD, Dallas
Hon. Susan Rankin, 301st Dist. Ct., Dallas County

Thur 5/18/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Proving the Value of Real Property

Panelists: Moderator: Wally Mahoney, Attorney at Law, Pasadena
_____, Real Estate Appraiser, _____
_____, Attorney at Law, _____
Hon. Craig Fowler, 253rd Dist. Court, Dallas County

Thur 6/15/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Abuse and Neglect of Children: Battered Child Syndrome, Fetal Alcohol Syndrome, Shaken Baby Syndrome, Munchaussen Syndrome by Proxy, etc.

Panelists: Moderator: Duke Hooten, TDPRS, Boerne
Nancy Kellog, MD, San Antonio
_____, Criminal Defense Attorney, _____
Hon. Randy Catterton; 231st Dist. Ct., Tarrant County

Thur 7/20/00 Noon-2:00pm Expert Witness telephone CLE

Topic: Proving Tax Considerations in Divorce

Panelists: Moderator: Gary Nickelson, Attorney at Law, Fort Worth
Dan Hanke, CPA, San Antonio
Doug Fejer, CPA, Dallas

Hon. Jim Squire, 312th Dist. Ct., Harris County

VII. APPENDICES

Attached as appendices to this article are the following excerpts from the Expert Witness Manual, as it exists today:

1. Table of Contents of Part 1 (Procedure and Evi dence Considerations);

2. Table of Contents of Part 2 (Mental Health and Family Relations);

1. Table of Contents of Part 3 (Financial Issues);

2. Chapter 2-15, on Mood Disorders, showing how the Expert Witness Manual approaches depression, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV);

3. Chapter 2-21, on Eating Disorders, showing how the Expert Witness Manual approaches eating disorders, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV);

4. An excerpt from Chapter 2-27 on Psychological Syndromes (the portion pertaining to Battered Women Syndrome);

5. An excerpt from Chapter 36 on Intelligence Tests (the portion pertaining to McCarthy Scales of Children's Abilities);

6. An excerpt from Part 3, Financial Issues, relating to a marketability discount and a control premium in valuing a business interest.

We on the Council hope that you will find these materials helpful, and look forward to the opportunity to present the entire Manual for your consideration.

APPENDIX 1

Part 1
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I. Experts Generally
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- B. Confidentiality Under Texas Law, Exceptions
- C. Choice-of-Law Issues on Confidentiality
- D. Confidentiality by Agreement
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- A. Consulting Experts Discovery Exemption [TRCP 166b(3)(b)]
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  - 3. No Expert Testimony Where Jury to Decide Based on General Knowledge
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State Bar of Texas
Family Law Section's

EXPERT WITNESS MANUAL

PART 2

Mental Health and Family Relations

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15:01 Overview

15:01(1) General Description

Everyone experiences a wide range of emotions from happiness to sadness, elation to depression. However, when a person experiences abrupt or very intense changes of emotions, or ones that last for long periods or time, that person may have a Mood Disorder.[2] Mood Disorders are the most prevalent serious mental health problem today in America.[3] It is estimated that approximately 20 million Americans now or will in the future suffer from diagnosed mood disturbances, leading to an annual loss in national productivity of around $35 billion.[4] The seriousness of the problem is reflected in the fact that the space devoted to Mood Disorders has tripled in DSM-IV as compared to DSM-III-R.[5]

DSM-IV defines "mood" as "a pervasive and sustained emotion that colors the perception of the world."[6] Depression, elation, anger, and anxiety are examples of moods.[7] In psychiatric terms, moods are described as dysphoric, elevated, euthymic, expansive, or irritable.[8] A "Mood Disorder" is a mental disorder in which the predominant disturbance is in the patient's mood.[9]

"Affect" is related to mood. DSM-IV defines "affect" as a fluctuating "pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion)."[10] Common examples of affect include sadness, elation, and anger.[11] Affect disturbances include blunted, flat, inappropriate, labile, and restricted or constricted.[12] DSM-IV distinguishes affect from mood in the following way: "[Affect is] the subjective experience or expression of a feeling state (emotion) . . . . [I]n contrast to mood, which refers to a more pervasive and sustained emotional `climate,' affect refers to more fluctuating changes in emotional `weather'."[13]

DSM-IV divides Mood Disorders into four categories: (1) depression, which includes major depression and dysthymia; (2) bipolar, which includes bipolar I, bipolar II, and cyclothymia; (3) mood disorders due to a medical condition; and (4) substance-induced mood disorders.[14] The two most severe Mood Disorders are Major

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2 "Order and Disorder: an Exploration of the Mind and the Brain," *Virtual Hospital*, <http://www.vh.org/Welcome/UIHC/MedMuseum/OrderAndDisorder/05MentalDisorders.html> [12/28/98].

3 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

4 "Order and Disorder: an Exploration of the Mind and the Brain," *Virtual Hospital*, <http://www.vh.org/Welcome/UIHC/MedMuseum/OrderAndDisorder/05MentalDisorders.html> [12/28/98].

5 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

6 DSM-IV, Appendix C, p. 768; DSM-IV GUIDEBOOK 193-94.

7 DSM-IV, Appendix C, p. 768; DSM-IV GUIDEBOOK 193-94.

8 "Dysphoric" refers to unpleasant moods such as sadness, anxiety, or irritability. "Elevated" refers to exaggerated feelings of well-being, or euphoria or elation. Patients may describe the feeling as "high," "ecstatic," "on top of the world," etc. "Euthymic" refers to moods in the normal range, neither depressed nor elevated. "Expansive" refers to a lack of restraint in describing one's feeling with a tendency toward exageration. DSM-IV, Appendix C, pp. 768-69.

9 DSM-IV 317; DSM-IV GUIDEBOOK 193. In DSM-III, mood disorders were labeled as "Affective Disorders."

10 DSM-IV, Appendix C, p. 763; DSM-IV GUIDEBOOK 193-94.

11 DSM-IV, Appendix C, p. 763; DSM-IV GUIDEBOOK 193-94.

12 "Blunted" describes a marked reduction in the intensity of emotional display. "Flat" describes the absence or almost absence of any emotional display. "Inappropriate" describes a marked difference between the emotion being displayed and the verbalizations of that emotion. "Labile" refers to repeated and abrupt changes in emotional display. "Restricted or Constricted" refers to a slight reduction in emotional display. DSM-IV, Appendix C, p. 763; DSM-IV GUIDEBOOK 193-94.

13 DSM-IV, Appendix C, p. 768; DSM-IV GUIDEBOOK 193-94.

14 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

Depression and Bipolar I (manic-depressive) Disorder. Most of these Mood Disorders follow an episodic pattern with various combinations of mood episodes[15]--Major Depressive Episodes,[16] Manic Episodes,[17] Mixed Episodes,[18] and Hypomanic Episodes.[19] These mood episodes are described in further detail through the use of "specifiers"[20]--psychotic,[21] catatonic,[22] melancholic,[23] atypical,[24] and postpartum onset.[25] Other specifiers apply to the longitudinal course of the disorders--seasonal pattern, rapid cycling, and with and without full interepisode recovery.[26] Because mood symptoms[27] are found in a number of other disorders such as Schizophrenia, Dementias, Adjustment Disorders to name only a few, Mood Disorders are difficult to diagnosis.[28]

For persons with Mood Disorders, the disturbed moods are not continuous, but instead occur episodically, with periods of disturbed mood alternating with periods of normal functioning.[29] Part of the diagnostic criteria for Mood Disorders involve major episodes, including Major Depressive Episode, Manic Episode, Mixed Episode, and Hypomanic Episode. These Mood Episodes are not diagnoses in and of themselves.

Depression is one of the most prevalent psychiatric disorders.[30] One survey indicated that 20% of the U.S. population has at least one depressive symptom in any given month and 12% have two or more in a year.[31]

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15 DSM-IV 320-38; DSM-IV GUIDEBOOK 194-206. A "mood episode" is a period of disturbed mood, which alternates with often extended periods of normal functioning. DSM-IV GUIDEBOOK 194.

16 "Major Depressive Episode" lasts at least two weeks with a characteristic pattern of depressive symptoms lasting most of the day, nearly every day. Untreated these episodes may last for six months or longer.

17 "Manic Episode" lasts at least seven days with an elevated, euphoric, or irritable mood along with a characteristic pattern of manic symptoms.

18 "Mixed Episode" lasts at least seven days with a mixture of depressive and manic symptoms.

19 "Hypomanic Episode" lasts at least four days with an elevated, euphoric, or irritable mood that are not as severe as those found during manic episodes.

20 DSM-IV 382-87; DSM-IV GUIDEBOOK 224-31; "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com /mag1/p5h-md01.html> [12/31/98].

21 "Psychotic" depression and mania implies the presence of delusions or hallucinations. With depression, the delusions or hallucinations usually involve poverty, physical illness, or moral transgressions. With mania, the delusions or hallucinations usually involve wealth or unlimited personal power. "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com /mag1/p5h-md01.html> [12/31/98].

22 "Catatonia" symptoms include immobility, rigidity, staring, muteness, echolalia, or echopraxia. Half of all episodes of catatonia are cause by mood disorders. DSM-IV 382; "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com /mag1/p5h-md01.html> [12/31/98].

23 "Melancholia" symptoms include weight loss, early morning awakening, extreme tiredness, intense guilt, and inability to cheer up even for a moment. DSM-IV 383; "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com /mag1/p5h-md01.html> [12/31/98].

24 "Atypical" depression is characterized by increased appetite, weight gain, and excessive sleep. DSM-IV 384-85; "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com /mag1/p5h-md01.html> [12/31/98].

25 "Postpartum Onset" occurs within four weeks following the birth of a child and is accompanied by psychotic symptoms, sometimes including hallucinations and delusions threatening the welfare of the baby. DSM-IV 385-86.

26 DSM-IV 38, 387-91; DSM-IV GUIDEBOOK 232-34.

27 A mood symptom is a subjective manifestation reported by the affected individual rather than observed by the examiner. Specific diagnosis of Mood Disorder or other conditions depends on the combination of mood symptoms reported by the affected individual.

28 DSM-IV GUIDEBOOK 193.

29 DSM-IV GUIDEBOOK 194.

30 "Mood Disorders: an Overview," *The Harvard Mental Health Letter*, December 1997 (Part I) <http://www.mentalhealth.com/mag1/1997/h97-md06.html> [12/31/98]

31 "Mood Disorders: an Overview," *The Harvard Mental Health Letter*, December 1997 (Part I) <http://www.mentalhealth.com/mag1/1997/h97-md06.html> [12/31/98] citing to the Epidemiologic Catchment Area (ECA) Survey of the National Institute of Mental Health. The ECA is discussed in Chapter 2-4.

Another study found that rates of major depression approached 5% in the previous 30 days and 17% over a lifetime.[32] Bipolar disorder occurs in approximately 1% of the general population.[33]

15:01(2) Common Treatment Methods

Common treatment methods for mood disorders include pharmacotherapy and various types of psychotherapy.[34] In those patients who have had a poor response to or tolerance for antidepressants, who have severe vegetative symptoms, or who have psychotic features, electroconvulsive therapy is sometimes used.[35]

15:01(3) Common Issues, Critical Analysis, and Case Law

Mood symptoms are not confined to Mood Disorders, and can occur in connection with a wide variety of disorders classified in other parts of DSM-IV.[36] For Mood Disorders, there is no absolute boundary with either Schizophrenia or Anxiety Disorders.[37] Consequently, diagnosing a Mood Disorder as compared to another Mental Disorder is sometimes arguable. Additionally, persons with Mood Disorders can manifest other features, such as paranoia (i.e., psychotic depression).

Studies have shown that Mood Disorders, depression in particular, can impact parenting either directly or indirectly.[38] One study concluded that a parent's depression interferes with their children's ability to attain social competence through imitating and mirroring their parents' emotional expressions, problem-solving methods, and cognitive styles; through the parents coaching and teaching efforts; and through their parent's management of their child's social activities.[39] Another study concluded that infants of depressed mothers appear to react more to their mother's negative behaviors, whereas infants of nondepressed mothers are more responsive to their mother's positive behaviors.[40] A third study, which compared the interactions of two month old infants and their working and non- working mothers suffering from postpartum depression with nondepressed mothers and their two month

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32 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 58 (1996), citing to the National Comorbidity survey, which is discussed in Chapter 2-4.

33 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 106 (1996), citing to the ECA survey.

34 *"Order and Disorder: an Exploration of the Mind and the Brain,"* Virtual Hospital, <http://www.vh.org/Welcome/UIHC/MedMuseum/OrderAndDisorder/05MentalDisorders.html> [12/28/98].

35 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: MOOD DISORDERS (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/01-15.html> [12-29-98].

36 DSM-IV GUIDEBOOK 193.

37 DSM-IV GUIDEBOOK 18.

38 Kenneth A. Dodge, *Developmental Psychopathology in Children of Depressed Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 3-6 (1990); Tiffany Field, et al., *Behavior-State Matching and Synchrony in Mother-Infant Interactions of Nondepressed Versus Depressed Dyads*, 26 DEVELOPEMENTAL PSYCHOLOGY 7-14 (1990); Jeffrey Cohn, et al., Face-to-Face *Interactions of Postpartum Depressed and Nondepressed Mother–Infant Pairs at 2 Months*, 26 DEVELOPMENTAL PSYCHOLOGY, 15-23 (1990); Constance Hammen, et al., *Relationship of Mother and Child Variables to Child Outcomes in a High-Risk Sample: A Causal Modeling Analysis*, 26 DEVELOPMENTAL PSYCHOLOGY 24-30 (1990); Sherryl H. Goodman and H. Elizabeth Brumley, *Schizophrenic and Depressed Mothers: Relational Deficits in Parenting*, 26 DEVELOPMENTAL PSYCHOLOGY 31-39 (1990); Michael Fendrich, et al., *Family Risk Factors, Parental Depression, and Psychopathology in Offspring*, 26 DEVELOPMENTAL PSYCHOLOGY 40-50 (1990); Carolyn Zahn-Waxler, et al., *Patterns of Guilt in Children of Depressed and Well Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 51-59 (1990); Marian Radke-Yarrow, et al., *Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression*, 56 CHILD DEVELOPMENT 884-93 (1985); Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 60-67 (1990). For more indepth discussion, see specific the Mood Disorders discussed below.

39 Kenneth A. Dodge, *Developmental Psychopathology in Children of Depressed Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 4 (1990).

40 Tiffany Field, et al., *Behavior-State Matching and Synchrony in Mother-Infant Interactions of Nondepressed Versus Depressed Dyads*, 26 DEVELOPEMENTAL PSYCHOLOGY 13 (1990).

old infants, concluded that non-working depressed mothers and their infants were less positive than nondepressed mothers, with the exception of those depressed mothers who worked outside of the home in excess of twenty hours per week.[41] Another study cautiously concluded that children between the ages of 8 and 16 were negatively influenced by their depressed mother's behavior, that the mother was similarly negatively influenced by their children's behavior, and that the mothers and children displayed a cycle of negative mutual influence.[42] A fifth study, which compared the quality of parenting of children between the ages of 3 months and 5 years by poor, African-American women 53 of whom were diagnosed with Schizophrenia, 25 of whom were depressed, and 23 of whom were well, concluded that those women with Schizophrenia had the lowest quality parenting and that depressed women's parenting was not significantly poorer than that of well women, with the exception that depressed women were not able to provide as much structure or discipline as either other group.[43] Another study, which compared the occurrence of major depression, anxiety disorder, and conduct disorder in children with various family risk factors including a parent who had experienced at least one major depressive episode lasting a minimum of 4 weeks to children with parents who had no history of psychiatric illness, concluded that family risk factors–family discord, low family cohesion, and parental divorce–were more prevalent among children of depressed parents, and the presence of these factors were associated with a higher incidence of major depression, conduct disorder, and any other psychiatric diagnosis in the children.[44] A seventh study compared expressions of guilt in children between the ages of 5 and 9 with mothers who had been diagnosed with depression to similarly aged children with well mothers, and concluded that expressions of guilt in children of depressed mothers were more often aberrant, distorted, and unresolved, which indicated possible differences in etiology and functions of their guilt.[45] Another study, which compares the patterns of attachment in two- and three-year-olds in normal families and in families with parental depression, the authors conclude that mothers with unipolar depression were more likely to be insecurely attached to their own mothers and that mothers with bipolar depression were more than twice as likely to be insecurely attached as children with normal mothers.[46] Another study summarizes the above studies along with some additional earlier studies to conclude that, although parental depression seems to have an effect on their children, the data is insufficient to draw general conclusions and more long term studies need to be conducted focusing on individual differences in both parents and their children.[47]

Texas cases referring to mood disorders are discussed below, in connection with the particular Disorder.

15:01(4) Proposing and Opposing Admissibility

Because mood symptoms are not confined to Mood Disorders, but appear in connection with other Mental Disorders, and because Mood Disorders are not easily distinguishable at their limits from Schizophrenia or Anxiety Disorders, a Mood Disorder diagnosis can be controversial and difficult.[48] Preferably a full differential diagnostic process was used in arriving at the diagnosis, and the proponent of the evidence can develop that process in laying the groundwork for the diagnosis. The party opposing the diagnosis can attack the diagnostic process if it was not a comprehensive assessment.[49] The use of specifiers to qualify a Mood Disorder diagnosis is also a rich source of potential disputes.

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41 Jeffrey Cohn, et al., Face-to-Face *Interactions of Postpartum Depressed and Nondepressed Mother–Infant Pairs at 2 Months*, 26 DEVELOPMENTAL PSYCHOLOGY, 15-22 (1990).

42 Constance Hammen, et al., *Relationship of Mother and Child Variables to Child Outcomes in a High-Risk Sample: A Causal Modeling Analysis*, 26 DEVELOPMENTAL PSYCHOLOGY 24, 29 (1990).

43 Sherryl H. Goodman and H. Elizabeth Brumley, *Schizophrenic and Depressed Mothers: Relational Deficits in Parenting*, 26 DEVELOPMENTAL PSYCHOLOGY 31-39 (1990).

44 Michael Fendrich, et al., *Family Risk Factors, Parental Depression, and Psychopathology in Offspring*, 26 DEVELOPMENTAL PSYCHOLOGY 40-50 (1990).

45 Carolyn Zahn-Waxler, et al., *Patterns of Guilt in Children of Depressed and Well Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 51-59 (1990).

46 Marian Radke-Yarrow, et al., *Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression*, 56 CHILD DEVELOPMENT 884-93 (1985).

47 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 60-67 (1990).

48 See Chapters 2-6 and 2-8.

49 See Chapter 2-8, on Making Psychological Assessments.

If a Mood Disorder diagnosis is based partly on psychological tests, such as the 2 Scale on the MMPI-II, or the Beck Depression Inventory, or the Rorschach, the reliability and validity of those tests can be put in issue by a *Gammill* objection and the proponent will need to establish the reliability and validity of the tests.[50]

If the Mood Disorder is offered in connection with a parent-child issue, an issue can be made regarding the scientific basis for the conclusions drawn by the expert from the Mood Disorder diagnosis.

15:02 Major Depressive Disorder

15:02(1) General Description

Common symptoms of Major Depressive Disorder are persistent feelings of worthlessness and hopelessness, thoughts of death and suicide, and an inability to feel pleasure or take interest in life. In a few people, despair and guilt become so intense that they turn into delusions about imagined illnesses or sins -- a condition known as psychotic depression.[51]

Delusions occur in approximately 10% to 25% of major depressive episodes.[52] Depressed people are often physically depressed as well -- constantly tired and sometimes insomniac or lacking in appetite. In bipolar (manic-depressive) disorder, these symptoms alternate with mania -- uncontrollable elation, excessive loquacity, sleeplessness, reckless hyperactivity, intrusive gregariousness, exaggerated self-assurance, and sometimes irritability, paranoia, rage, and grandiose delusions. Similar but briefer or differently-timed and less disabling emotional changes go by the names of Adjustment Disorder With Depressed Mood, Minor Depression, Brief Depressive Disorder, Cyclothymia (a milder form of bipolar disorder), and Dysthymia (a milder chronic form of unipolar depression).[53]

Men have a lifetime risk of from 7 to 12%, and women from 20-25%, of developing a Major Depressive Disorder.[54] Risk factors include post-partum for females, a family history of depressive illness, prior episodes of major depression, failed suicide attempts, stressful life events, and current substance and alcohol abuse.[55] The average major depressive episode lasts more than four months, more than 50% of people who experience one depressive episode will have a second, and approximately 80% of people who experience two depressive episodes will have a third.[56]

DSM-IV distinguishes two major depressive diagnoses: Major Depressive Disorder, Single Episode; and Major Depressive Disorder, Recurrent.[57] The distinguishing factor between these two diagnoses is having only one Major Depressive Episode versus having two or more such episodes. Diagnosis, however, can be difficult because it is often difficult to tell when one depressive episode has ended and another one has started. A new depressive episode should be considered to have started only when there has been an interval of at least two consecutive months since the last such episode in which criteria are not met for a Major Depressive Episode.[58]

Depression often co-occurs with medical conditions (e.g., stroke, heart disease, cancer diabetes, etc.), other psychiatric disorders (e.g., anxiety disorders, eating disorders, etc.), and alcohol and other substance abuse.[59]

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50 The MMPI-II is discussed in Chapter 2-40. The Beck Depression Inventory is discussed in Section 2-39:03. The Rorschach is discussed in Section 2-39:13.

51 "Mood Disorders: an Overview," *The Harvard Mental Health Letter*, December 1997 (Part I) <http://www.mentalhealth.com/mag1/1997/h97-md06.html> [12/31/98]

52 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

53 "Mood Disorders: an Overview," *The Harvard Mental Health Letter*, December 1997 (Part I) <http://www.mentalhealth.com/mag1/1997/h97-md06.html> [12/31/98]

54 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: MOOD DISORDERS (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/01-15.html> [12-29-98].

55 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: MOOD DISORDERS (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/01-15.html> [12-29-98].

56 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

57 DSM-IV 344-45.

58 DSM-IV GUIDEBOOK 208.

59 D/ART Facts, <http://www.nimh.nih.gov/newdart/dar_fact.htm> [10-11-98].

It is estimated that approximately 40% of persons with cancer, 20% to 50% of persons with heart disease, and 20% of patients in nursing homes are depressed.[60]

An important source of information about depression is the Depression/Awareness, Recognition, and Treatment (D/ART) program.[61] D/ART, established in 1985 and funded by the National Institute of Mental Health, is designed to educate the public, primary care providers, and mental health specialists about depressive illnesses--their symptoms, diagnosis, and treatment.[62]

15:02(2) Common Treatment Methods

Major Depressive Disorder is usually treated with psychotherapy, or medication, or both.

Psychotherapy generally falls into two categories–interpersonal therapy and cognitive behavior therapy. Interpersonal therapy concentrates on the immediate social context of depression and the depressed person's interpersonal relationships. The goal of cognitive therapists is to attempt to correct the depressed person's faulty thinking.[63]

The primary medications used to treat depression include tricyclic antidepresssants, second-generation antidepressants (SSRIs, Wellbutrin, Effexor, Desyrel, Serzone, Remeron); and monoamine oxidase inhibitors. More recently, St. John's wort, an herbal remedy, has become a popular treatment for depression being more often prescribed than floxuoxetine (Prozac) in Germany. The herb is sold through health food stores in the form of a liquid extract and, in some studies, has proved as effective as tricyclic antidepressants.[64] In those patients who have had a poor response to or tolerance for antidepressants, who have severe vegetative symptoms, or who have psychotic features, electroconvulsive therapy is sometimes used.[65]

The U.S. Public Health Service's Agency for Health Care Policy and Research (AHCPR) conducted a thorough review of psychopharmacological and psychotherapeutic treatments. The AHCPR looked at 39 treatment reviews, covering 3,500 studies published in peer-reviewed journals between 1975 and 1990.[66] In addition to the AHCPR study, there have been six meta-analysis reviews of treatments for depression in which psychological treatments are contrasted against one another and against psychopharmocological interventions. Then there have been three other studies that focus on the efficacy of psychotherapeutic treatment in comparison to pharmacotherapy.[67] After reviewing all of these meta-analytical studies, Roth and Fonagy's primary conclusion was that, because most of these studies were conducted prior to the introduction of the newer antidepressants, which have fewer side effects and better patient tolerance, and because there has been a significant cultural change that may have made drug therapy more acceptable, the relative usefulness of pharmacology and psychotherapy should not be judged using existing studies.[68]

15:02(3) Common Issues, Critical Analysis, and Case Law

Several Texas appellate cases have dealt with Major Depressive Disorder.

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60 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part I) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

61 D/ART home page, <http://www.nimh.nih.gov/newdart/darthome.htm> [10-11-98].

62 D/ART Facts, <http://www.nimh.nih.gov/newdart/dar_fact.htm> [10-11-98].

63 "Update on Mood Disorders," *The Harvard Mental Health Letter*, December 1994 (Part II) <http://www.mentalhealth.com/mag1/p5h-md01.html> [12/31/98].

64 "Mood Disorders: an Overview," *The Harvard Mental Health Letter*, December 1997 (Part I) <http://www.mentalhealth.com/mag1/1997/h97-md06.html> [12/31/98]

65 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: MOOD DISORDERS (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/01-15.html> [12-29-98].

66 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 75-76 (1996).

67 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 76 (1996).

68 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 84-85 (1996).

In *Torres v. State*,[69] the defendant was convicted of murdering her children. Although the evidence established that the defendant suffered from major depression, the jury determined that the defendant was not entitled to an insanity defense. A majority of the appellate court sitting en banc affirmed.[70] However, in a strongly worded dissent, Justice Yanez joined by Justice Dorsey strenuously disagreed with the majority stating that, in order to establish the defense of insanity, the defendant needs to establish by a preponderance of the evidence that she was suffering from a severe mental disease or defect and, as a result of that disease or defect, did not know that her conduct was wrong.[71] Justice Yanez outlined the following testimony in support of her dissent.

Dr. Collier, who performed a court-ordered psychiatric evaluation found that the defendant's mother had suffered from a severe form of depression requiring shock treatments; that the defendant over a several year period had experienced sleep disturbances, weight fluctuations, and a degree of depression that was psychotic. Dr. Collier "described major depression as a biological ailment, rather than a psychological ailment, which 'actually twists and distorts the person's perceptions of reality` if it is to a psychotic degree. He said appellant perceived the world as 'dangerous and evil` for her and her children." Dr. Collier further stated, "a severely depressed person can maintain 'superficial` functionality, and perform such tasks as dressing, eating, putting food on the table, and caring for children." He further testified that the defendant "had told him she was suicidal and 'it had been her intent to kill her children and herself to spare all three of them from further suffering.` Although he had evaluated [the defendant] to determine her competency to stand trial, he also formed an opinion as to her legal sanity at the time of the offenses. He stated, 'my professional opinion is that at the time of the shooting, the death of her son, she was insane, that she did not know--perceive right, was unable to perceive right from wrong and adhere her conduct to do right due to mental illness.'"[72]

Dr. Moron, who was appointed by the court to determine the defendant's sanity or insanity at the time of the offense, testified that the defendant had disruptive thought processes, difficulty concentrating, and displayed 'psychomotor retardation' during their interview. He concurred with Dr. Collier that the defendant suffered from severe major depressive disorder with a high risk of suicide. Dr. Moron further testified that, based upon an interview with the defendant's mother, in the months prior to shooting of her children, the defendant's physical condition had markedly deteriorated, she appeared sad and withdrawn, had a significant weight loss, and looked extremely depressed and was reclusive. In his report, which was admitted at trial, and in his testimony at trial, Dr. Moron testified that, in his opinion, the defendant "'was suffering from a severe mental illness and that, at the time of the incident, she was unable to distinguish right from wrong.'" "On cross-examination, Dr. Moron admitted that, hypothetically, a person with severe depression could be considered sane at the time of an offense, and could know the difference between right and wrong. He also admitted that being charged and having to defend oneself against serious criminal charges could be enough to cause someone to be depressed. He said it takes some organizational skills to get up, load a gun, walk down the hall, and fire at a person, then walk to another room and fire at someone else, then urge a third party not to call police. He also stated that one of appellant's friends who he interviewed, but did not identify, told him appellant "had been doing fairly well" the day before the shooting."[73]

Other persons including police, investigators, and family members testified as to the defendant's demeanor before, during, and after the shooting. Justice Yanez further states that there was no expert testimony controverting that the defendant was mentally ill; therefore, the jury was not free to "arbitrarily disregard" the testimony in that respect. She conceded that the jury was free to reject an expert's testimony regarding an insanity defense and to rely upon "lay testimony as to the lucidity of the defendant prior to the commission of the crime, testimony regarding other possible motives for committing a crime, other explanations for erratic behavior, attempts to 'eliminate' witnesses or evade police, attempts to conceal incriminating evidence, and expressions of regret for an act and fear of consequences." Justice Yanez states that, in her view, such circumstances were not present in this case and that only by skewing the testimony can the circumstances accumulate against an insanity finding. Justice Yanez's opinion further goes on to counter the evidence cited by the majority before finally stating that the defendant's conviction should be reversed.[74]

In *Kehler v. Eudaly*,[75] the court was asked to decide whether a psychiatrist had a duty to warn the public about the defendant's condition. This case involved a double murder by a man named Bilby. Bilby had previously been diagnosed with "major depression with melancholia, passive-aggressive personality and prominent anti-social

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69 *Torres v. State*, 976 S.W.2d 345 (Tex. App.–Corpus Christi 1998, no pet.).

70 *Torres v. State*, 976 S.W.2d at 347.

71 *Torres v. State*, 976 S.W.2d at 348 (Yanez, J., dissenting).

72 *Torres v. State*, 976 S.W.2d at 348-49 (Yanez, J., dissenting).

73 *Torres v. State*, 976 S.W.2d at 349-50 (Yanez, J., dissenting).

74 *Torres v. State*, 976 S.W.2d at 350-54 (Yanez, J., dissenting).

75 *Kehler v. Eudaly*, 933 S.W.2d 321 (Tex. App.–Fort Worth 1996, writ denied).

traits." Just after completing a series of electroshock treatments, Bilby called the hospital and told them he was not coming back. Dr. Eudaly, the treating psychiatrist, attempted to talk Bilby into returning to his treatment, or at least into continuing his medication. Bilby did not return. Doctor Eudaly changed Bilby's status to "discharged," with a final psychiatric diagnostic impression of major depressive disorder. Eleven days later Bilby killed two people and the next day, two more. Some of the survivors sued Dr. Eudaly. The issue in the case focused on what duty Dr. Eudaly had to the public at large. Bilby had not expressed any specific intention to kill anyone, or identified anyone that he wanted to harm. Dr. Eudaly filed a motion for summary judgment, which was granted and affirmed on appeal. The court concluded that "Texas only recognizes duties to third parties if the potential act is foreseeable." Here, the court found forseeability lacking.[76]

15:02(4) Proposing and Opposing Admissibility

There is some controversy about the Mood Disorder categories and the diagnostic criteria.[77] Additionally, a diagnosis of any Mood Disorder can be difficult. Accordingly, it is necessary to determine the validity and reliability of the assessment techniques used to formulate the diagnosis. It is also important to evaluate the diagnostic process followed, to see to what extent the diagnosis was made on the bases of objective data versus subjective judgment.

Case law indicates that the courts and juries are disinclined to accept that a criminal defendant suffering from major depression lacks the capacity to differentiate right from wrong, even in cases of severe paranoia.[78] By extrapolating the findings in these cases, one might attempt to argue that a parent suffering from major depression is capable of adequately parenting a child. Various studies, however, disagree with this conclusion.[79]

As noted above, there have been a number of studies specifically addressing the effects of parental depression on children, whether the effect of parental depression are uniform, which psychological functions in the child are affected, and why children differ in their responses.[80] The studies found that depressed parents are less likely to or are slower to respond to their infants and children, that they are less likely to facilitate social interaction, and that they are less adept at responding to their children's clues.[81] In studies supported by the National Institute of Mental Health, depressed mothers tended to be disorganized, unhappy, tense, and inconsistent with their children.[82] Studies also show that parenting skills vary depending upon the level of parental depression, the age of the children, and the gender of a child. For example, parental irritability and anger are more prominent towards school aged

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76 *Kehler v. Eudaly,* 933 S.W.2d at 328, 331.

77 Jay Ziskin, 1 PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 146-148 (5th Ed. 1995).

78 *Torres v. State,* 976 S.W.2d 345 (Tex. App.–Corpus Christi 1998, no pet.); *Kehler v. Eudaly*, 933 S.W.2d 321 (Tex. App.–Fort Worth 1996, writ denied).

79 Kenneth A. Dodge, *Developmental Psychopathology in Children of Depressed Mothers,* 26 DEVELOPMENTAL PSYCHOLOGY 3-6 (1990); Tiffany Field, et al., *Behavior-State Matching and Synchrony in Mother-Infant Interactions of Nondepressed Versus Depressed Dyads,* 26 DEVELOPEMENTAL PSYCHOLOGY 7-14 (1990); Jeffrey Cohn, et al., Face-to-Face *Interactions of Postpartum Depressed and Nondepressed Mother–Infant Pairs at 2 Months,* 26 DEVELOPMENTAL PSYCHOLOGY, 15-23 (1990); Constance Hammen, et al., *Relationship of Mother and Child Variables to Child Outcomes in a High-Risk Sample: A Causal Modeling Analysis,* 26 DEVELOPMENTAL PSYCHOLOGY 24-30 (1990); Sherryl H. Goodman and H. Elizabeth Brumley, *Schizophrenic and Depressed Mothers: Relational Deficits in Parenting,* 26 DEVELOPMENTAL PSYCHOLOGY 31-39 (1990); Michael Fendrich, et al., *Family Risk Factors, Parental Depression, and Psychopathology in Offspring,* 26 DEVELOPMENTAL PSYCHOLOGY 40-50 (1990); Carolyn Zahn-Waxler, et al., *Patterns of Guilt in Children of Depressed and Well Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 51-59 (1990); Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children,* 26 DEVELOPMENTAL PSYCHOLOGY 60-67 (1990); Marian Radke-Yarrow, et al., *Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression,* 56 CHILD DEVELOPMENT 884-93 (1985).

80 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 60 (1990).

81 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 61 (1990) citing A.D. Cox, et al., *The Imact of Maternal Depression on Young Children*, 28 J. OF CHILD PSYCHOLOGY AND PSYCHIATRY 917-28 (1987).

82 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 61 (1990) citing Y.B. Davenport, et al., *Early Child-Rearing Practices in Families with a Manic-Depressive Parent,* 141 J. OF CHILD PSYCHOLOGY AND PSYCHIATRY 230-35 (1984).

children, and mothers tend to use daughters as comfort objects. Additionally, depression may influence behavior in significantly different ways. Children of depressed parents may experience and/or be exposed to unusual levels of conflict, distress, comfort-seeking, scapegoating, or emotional withdrawal.[83] Children also vary in their response to parental depression, with younger children expressing more guilt and responsibility than older children.[84] However, it is less likely that children will be affected by parental depression if the parental disorder: (1) is mild, (2) of short duration, (3) unassociated with family discord or conflict, (4) unaccompanied by impaired parenting, and (5) does not result in family break-up.[85]

When relying upon studies to support one's position, great care must be used to determine the reliability and validity of such studies and whether a particular study was peer reviewed. A careful analysis should be done as to the particular populations studied, the limited conclusions drawn, the age of the study, and other aspects of the study to determine the efficacies of the conclusions reached based upon the data presented. Although the studies discussed herein appear to justify a conclusion that depression significantly impacts parenting, none of these studies noted the specific type of treatment that the parent was receiving or the effects of that treatment on the parent's illness.[86] Given the cultural changes that have occurred and the newer antidepressants that have been introduced in the ten years since the conducting of these studies,[87] the conclusions drawn might be impacted depending on the type of, length of, and effectiveness of the treatment being received.

15:03 Dysthymic Disorder

15:03(1) General Description

Dysthymic Disorder was first introduced in DSM-III. Dysthymic Disorder is characterized as a nonepisodic chronic depression, which has less severe symptoms and lasts for a period of at least two years. In children and adolescents, the symptoms must last at least one year and their mood may be irritable. Persons with this disorder must not go more than two months without experiencing at least two of the following symptoms–poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decision; feelings of hopelessness. These symptoms must cause a marked impairment in social, occupational, educational, or other major areas of functioning. Also, there must have been no Major Depressive Episode during the first two years (one year for children and adolescents) and the person must have never experienced a Manic Episode, Mixed Episode, Hypomanic Episode, or met the criteria for Cyclothymic Disorder.[88]

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83 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 62 (1990).

84 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 63 (1990); Carolyn Zahn-Waxler, et al., *Patterns of Guilt in Children of Depressed and Well Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 51-59 (1990).

85 Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 64 (1990).

86 Kenneth A. Dodge, *Developmental Psychopathology in Children of Depressed Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 3-6 (1990); Tiffany Field, et al., *Behavior-State Matching and Synchrony in Mother-Infant Interactions of Nondepressed Versus Depressed Dyads*, 26 DEVELOPEMENTAL PSYCHOLOGY 7-14 (1990); Jeffrey Cohn, et al., Face-to-Face *Interactions of Postpartum Depressed and Nondepressed Mother–Infant Pairs at 2 Months*, 26 DEVELOPMENTAL PSYCHOLOGY, 15-23 (1990); Constance Hammen, et al., *Relationship of Mother and Child Variables to Child Outcomes in a High-Risk Sample: A Causal Modeling Analysis*, 26 DEVELOPMENTAL PSYCHOLOGY 24-30 (1990); Sherryl H. Goodman and H. Elizabeth Brumley, *Schizophrenic and Depressed Mothers: Relational Deficits in Parenting*, 26 DEVELOPMENTAL PSYCHOLOGY 31-39 (1990); Michael Fendrich, et al., *Family Risk Factors, Parental Depression, and Psychopathology in Offspring*, 26 DEVELOPMENTAL PSYCHOLOGY 40-50 (1990); Carolyn Zahn-Waxler, et al., *Patterns of Guilt in Children of Depressed and Well Mothers*, 26 DEVELOPMENTAL PSYCHOLOGY 51-59 (1990); Michael Rutter, *Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children*, 26 DEVELOPMENTAL PSYCHOLOGY 60-67 (1990); Marian Radke-Yarrow, et al., *Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression*, 56 CHILD DEVELOPMENT 884-93 (1985).

87 *See* ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 84-85 (1996).

88 DSM-IV GUIDEBOOK 209-210.

Approximately three percent of the population will develop dysthymia some time during their lifetime--a rate slightly less than the rate for major depression.[89] Women are diagnosed with the disorder twice as often as men, and the disorder is more common in the poor and unmarried. Typically, symptoms appear in adolescence or early adulthood. At least one study has found that on average dysthymia lasts for a period of five-and-one-half years.[90] Seventy-nine percent of persons who suffer from this disorder will eventually experience major depression.[91] This disorder is sometimes also associated with alcoholism, panic disorder, and eating disorders and successful treatment of these related conditions usually relieves the associated dysthmyia.[92]

15:03(2) Common Treatment Methods

Patients with Dysthymic Disorder may benefit from treatment with psychotherapy, antidepressants, or some combination of both. Tricyclic antidepressants are helpful in the treatment of dysthymia. For example, in one study using the trycyclic antidepressant imipramine in the same dosage as that used for the treatment of major depression, 59 percent of the patients recovered from dysthymia versus only 13 percent of the patients who were treated with a placebo.[93] Drugs are less effective, however, when the depressed patient is angry or hypersensitive rather than fatigued and inconsolably despondent.[94] In fact, there is evidence that approximately half of dysthymics do not respond to medication or refuse medication.[95] These patients may benefit more from supportive psychotherapy.[96]

15:03(3) Common Issues, Critical Analysis, and Case Law

Two Texas cases were found involving Dysthymic Disorder. Both cases reflect the role that the disorder played in the court below, but in neither case was the legal reliability of the diagnosis challenged.

In *Coffin v. State*,[97] a minor defendant who was tried as an adult raised the issue of whether former testimony of an examining psychologist from certification hearing held to determine whether minor should be tried as an adult was admissible during the punishment phase of the murder trial. It is the testimony at the certification hearing of a psychiatrist, who diagnosed the minor as suffering from Dysthymic Disorder, that is most pertinent to the discussion herein. In particular, it was the psychiatrist's recommendation that, because of the minor's psychological condition, he needed a very structured environment and several years of therapy, because youths referred to the Texas Youth Commission would only remain their for a period of two years, and because probation would not offer the structure and therapy the minor needed for rehabilitation, the minor should be certified as an adult.[98]

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89 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH, p. 92 (1996), citing to L.N. Robins and D.A. Regier (Eds.), PSYCHIATRIC DISORDERS IN AMERICA: THE EPIDEMIOLOGIC CATCHMENT AREA STUDY (1991).

90 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

91 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 94 (1996), citing McCullough, et. al., *Review of DSM-IV in the Field Trials*. Paper presented at the 100th Meeting of the American Psychological Association, Washington, D.C. (September 1992).

92 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

93 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

94 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

95 ANTHONY ROTH & PETER FONAGY, WHAT WORKS AND FOR WHOM: A CRITICAL REVIEW OF PSYCHOTHERAPY RESEARCH 94 (1996), citing J.C. Markowitz, *Psychotherapy of Dysthymia: Is it Effective?*," 151 AMERICAN J. OF PSYCHIATRY 1114-21 (1994).

96 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

97 *Coffin v. State*, 885 S.W.2d 140 (Tex. Crim. App. 1994).

98 *Coffin v. State*, 885 S.W.2d at 143-45.

Toney v. State[99] involved a minor who had engaged in delinquent conduct by committing murder. She was appealing her transfer to the Texas Department of Criminal Justice. At the defendant's transfer/release hearing, the evaluating psychologist determined that the minor was suffering from Dysthymic Disorder, that it was "highly unlikely" she would benefit further from Texas Youth Commission, and that she should be transferred to TDCJ where she would be in a structured environment.

15:03(4) Proposing and Opposing Admissibility

Because an overwhelming percentage of individuals diagnosed with Dysthymic Disorder eventually develop Major Depressive Disorder, the same caveats should generally apply as to proposing and opposing admissibility.[100] Symptoms of Dysthymic Disorder tend to first appear in adolescence or early childhood, so that, the discussion of this disorder and its tendency to lead to Major Depressive Disorder in family cases may be presented as a special need of a child, requiring special parenting skills and intervention with medications and counseling, increasing the need for child support or requiring child support during majority.[101]

15:04 Cyclothymic Disorder

15:04(1) General Description

Cyclothymic Disorder is a Mood Disorder related to both Personality Disorders and Dysthymia.[102] Persons with Cyclothymic Disorder alternate between mania and depression but the symptoms are milder and less disabling than those found in bipolar disorder.[103] They suffer brief, irregular cycles of energetic activity and fatigue, optimism and pessimism, insomnia and oversleeping, giddiness and crying, conceit and self-pity, passionate involvement and sudden loss of interest.[104] They get divorced, periodically abuse alcohol and other drugs, and repeatedly change employment and move. Persons with cyclothymia are susceptible to both major depression and mania. However, usually their capricious behavior and troubled personal lives are noticed more than any underlying mood cycle.[105]

15:04(2) Common Treatment Methods

If a person's functioning is significantly impaired with Cyclothymic Disorder, Lithium may reduce manic symptoms and reduce the frequency of cycles. Psychotherapy may also be helpful.[106]

15:04(3) Common Issues, Critical Analysis, and Case Law

The DSM-IV Guidebook says that Cyclothymic Disorder "has received virtually no systematic study."[107] This suggests that legal reliability is lacking for this diagnosis.

No Texas cases have referred to Cyclothymic Disorder. This is most likely due to its rather benign symptoms. However, since it is often a precursor to more serious conditions and is characterized by an unstable personal life, its diagnosis [if permitted into evidence] could be significant in a child custody determination in predicting which parent will provide the better environment.

15:04(4) Proposing and Opposing Admissibility

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99 *Toney v. State*, 1995 WL 376493 (Tex. App.–Dallas 1995, no pet.) (unpublished).

100 *See* Section 15:02(4).

101 *See generally* Section 15.03(2) and Section 15.02.

102 DSM-IV GUIDEBOOK 218.

103 DSM-IV GUIDEBOOK 219.

104 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

105 "Dysthymia and Other Mood Disorders," *The Harvard Mental Health Letter*, May 1991. <http://www.mentalhealth.com/fr20.html> [12/30/98].

106 See "Cyclothymic Disorder: Treatment," *Internet Mental Health*. <http://www.mentalhealth.com/rx/p23-md03.html> [12/31/98].

107 DSM-IV GUIDEBOOK 218.

Admissibility issues are similar to those discussed for Mood Disorders generally.[108]

15:05 Depressive Disorder Not Otherwise Specified

15:05(1) General Description

The Depressive Disorder Not Otherwise Specified refers to disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood. Examples of this category include: premenstrual dysphoric disorder, minor depressive disorder, recurrent brief depressive disorder, post-psychotic depressive disorder of Schizophrenia, and situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.[109]

15:05(2) Common Treatment Methods

Common treatment methods for mood disorders include pharmacotherapy and various types of psychotherapy.[110] In those patients who have had a poor response to or tolerance for antidepressants, who have severe vegetative symptoms, or who have psychotic features, electroconvulsive therapy is sometimes used.[111]

15:05(3) Common Issues, Critical Analysis, and Case Law

The comments made in Section 15:01(3) apply here.

15:05(4) Proposing and Opposing Admissibility

The comments made in section 15:01(4) apply here.

15:06 Bipolar I Disorder

15:06(1) General Description

DSM-IV describes Bipolar I Disorder, also referred to as manic-depressive disorder, as the occurrence of Single Manic Episodes and various types of recurrent episodes--manic,[112] hypomanic,[113] mixed,[114] depressed,[115] or unspecified.[116] During these episodes, a patient's mood and activity levels are markedly changed,

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108 *See* Section 15:01(4).

109 DSM-IV 350; DSM-IV GUIDEBOOK 213.

110 *"Order and Disorder: an Exploration of the Mind and the Brain,"* Virtual Hospital, <http://www.vh.org/Welcome/UIHC/MedMuseum/OrderAndDisorder/05MentalDisorders.html> [12/28/98].

111 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: MOOD DISORDERS (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/01-15.html> [12-29-98].

112 Mania may occur with or without psychotic symptoms. Without psychotic symptoms, the person's mood may vary between increased animation to euphoria and experience a heightened perception of colors, textures, and sounds. With psychotic symptoms, the person may experience delusions and hallucinations and may be difficult to differentiate from schizophrenia. Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

113 Hypomania is a lesser degree of mania unaccompanied by either hallucinations or delusions. Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

114 Mixed Episode is characterized by individuals who experience over a period of at least one week duration symptoms of both a Manic Episode and a Major Depressive Disorder. DSM-IV 333.

115 Depression may be classified as mild, moderate, or severe depending upon the number, type, and severity of the symptoms present, which include depressed mood, loss of interest, decreased energy and activity, increased fatiguability, decreased concentration, decreased self-esteem, disturbed sleep, ideas of guilt and worthlessness, and

with the patient either displaying an elevation of mood and increased energy and activity (mania or hypomania) or a lowering of mood and decreased energy and activity (depression). Manic episodes have a sudden onset and last between two weeks and four to five months. Depressive episodes generally last longer, approximately six months, but rarely longer than a year, except in elderly persons. Both types of episodes may be triggered by stimulants and excessive stress.[117]

Frequently, this disorder is undiagnosed or misdiagnosed for an average of eight years, patients do not seek treatment for up to ten years after the first appearance of symptoms, and approximately sixty percent of patients are not treated, undertreated, or inappropriately treated at any given time.[118] Untreated patients often also have other problems that mask the disorder, ranging from alcohol and substance abuse, to dysfunctional personalities and relationships, to a breakdown of social and work relationships. In particular, there is a clear correlation between cocaine abuse and bipolar disorder.[119]

Unlike Major Depressive Disorder, Bipolar I Disorder is found with equal frequency in both men and women. Although this disorder occurs less frequently than Major Depressive Disorder, persons suffering from this disorder tend to have significantly more episodes during their lives, with the frequency of the episodes increasing as the course of the disorder progresses, and depressive episodes becoming more common and longer lasting after middle age. This disorder's usual onset begins in adolescence or early adulthood.[120]

15:06(2) Common Treatment Methods

For patients with Bipolar I Disorder, psychoeducation, psychotherapy, and life style changes can significantly reduce the risk of suicide, increase life expectancy, and increase productivity.[121] This involves teaching the patient about regulation of social and biorhythms; avoiding or regulating substance use, including nicotine and caffeine, and alcohol use; encouraging regular sleep patterns; and teaching techniques for dealing with stress and family conflicts, which commonly cause these patients to overreact.[122] Lithium has proved successful in the treatment of mania/hypomania- depression episodes of this disorder. It has proved less effective when the patient is experiencing rapid cycling, mixed states, or has an accompanying substance abuse disorder.[123] Divalproex Sodium (DVPX) is an effective alternative to Lithium and is effective in acute mania, rapid cycling, mixed states, and with accompanying substance abuse disorders.[124] Other effective drugs include Carbamazepine;[125] Benzodiazepines such as Lorazepam and Clonazepam[126]; and more novel drug treatment includes the use of Thyroxine, Risperidone, calcium channel blockers, Lamotrigine, Gabapentin, adrenergic

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ideas of suicide. Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

116 DSM-IV 350-58; DSM-IV GUIDEBOOK 214; Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

117 Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

118 Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98] Bipolar Disorder: Effects of Undertreated and Untreated Bipolar Disorder, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

119 Bipolar Disorder: Epidemiology of Bipolar Disorder, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

120 DSM-IV 350-58; DSM-IV GUIDEBOOK 214; Bipolar Disorder: European Description, <http://www.mentalhealth.com/icd/pp22-md02.html> [12/16/98].

121 Bipolar Disorder: Changed Outcome with Mood Stabilizer Treatment, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

122 Bipolar Disorder: Psychoeducation, Psychotherapy and Life Style Changes, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

123 Bipolar Disorder: Lithium, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98]; Paul J. Perry (Ph.D.), Bruce Alexander (Pharm.D.), Vicki L. Ellingrod (Pharm.D.), "Drug Therapy in the Prevention of Recurrences in Affective Illness," *Clinical Psycho-pharmacology Seminar* 1996-1997. <http://www.vh.org/Providers/Conferences/CPS/21.html> [12/22/98].

124 Bipolar Disorder: Divalproex Sodium, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

125 Bipolar Disorder: Carbamazepine, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

126 Bipolar Disorder: Benzodiazepines, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

blockers, acetazolamide, sex hormones, choline, and trytophan.[127] In some patients, Electroconvulsive Therapy (ECT) has been reported to be as effective as mood stabilizer medications.[128]

15:06(3) Common Issues, Critical Analysis, and Case Law

Several Texas appellate courts have addressed the legal effect of Bipolar Disorder. One issue was the disorder's effect on a person's ability to form the requisite intent necessary to commit homicide. The other issue was the consideration of Bipolar Disorder as a factor mitigating punishment.

In *Venhaus v. State*,[129] the defendant fired a shotgun through the victim's front door, killing the victim. The defendant claimed that, because he suffered from bipolar disorder, he could not be guilty of involuntary manslaughter, which required that he be consciously aware of the risk of his actions but consciously disregard that risk. Rather, at most he was guilty of criminally negligent homicide, which requires that the defendant ought to be aware of the risk but failed to perceive it. Based upon the testimony of the defendant's two treating psychiatrists, the appellate court agreed that the jury should have been instructed on criminally negligent homicide. The defendant's first psychiatrist testified that "Bipolar disorder involves mood shifts from extreme depression to manic phases characterized by restlessness, sleeplessness, and impulsive behavior. A bipolar patient in the manic phase may have an inhibited ability to recognize the consequences of impulsive behavior, and may not even know what the consequences of a given act are at the time. A patient in the related hypomanic phase of the disease will likewise have diminished judgment." The second psychiatrist testified that the defendant, "if in a hypomanic phase, would be unable to understand or appreciate the consequences of his actions. She further testified that based upon the description of [the defendant] provided by [one of the other witnesses], the defendant was probably in a hypomanic phase of his illness the night of the shooting. She stated that: I think his judgment was diminished, not completely impaired, because he was aware that he was doing something wrong, but not knowing that what are the consequences of what he's doing will be."[130]

In *Davis v. State*,[131] the defendant was convicted of killing her husband. The defendant argued that she could not have killed her husband knowingly and intentionally because she suffered from bipolar disorder and battered spouse syndrome and, therefore, could not control her impulses. The jury convicted. The court of appeals opinion states that there were eighteen pages of testimony by psychologist Barry Coakley regarding the defendant's condition and battered woman's syndrome. He testified, "even though Carla suffered from bipolarity and in his opinion was a battered spouse, she still knew that she was shooting her husband. Coakely also testified that he 'personally believed they [battered women] are responsible for their crimes.`" Unlike in *Venhaus*, there is no indication that the jury was provided with evidence regarding the effects of bipolar disorder on a person's ability to form the requisite intent to commit murder or the extent to which the defendant suffered from bipolar disorder.

In *Mines v. State*,[132] the defendant was convicted of murder. The defendant complained that the jury question given during the punishment phase failed to adequately encompass the relevant, mitigating characteristics of his evidence and did not give the jury a vehicle by which it could express its reasoned moral response to this evidence. The appellate court disagreed. The court found that there was testimony that, if the defendant was suffering from bipolar disorder, proper treatment would reduce the odds that he would commit future acts of violence and that, when bipolar disorder is in remission, with or without treatment, a person is capable of conforming his behavior to societal expectations. There was no testimony of any long term mental illness that would preclude the defendant from conforming his behavior to societal norms. It does not appear that the jury was given evidence regarding the effects of bipolar disorder on a person's ability to form the requisite intent to commit murder or the extent to which the defendant suffered from bipolar disorder.[133]

15:06(4) Proposing and Opposing Admissibility

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127 Bipolar Disorder: Novel treatments, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

128 Patients usually require from between six and fifteen ECT treatments, and bilateral treatments have proved more effective than unilateral treatments. Bipolar Disorder: ECT, <http://www.mentalhealth.com/rx2/bp-can1.html> [12/16/98].

129 *Venhaus v. State*, 950 S.W.2d 158 (Tex. App.--El Paso 1997, pet. ref'd).

130 *Venhaus v. State*, 950 S.W.2d at 162.

131 *Davis v. State*, WL 311874 (Tex. App.--San Antonio 1996, no pet.) (unpublished).

132 *Mines v. State*, 888 S.W.2d 816 (Tex. Crim. App. 1994).

133 *Mines v. State*, 888 S.W.2d 816, 816-17 (Tex. Crim. App. 1994), *cert. denied*, ___ U.S. ___, 115 S.Ct. 1978, 131 L.Ed.2d 866 (1995).

Admissibility issues are similar to those discussed for Mood Disorders generally and for Major Depressive Disorder.[134]

15:07 Bipolar II Disorder

15:07(1) General Description

Although Bipolar II Disorder has been observed for over twenty years, it was one of the "new" diagnoses added to DSM-IV. According to DSM-IV, some patients had been observed to exhibit symptoms and to run a course somewhere between the unipolar and the bipolar mood disorders. Thus, this new category was created.[135] This disorder is characterized by recurrent Major Depressive Episodes and Hypomanic Episodes. The difference between Bipolar I Disorder and Bipolar II Disorder is whether the patient experiences a "hypomanic" episode versus a "manic" episode. Since the symptoms for these episodes are identical, the difference rests solely on the duration of the episode--4 days versus 7 days.[136] In other words, if a patient experiences a 7-day episode or a mixed episode, the diagnosis should be changed from Bipolar II to Bipolar I. It is often difficult to distinguish Bipolar II Disorder with Major Depressive Episodes from Major Depressive Disorder. Typically, Bipolar II Disorder tends to have a seasonal pattern. Clinicians, however, often overlook a patient's hypomanic episodes since any temporary lifting of mood may be incorrectly interpreted as merely a relative high.[137]

15:07(2) Common Treatment Methods

Treatment of Bipolar II Disorder is similar to that for Bipolar I Disorder, with two exceptions: psychotherapy is somewhat more effective in Bipolar II Disorder and mood stabilizers may sometimes be omitted in patients with minimal hypomania.[138] Also, although not the first choice for the treatment of depression, Bipolar II Disorder patients often respond well to monoamine oxidase inhibitors (MAOIs).[139]

15:07(3) Common Issues, Critical Analysis, and Case Law

The case law in Texas has not differentiated between Bipolar I Disorder and Bipolar II Disorder. Comments made by the courts would be equally applicable to both disorders.

15:07(4) Proposing and Opposing Admissibility

Admissibility issues are similar to those discussed for Mood Disorders generally.[140]

15:08 Mood Disorder Not Otherwise Specified

15:08(1) General Description

According to DSM-IV, Mood Disorder Not Otherwise Specified (MD-NOS) is a Mood Disorder resulting from a general medical condition or resulting from chemical substances. Some of the general medical conditions that are the direct physiological cause Mood Disorders include neurological illnesses (e.g., Parkinson's disease, Huntington's disease), cerebrovascular disease (e.g., strokes), metabolic conditions (e.g., B_{12}), endocrine conditions (e.g., hypo- and hyperthyroidism), autoimmune conditions (e.g., lupus), viral or other infectious conditions (e.g., HIV, hepatitis), and certain cancers (e.g., pancreatic). In contrast, if mood symptoms are a psychological response

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134 *See* Sections 15:01(4) and 15:02(4).

135 DSM-IV GUIDEBOOK 216.

136 Hypmanic Episodes last approximately four days and Manic Episodes last for seven or more days. DSM-IV 332, 338.

137 DSM-IV 359-63; DSM-IV GUIDEBOOK 216-18.

138 Treatment of Bipolar Disorder: Guideline 4: Acute Phase Treatment BiPolar Depression–Selecting an Overall Strategy–Selecting Treatments for BiPolar II Depression. <http://psychguides.com/eks_bpgl.htm> [12/23/98].

139 Hagop S. Akiskal, Jack D. Maser, Pamela J. Zeller, et al., *Switching From 'Unipolar` to Bipolar II,* 52 ARCHIVES OF GENERAL PSYCHIATRY 114-123 (February 1995). <http://www.mentalhealth.com/fr20.html>

140 *See* Section 15:01(4).

to a general medical condition, then the proper diagnosis would be the mood disorder that best fits the symptoms presented.[141] Substance- induced Mood Disorders may result from substance intoxication (e.g., alcohol amphetamines, cocaine, opiates), substance withdrawal (e.g., alcohol, amphetamines, cocaine, sedatives, hypnotics), medications (e.g., analgesics, antihypertensives, cardiac medications, oral contraceptives, steroids), and heavy metals and toxins (e.g., carbon monoxide, carbon dioxide, nerve gas).[142]

15:08(2) Common Treatment Methods

Other than treating the underlying medical condition and presenting symptoms, no specific medical protocols are offered for Mood Disorders Not Otherwise Specified.

15:08(3) Common Issues, Critical Analysis, and Case Law

Texas case law has not addressed Mood Disorders Not Otherwise Specified. However, since these non-specific mood disorders tend to resolve themselves once the underlying conditions are treated or otherwise resolved, a specific medical diagnosis that would account for various mood alterations may prove important if a parent's behavior is put at issue in a custody determination or if raised as a basis for a disproportionate division of property in a divorce. The substance-induced Mood Disorders could be an issue in a tort suit for poisoning.

15:08(4) Proposing and Opposing Admissibility

Admissibility issues are similar to those discussed for Mood Disorders generally.[143]

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141 DSM-IV GUIDEBOOK 220-22.

142 DSM-IV GUIDEBOOK 222-24.

143 *See* Section 15:01(4).

EXPERT WITNESS MANUAL

PART 2

Mental Health and Family Relations

Chapter 21

Eating Disorders[144]

21:01 General Description

Eating disorders have existed throughout history. However, cases were fairly isolated until the last few decades. "Anorexia Nervosa" was first used as a term to describe this phenomena in 1874 by an English medical doctor.

Eating disorders were not included in the DSM until the DSM III (1980).[145] The two principal DSM-IV eating disorders are Anorexia Nervosa and Bulimia Nervosa.[146] A DSM-IV category of Eating Disorder Not Otherwise Specified is given for eating disorders that do not meet the criteria for Anorexia Nervosa or Bulimia Nervosa.[147] According to the DSM-IV GUIDEBOOK, Anorexia Nervosa and Bulimia Nervosa "are both characterized by the individual's overemphasis on body image."[148] Anorexia Nervosa involves low body weight and, in women, amenorrhea (missing 3 or more consecutive menstrual cycles).[149] Bulimia Nervosa involves normal or above-normal body weight, with a pattern of binge eating and offsetting behaviors to avoid weight gain, such as induced vomiting.[150]

Eating disorders are commonly found in industrialized countries such as North America, Europe and Japan, where large or rounded body shapes are not culturally defined as attractive. In the United States there are some cultural pockets[151] holding broader definitions of female attractiveness and in these communities, there are significantly less frequency of eating disorders.[152] In third world or less industrialized countries, thinness is associated with poverty and eating disorders are virtually non-existent in these countries.[153]

The causes of eating disorders are likely varied and may include hormonal changes[154], struggles for personal independence[155], or problems with sexuality.[156] Nevertheless, the socio-cultural impact on the presence

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144 Authors: Richard R. Orsinger, Attorney at Law, San Antonio; Jan DeLipsey, Ph.D., Dallas. Legal research assistance provided by Duke Hooten, Attorney at Law, Boerne.

145 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 547 (1995).

146 DSM-IV 539-550.

147 DSM-IV 550.

148 DSM-IV GUIDEBOOK 325.

149 DSM-IV GUIDEBOOK 325; DSM-IV 545.

150 DSM-IV GUIDEBOOK 325.

151 One example would be African American communities

152 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 547 (1995).

153 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 548 (1995).

154 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 548-549 (1995). See also P. GARFINKEL & D. GARNER, ANOREXIA NERVOSA: A MULTIDIMENSIONAL PERSPECTIVE (1982).

155 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 548-549 (1995). See also SALVADOR MINUCHIN, B. ROSMAN, & L. BAKER, PSYCHOSOMATIC FAMILIES (1978).

156 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 548 (1995); *see also* D. Coovert, B. Kinder & J. Thompson, *The Psychosexual Aspects of Anorexia Nervosa and Bulimia Nervosa: A Review of the Literature*, 9 CLINICAL PSYCHOLOGY REVIEW 169-180 (1989).

of this type of affliction appears to be the most significant factor in their etiology, which makes these disorders quite different from most other mental disorders and conditions outlined in the DSM.[157]

A video archive on "Eating Disorders: Fads and Facts" in available from the National Institute of Mental Health, on the World Wide Web.[158]

21:02 Common Treatment Methods

Treatments for Anorexia Nervosa and Bulimia Nervosa are set out below, underneath the related topic. Several follow up studies on successfulness of treatment for eating disorders have been conducted. For Anorexia Nervosa, 10 to 20 % of the treated patients continued to have problems keeping on enough weight to be within a normal weight range.[159] About 10% of the anorexic patients, even with therapy intervention, die. There is very little outcome research regarding Bulimia Nervosa. However, recovery appears to be better than that of Anorexia Nervosa.[160]

21:03 Common Issues, Critical Analysis, and Case Law

The usefulness of distinguishing Anorexia Nervosa from Bulimia Nervosa has been challenged, and patients move from one diagnosis to the other depending on fluctuations in weight and the presence or absence of menses.[161] The DSM- IV makes the distinction because each category has different treatment implications.[162] Some observers say that these eating disorders are culture specific to industrialized countries where the women are preoccupied with dieting and thinness in midst of an abundance of food. This view is supported by the increase in these disorders in recent decades and the fact that among the people with these disorders females markedly outnumber males.[163] Also, immigrants from cultures in which Anorexia Nervosa is rare can develop the disorder as "thin-body ideals are assimilated."[164]

In one Louisiana case, the appellate court reversed the trial court and took custody of a minor child away from a mother largely on the grounds of her anorexia nervosa.[165]

21:04 Proposing and Opposing Admissibility

Clinical lore indicates that eating disorders of adults are highly associated with childhood abuse. There have been some instances where clinicians have attempted to use the presence of an eating disorder as a "proof" of previous childhood abuse, particularly in tort claims where the credibility of the plaintiff may be at issue. Research regarding etiology of eating disorders, as outlined in Section 21:01 above, does not support this position. Claims that eating disorders nearly always "red flag" child sexual abuse can be challenged by requiring the clinician to offer research evidence to support the assertion. General issues regarding the reliability and validity of DSM-IV classifications,[166] diagnostic criteria, and the process of arriving at a clinical judgment,[167] would also apply to diagnoses of Eating Disorders.

21:05 Anorexia Nervosa

21:05(1) General Description

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157 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 548 (1995).

158 *Eating Disorders: Fads and Facts*, (9-13-98) <http://www.nimh.nih.gov/events/eatconf.htm> [4-18-99].

159 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 549 (1995).; See also L. HSU, EATING DISORDERS (1990).

160 THOMAS OLTMANNS, PH.D. & ROBERT EMERY, PH.D., ABNORMAL PSYCHOLOGY 551 (1995).

161 DSM-IV GUIDEBOOK 325.

162 DSM-IV GUIDEBOOK 326.

163 DSM-IV 542-43; DSM-IV GUIDEBOOK 326.

164 DSM-IV 543.

165 *Spohrer v. Spohrer*, 428 So.2d 1250 (La. App. 1983) (in this case, no admissibility issues were considered).

166 *See* Chapter 2-6.

167 *See* Chapter 2-8.

Anorexia Nervosa affects 1% of young women, and afflicts women versus men by a ratio of 10:1.[168] Anorexia can be life-threatening, and has a mortality rate of 10%.[169] The mean age at onset is 17 years, with some data suggesting bimodal peaks at ages 14 and 18 years.[170] The onset of Anorexia Nervosa is sometimes associated with a stressful life event, such as leaving home for college.[171] The course of Anorexia Nervosa is highly variable, with some persons recovering fully after one episode, and others cycling through fluctuations of weight gain and relapse, and other progressively deteriorating over a period of years.[172]

The hallmark of Anorexia Nervosa is the patient's refusal to maintain normal body weight due to an extreme fear of becoming fat.[173] In fact, the patient's perception of body image often appears to be distorted with the patient being unable to recognize the significant "unattractiveness" of low body weight. In diagnosing a patient, the mental health practitioner must rule out other causes of excessively low weight, such as general medical conditions, other mental disorders (e.g., Major Depressive Disorder, Substance Dependence), and poor nutrition.[174] There are four diagnostic criteria for Anorexia Nervosa involving: refusal to maintain body weight above minimally normal; intense fear of being fat even when underweight; disturbance in the way body weight or shape is experienced; and amenorrhea.[175]

21:05(2) Common Treatment Methods

Treatment for anorexia usually follows a two level approach: 1) ensuring that the person gains weight; and 2)participation in therapy to address issues thought to contribute to the disorder.

Outpatient treatment for Anorexia Nervosa includes: treatment for starvation; nutritional counseling; behavioral psychotherapy; individual and group cognitive therapy; family therapy; and treatment for any associated mood disorder.[176]

Hospitalization is indicated: if the patient is less than 70% of ideal body weight; there is persistent suicidal ideation; the patient is addicted to laxatives, diuretics, or diet pills; there is an expectation that outpatient treatment will fail.[177]

21:06 Bulimia Nervosa

21:06(1) General Description

The essential features of Bulimia Nervosa are binge eating and inappropriate compensating behavior to avoid weight gain [178] "Binge eating" is defined as eating in a discrete period of time (usually less than 2 hours) more food than most individuals would eat under similar circumstances.[179] Compensating behavior includes induced vomiting (80-90% of bulimics use this method), misuse of laxatives and diuretics (about one-third of

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168 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

169 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

170 DSM-IV 543.

171 DSM-IV 543.

172 DSM-IV 543.

173 DSM-IV GUIDEBOOK 326.

174 DSM-IV GUIDEBOOK 326.

175 DSM-IV 543.

176 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

177 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

178 DSM-IV 545.

179 DSM-IV 545.

bulimics abuse these substances), fasting, exercising, and more rarely enemas.[180] There are five diagnostic criteria for Bulemia Nervosa: recurrent episodes of binge eating; recurrent inappropriate compensatory behavior to prevent weight gain; binge eating and inappropriate compensating behavior both occur on average at least twice a week for 3 months; self-evaluation is unduly influenced by body shape and weight; and the disturbance does not occur solely during episodes of Anorexia Nervosa.[181]

Bulimia Nervosa usually begins in late adolescence or early adulthood. Disturbed eating behavior usually persists for several years. The course of the illness can be chronic or intermittent, with periods of remission. The long-term outcome of Bulimia Nervosa is not known.[182]

The prevalence of Bulimia Nervosa among female adolescents and young adults is 1-3%, and about 1/10th of that for males.[183] As many as 17% of college-aged females engage in bulimic behavior.[184] Dysphoria or depression commonly appears with Bulimia Nervosa.[185] Thirty to 80% of bulimics have a history of Anorexia Nervosa.[186] The frequency of Bulimia Nervosa is roughly the same in most industrialized countries. In the USA, most afflicted individuals are caucasian.[187]

21:06(2) Common Treatment Methods

Common treatment methods for Bulimia Nervosa include medical stabilization, routine monitoring of serum, education about medical consequences, supportive and cognitive behavioral therapy, and nutritional counseling. In acute cases, hospitalization is indicated.[188] Antidepressant medications appear to be the most effective pharmocological intervention for Bulimia Nervosa.[189]

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180 DSM-IV 546.

181 DSM-IV 549-550.

182 DSM-IV 548.

183 DSM-IV 548.

184 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

185 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-1-2 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

186 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-2 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

187 DSM-IV 548.

188 NORA R. FROBERG, M.D. & ROBERT L. HERTING, JR., M.D., UNIVERSITY OF IOWA FAMILY PRACTICE HANDBOOK, CHAPTER 15, PSYCHIATRY: EATING DISORDERS E-2 (3rd Ed.) (1997) <http://www.vh.org/Providers/ClinRef/FPHandbook/Chapter15/06-15.html> [4-11-99].

189 THOMAS OLTMANNS, Ph.D. & ROBERT EMERY, Ph.D., ABNORMAL PSYCHOLOGY 550 (1995).

APPENDIX 6

State Bar of Texas
Family Law Section's

EXPERT WITNESS MANUAL

PART 2

Mental Health and Family Relations

Chapter 27

Psychological Syndromes

27:01 What is a Syndrome?[190]

As discussed in Chapter 5, a syndrome is a collection of related symptoms, cluster of traits, or behavior patterns.[191] Over the past few decades, several syndromes associated with specific events or mental conditions have emerged. These categories of syndromes (e.g., child sexual abuse accommodation syndrome, battered woman's syndrome) generally assert that there are specific symptoms, findings, and/or patterns of responses which are associated with specific traumatic events. Mental health or medical syndrome testimony sometimes serves to support a claim of injury or abuse or to explain confusing or illogical behaviors exhibited by a person claiming injury.

The DSM-IV does not reference any of these specific syndrome as such. Some experts nonetheless claim reliance on the DSM-IV by attempting "to fit" the syndrome testimony within the diagnostic criteria of anxiety disorders[192] or adjustment disorders [193] or even Dissociative disorders.[194] Thus, when syndrome evidence and DSM-IV diagnostic labels are combined to support a conclusion that specific syndromes are caused by specific past events, caution is indicated. This may be an effort to "borrow" legitimacy for the syndrome from the DSM IV. It is be noted; however, that a DSM-IV diagnosis is descriptive and most of the descriptive diagnoses do not support or suggest a similar etiology. Given that syndrome testimony continues to be offered and accepted into evidence, concluding that a syndrome exists in a particular case, and the correctness of inferences that follow from that determination, make syndrome testimony important as well as controversial in litigation.[195]

The following sections review several syndromes that commonly arise in expert testimony involving criminal, family law, and tort litigation. A general description and history of each syndrome is provided. The syndrome is then critically reviewed, followed by a synopsis of relevant case law and ideas on seeking and opposing admission of evidence about the syndrome.

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190 Primary authors: J. M . De Lipsey, Ph.D., Dallas; Richard R. Orsinger, Attorney at Law, San Antonio; and Georganna Simpson, Attorney at Law, Dallas.

191 James P. Chaplin, DICTIONARY OF PSYCHOLOGY 458 (Dell: New York) (1985). The DSM-IV GUIDEBOOK defines "syndrome" as "a group or pattern of symptoms, affects, thoughts, and behaviors that tend to appear together in clinical presentations." See also the DSM-IV GUIDEBOOK 16-17.

192 According to the DSM-IV, "Posttraumatic Stress Disorder is characterized by re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma." DSM-IV 393. "Acute Stress Disorder is characterize by symptoms similar to those of Posttraumatic Stress Disorder that occur immediately in the aftermath of an extremely traumatic event." DSM-IV 393.

193 According to the DSM-IV, "The essential feature of an Adjustment Disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psycho social stressor or stressors." DSM-IV 623.

194 According to the DSM IV, Dissociative disorders involve "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment." DSM-IV 477.

195 For additional information regarding syndromes, profiles and typologies see Chapter 5.

27:03 Battered Woman's Syndrome

27:03(1) General Description

"Battered Woman's Syndrome" (BWS) includes both behavioral actions and *reactions* a battered woman may exhibit that are associated with physical abuse by a spouse or intimate. In other words, BWS has been used to explain both the abused woman's experiences as well as her actions, lack of actions, and reactions to domestic violence. Psychologist Lenore Walker authored some of the earliest works on BWS. The syndrome has evolved from Walker's application of a "learned helplessness" model (1977)[196] to a theory that frames domestic violence as a cycle of violence which involves helplessness (1984).[197] Currently, Walker defines BWS as a "name given to the measurable psychological changes that occur after exposure to repeated abuse."[198] This latter definition frames BWS as a sub-category of "Posttraumatic Stress Disorder."[199]

It is important to examine one of Walker's most cited studies in THE BATTERED WOMAN SYNDROME because a great deal of prior case law and expert opinion and testimony relied on and current expert opinion and testimony continues to rely on Walker's *cycle of violence* and *learned helplessness* as well as other assertions made in this book. This book is a compilation of data from a research project funded by the National Institute of Health in 1978.[200]

Walker's study, which is contained in THE BATTERED WOMAN SYNDROME, was conducted at a small women's college over a three-year period in the late 1970's and early 1980's. Four hundred women participated in the study. These subjects were self-identified and self-referred to the study as "battered women."[201] The study defined a battered woman to be "a woman, 18 years of age or over, who is or has been in an intimate relationship with a man who repeatedly subjects or subjected her to forceful physical and/or psychological abuse."[202] An "intimate relationship" was defined as having a "romantic, affectionate, or sexual component."[203] "Repeatedly" was defined as at least two incidents of "abuse."[204] "Abuse" was defined as:

*Excessive possessiveness and/or jealousy
*Extreme verbal harassment and expressing comments of a derogatory nature with negative value judgements
*Restriction of her activity through physical or psychological means
*Nonverbal and verbal threats of future punishment and/or deprivation
*Sexual assault whether or not married
*Actual physical attack with or without injury.[205]

As discussed earlier, Walker previously put forth theories of "learned helplessness" and the "Walker cycle of violence." In a 1984 study, Walker concluded that there was research support for the cycle of violence. Walker claimed that two-thirds of the subjects had experienced violence that followed a predictable pattern of three phases: *tension- building (*Phase I), *acute battering* (Phase II), and *loving-contrition* (Phase III).[206] Walker

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196 Lenore Walker, *Battered Women and Learned Helplessness*, 2 VICTIMOLOGY: AN INTERNATIONAL JOURNAL 525-534 (1977).

197 LENORE WALKER, THE BATTERED WOMAN SYNDROME 95-104 (New York: Springer Publishing Co., 1984).

198 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY 326 (1992).

199 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY 321-334 (1992).

200 LENORE WALKER, THE BATTERED WOMAN SYNDROME ix (New York: Springer Publishing Co., 1984).

201 LENORE WALKER, THE BATTERED WOMAN SYNDROME 202 (New York: Springer Publishing Co., 1984).

202 LENORE WALKER, THE BATTERED WOMAN SYNDROME 202 (New York: Springer Publishing Co., 1984).

203 LENORE WALKER, THE BATTERED WOMAN SYNDROME 203 (New York: Springer Publishing Co., 1984).

204 LENORE WALKER, THE BATTERED WOMAN SYNDROME 202 (New York: Springer Publishing Co., 1984).

205 LENORE WALKER, THE BATTERED WOMAN SYNDROME 202 (New York: Springer Publishing Co., 1984).

206 LENORE WALKER, THE BATTERED WOMAN SYNDROME 95-104 (New York: Springer Publishing Co., 1984).

asserted that, during the first two stages, the battered intimate succumbs to fear and terror. During the third phase, the victim may perceive this "break" in the violence as the only opportunity to defend herself by striking out at the batterer, thus avoiding the next attack when the cycle again commences. Walker, as well as others, views "striking out" during this third phase as self-defense, although there is no outward sign of immediate threat.

As mentioned earlier, the concept of "learned helplessness" has played a key role throughout Walker's work. Walker has employed this phenomena to explain why many abused women do not protect their own safety and stay within an abusive relationship. She reasoned that the abused women learn that they have no control over what happens to them and therefore believe "not to trust in their own natural responses when under the threat of danger."[207]

27:03(2) Critical Analysis, Common Issues, and Case Law

27:03(2)(a) Methodological Weaknesses

Several of Walker's concepts (i.e. the battered woman's learned helplessness, the cycle of violence) associated with BWS lack the support of research findings. It is important to keep the theoretical development and "research findings" in perspective. Walker advanced the theoretical ideas of learned helplessness and of the cycle of violence before conducting research. The 1984 publications, THE BATTERED WOMAN SYNDROME, is the "data support" for the previously advanced theories. It should also be noted that Walker's foundation study of the cycle of violence was reported in a book and was therefore not subjected to the editorial scrutiny of a peer-reviewed journal to assess overall soundness and methodology before publication.

As it is, there are a host of methodological problems in Walker's 1984 work, which call into question the validity of claims from this three-year study. For example, the group of subjects from the women's college was not representative of the general population of the United States, even at that time in history. The majority of subjects were Anglo, with only 6% of the sample represented by African-American women. Such a specialized sample group would limit generalizing ability of these findings to the population of women at large and to women of today. One very important concern regarding the population of women studied is the fact that only nine of Walker's battered subjects had killed their spouses.[208] Given that the BWS is frequently used in self-defense cases of murder, this low figure is particularly troubling.[209]

Walker's women subjects were self-referred and self-identified as being abused. The definitions of what constituted being a battered woman were overly-broad. Under Walker's criteria, a woman living alone, but in a dating relationship, who experienced two incidents of derogatory comments with no threat of injury or physical injury of any kind would fit the label "battered woman."

In the summary of her study, the details of Walker's research methodology and research protocol were noticeably lacking. Fundamental information regarding data analysis, which usually is included in research studies, was omitted from Walker's text.[210] Thus, the text does not provide adequate support for the research conclusions drawn, particularly about the cycle of violence. This study, as it is written, may not have passed the editorial scrutiny of a peer-reviewed journal.

Walker prefaced the text with emphasizing her "advocate" views, which suggest a lack of research objectivity.[211] Walker's research objectivity was also compromised by the bias of the interviewers. Walker herself admits that utilizing a politicized group of interviewers created problems with bias.[212] For example, as a part of their preparation to work in the study, interviewers were educated regarding battering issues and hypotheses regarding the cycles of violence and learned helplessness. They were even provided a copy of the grant proposal,

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207 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY, 330-332 (1992).

208 LENORE WALKER, THE BATTERED WOMAN SYNDROME 40 (New York: Springer Publishing Co., 1984).

209 LENORE WALKER, THE BATTERED WOMAN SYNDROME 40 (New York: Springer Publishing Co., 1984).

210 Information missing included statistical analysis, coding categories, and inter-coder reliability rates. Only three pages of the book are devoted to description of data analysis. *See* LENORE WALKER, THE BATTERED WOMAN SYNDROME 235-237 (New York: Springer Publishing Co., 1984). *See also* David L. Faigman, *The Battered Woman Syndrome & Self-Defense: A Legal & Empirical Dissent*, 72 VIRGINIA L. REV. 619, 637 (1986).

211 LENORE WALKER, THE BATTERED WOMAN SYNDROME x-xi (New York: Springer Publishing Co., 1984). Research objectivity and neutrality are necessary elements of methodologically sound studies.

212 LENORE WALKER, THE BATTERED WOMAN SYNDROME 216-218 (New York: Springer Publishing Co., 1984).

which stated the objectives of the study.[213] These types of events should have been avoided because they communicated to the interviewers what Walker probably hoped to find, i.e. support for her cycle theory of violence. Had Walker avoided these contaminating influences, the findings might hold more legitimacy. Descriptions of the cycles of violence were fleshed out from the interviewer's evaluation of the victim's responses during the interviews, not directly from an objective recording of data. The interviewer, after hearing the victim's response to questions, determined whether the response 'fit into' a particular portion of the cycle.[214] All of these events together likely set a trend of "confirmation bias" in interviewers, which is well known to be a common problem in research studies and, therefore, is avoided in sound research practices.[215]

The validity of Walker's study is further weakened because Walker utilized no control group for comparison.[216] A more solid research project would have compared data from battered versus non-battered women to measure the extent and nature of differences. As noted in a Virginia Law Review article, "The most legally significant flaw in Walker's research design is her failure to interview women who were never in battering relationships. Such a control group would provide valuable and necessary data with which to compare the responses of abused women."[217] There are several additional problems with Walker's research methodology, which are beyond the scope of this generalized review but which point to the overall weakness of the research work and call into question the validity of data and findings.[218]

Because of the numerous methodological problems already discussed, there is insufficient reliable and valid data to support the cycle of violence and or the theory of learned helplessness as applied to the battered woman.

27:03(2)(b) Learned Helplessness

'Learned helplessness' is a social science concept first put forth by Martin Seligman, whose original research work with dogs[219] was later generalized to depression and helplessness/hopelessness in people.[220] Walker has reasoned that the repeated beatings from which there was no escape and the battered woman's subsequent acquiesce was similar to Seligman's findings in experiments with electroshock and the dogs. Walker has also applied this concept as an explanation of why women remain in abusive relationships; i.e. the cycle of violence induces helplessness.[221] Even Walker's own 1984 research does not support her theoretical contention. For example, Walker tested the women in the study to assess their beliefs about control. Walker states: "Those women still in a violent relationship did not report powerful others as being in control of their lives. Perhaps one reason a battered woman does not terminate her marriage is this lack of realization that her batterer really is in control of her

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213 LENORE WALKER, THE BATTERED WOMAN SYNDROME 218-221 (New York: Springer Publishing Co., 1984).

214 LENORE WALKER, THE BATTERED WOMAN SYNDROME 96 (New York: Springer Publishing Co., 1984).

215 "Confirmation Bias" is like a self-fulfilling prophecy and has been well documented to be a problem in social science research. It is also called the "Rosenthal Effect." The "Rosenthal Effect" is the generalization that beliefs about what the individual expects to happen may lead him to behave in such a way that his expectations become self-fulfilling prophecies. James P. Chaplin, DICTIONARY OF PSYCHOLOGY 404 (Dell: New York) (1985).

216 LENORE WALKER, THE BATTERED WOMAN SYNDROME 203 (New York: Springer Publishing Co., 1984).

217 David L. Faigman, *The Battered Woman Syndrome & Self-Defense: A Legal & Empirical Dissent*, 72 VIRGINIA L. REV. 619, 642 (1986).

218 Numerous examples in Walker's text reflect clinical impression and possible bias. For example, Walker does not provide definitions of many of her key concepts or methods of measurement of these concepts. In Table 12 of the text, Walker asserts that battered women appeared isolated; however, the data Walker provided in Table 12 indicates small differences with no statistical analysis. True differences between numbers cannot be supported without a statistical basis. Another example is reflected in the book's introduction where Walker states: "It is foolish for academicians and professionals to stand behind the cloak of objectivity in a field of study as politicized as this" *Id.* p.x. or "The data were analyzed in order to clarify the psychological and sociological factors involved in the battered woman syndrome." *Id.* p.2. Both of these statements indicate a position of advocacy rather than research neutrality.

219 CHRISTOPHER PETERSON, STEVEN F. MAIER, MARTIN E. P. SELIGMAN, Oxford University Press, LEARNED HELPLESSNESS (1993).

220 CHRISTOPHER PETERSON, STEVEN F. MAIER, MARTIN E. P. SELIGMAN, Oxford University Press, LEARNED HELPLESSNESS (1993).

221 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY, 330-332 (1992).

everyday activities and of her life."[222] The fundamental element of "learned helplessness" is the perception or attribution of no control although the opportunity of control may exist. Walker's own data indicated the women perceived control. *Id*. It was Walker herself who disagreed with their perception. Also, Walker's text contains numerous examples of women trying to escape or to avoid violence. These types of active efforts do not support the application of Seligman's "learned helplessness" concept. Seligman's concept would apply to an individual who passively accepts pain and suffering despite opportunities to avoid or escape the problem. Of course, it also does not follow logic that a woman who uses deadly force or commits murder, is entirely helpless either. A 1994 U.S. Department of Justice crime victimization survey found that 40% of battered women engaged in active physical efforts and 40% engaged in active verbal efforts to resist the violence.[223] Therefore, it would seem that the fundamental issue is not whether the victim is helpless. Rather, it would be understanding the victim's beliefs and perception about the circumstances under which she is living.

27:03(2)(c) Cycle of Violence

The cycle of violence holds appeal because it tries to explain an otherwise illogical situation: "Why would a woman stay in an abusive relationship?" It also serves as a means by which self-defense can be broadened to cover circumstances where there is no clear imminent danger, i.e. the woman believes, because of the repeated cycles, that future violence is inevitable. The research support for the violence cycle is scarce at best. As discussed earlier, interviewers did not adopt a neutral stance in the collection of data as should be done in a methodologically sound study.[224] Rather, the research study designed was particularly vulnerable to the data being used to support or confirm pre-conceived theories. Walker herself acknowledged:

> Ideally, of course, those who collect data should be unaware of the hypotheses being tested. . . . Our data collection period coincided with the height of a national campaign on public education on this topic. . . . This was particularly the case with respect to the battered woman project because I and others were making many public appearances to advertise our work.[225]

This data contamination was further at risk for enhancement by the subjects being asked suggestive, forced choice questions instead of open-ended questions.[226] Walker also does not place time frames on the cycle, which is an important concept given her assertion that the battered woman develops a constant state of fear, i.e. cumulative fear, and the fear of imminent danger when there is no outside sign of this threat. According to the Department of Justice report on battering and its effect in criminal trials, there might be as much as one year between acute battering incidents.[227] Finally, according to Walker's own findings, less than half of the women subjects in her study believed that the battered would or could commit murder.[228]

Although the cycle may be present in some cases, there are also cases where violence is initiated with no apparent warning.[229] If common sense is applied, if there has been a history of battering, then the repetition, in and of itself, should be sufficient to establish the woman's state of mind regarding her appraisal of risk for death or serious injury without the necessity of there being a cycle of violence.

The early research work conducted by Walker was certainly on the frontiers of knowledge in the 1970's. This early work raised social awareness that many women had been battered as well as terrorized intimates. As

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222 LENORE WALKER, THE BATTERED WOMAN SYNDROME 100 (New York: Springer Publishing Co., 1984).

223 R. Bachman, *Violence Against Women: A National Crime Victimization Survey Report*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, NCJ-145325 (1994).

224 David Barlow, Steven Hayes & Rosemary Nelson, 149-154 THE SCIENTIST PRACTITIONER: RESEARCH AND ACCOUNTABILITY IN CLINICAL AND EDUCATIONAL SETTINGS (1985).

225 LENORE WALKER, THE BATTERED WOMAN SYNDROME 222-223 (New York: Springer Publishing Co., 1984).

226 LENORE WALKER, THE BATTERED WOMAN SYNDROME 223 (New York: Springer Publishing Co., 1984).

227 *The Validity and Use of Evidence Concerning Battering and Its Effects in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, "VALIDITY OF BATTERED WOMAN SYNDROME IN CRIMINAL CASES INVOLVING BATTERED WOMEN" [hereinafter referred to as, "Department of Justice Report"], [http://www.ojp.usdoj.gov.ocpa/94Guides/Trials/Valid].

228 LENORE WALKER, THE BATTERED WOMAN SYNDROME 177 (New York: Springer Publishing Co., 1984).

229 Department of Justice Report.

mentioned earlier, when researching a new topic or area, less stringent research protocols are acceptable. If Walker's work is viewed as an exploratory endeavor to describe the experiences of battered women who reached out for help, the study holds legitimate value. Nevertheless, using this type of data this many years afterward as a claim of empirical research support is not justified.

Walker, as well as other experts, assert BWS to be a sub-category of "Posttraumatic Stress Disorder."[230] Walker has argued that cognitive disturbances in memory, high arousal, anxiety, and high avoidance are characteristics of the battered woman as well as characteristics of a trauma victim and therefore frames the response of the battered woman under the diagnostic criteria of "Posttraumatic Stress Disorder."[231] The DSM-IV, however, does not recognize BWS as a subcategory of PTSD or as an independent diagnosis.

27:03(2)(d) The DOJ Report

A 1996 report issued by the U.S. Department of Justice noted a:

> strong consensus among the researchers, and also among judges, prosecutors, and defense attorneys interviewed for the assessment that the term "battered woman syndrome" does not adequately reflect the breadth or nature of scientific knowledge now available concerning battering and its effects.[232]

This finding further supports a critical analysis of BWS. The DOJ Report recommended that instead of using the term BWS, a broader term, "evidence concerning battering and its effects" be used to appropriately reflect the body of literature referenced.[233] This recommendation was made because the Report determined that a singular construct such as BWS was inadequate to reflect the breadth of the literature and because it projected a stereotyped image that implies that all battered intimates were characterized by BWS.[234]

National survey studies indicate that 15 to 35 % of intimate couples experience one or more events of physical aggression in a year.[235] Most of these incidents do not involve significant aggression; rather, they are most often characterized by shoving or slapping. Serious aggressive acts causing physical injury appear to affect less than 5% of these couples.[236] In terms of population prevalence, the National Crime Victimization Survey indicates that about one percent of women have been aggressively assaulted by an intimate.[237]

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230 Walker states "Battered Woman Syndrome is considered a sub-category of the generic Posttraumatic Stress Disorder which is the diagnostic category listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-III-R)." Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY, 327 (1992).

231 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY, 326-328 (1992).

232 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, p.1.

233 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, p.2.

234 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, p.4.

235 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, p. 4.

236 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, "VALIDITY OF BATTERED WOMAN SYNDROME IN CRIMINAL CASES INVOLVING BATTERED WOMEN", p.4.

237 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL

A review of research literature related to BWS indicates that there is not a clear set of symptoms uniquely displayed by the woman who is physically abused by an intimate. Rather, much like responses to other sorts of trauma, victims of battering respond to this trauma in an idiosyncratic manner. There is a large body of research regarding victim response to trauma.[238]

The responses of many battered women do rise to meet the diagnostic criteria of "Posttraumatic Stress Disorder"; however, there are also women who have been battered whose responses do not meet this criteria. The lack of meeting a set of clinical diagnostic criteria certainly should not be viewed as a question mark on the validity of a battered intimate abuse claim. Logically, one would expect that a woman's response to violence would be associated with several factors such as perception of danger, actual abuse suffered, pre-morbid adjustment prior to experiencing abusive incidents, or social support and financial resources.

From the literature reviewed, it seems there is little empirical research regarding patterns or cycles of battering. Rather, the most charitable conclusion that can be drawn at this time is that the abusive relationship between intimates can be as varied as the unique qualities of both of the individuals involved. Therefore, when trying to understand the abusive dynamics and relationship, it would seem prudent to start with the understanding of the individuals themselves.

As a matter of course, in self-defense cases, if there is a question of mental set, duress, or diminished capacity of the defendant, it is not unusual for the defense to offer mental health testimony regarding this issue or even for the court to appoint a neutral examiner to assess the question. In this sense, the battered intimate's state of mind would logically be of importance to the trier of fact. This type of assessment would also commonly occur in domestic relations cases or tort claims where the reliability of the victim's claim and additional data are provided by a mental health professional, either privately hired, appointed by the court, or hired by the opponent to assist the trier of fact in determining an answer to the ultimate question before the court. Regardless of the nature of the legal case, this state of mind assessment, i.e. forensic evaluation, would necessarily focus on the woman's "appraisal of danger" and her reports regarding the nature of the relationship with the abuser.[239] A forensic evaluation would evaluate and screen for malingering and deception as well as gather data from collateral sources that might lend support or lack thereof to the battered intimate's claims. This examination would necessarily include the victim's perception of the alleged abusive relationship, perception of danger, and perception of alternatives. For example, if the woman reports a significantly abusive history with elements of fear for her life, fear for her children, limited resources, numerous injuries, death threats or similar events and she was judged not to be malingering or exaggerating symptoms, this information would be helpful to the trier of fact in understanding her possible state of mind and appraisal of danger. This assessment would specifically assess the alleged victim's unique history and relationship with the offender as well as present a picture of her probable or possible state of mind.

27:03(2)(e) Case Law

BWS has been used to support a defense in several different types of criminal cases. In murder or assault cases, BWS has served as a support for self-defense. BWS testimony has also been used to explain why the abused woman is vulnerable to committing other criminal acts at the demand of the abuser. In some criminal cases, BWS has been used to support a defense of insanity or to support mitigating factors both in charging and sentencing. In one Texas case, the prosecution offered BWS evidence to show why the wife didn't try to escape when kidnapped at gunpoint by her husband.

BWS testimony has been drawn upon in domestic relations cases to address questions of custody and possession, to demonstrate the risk to children or the mother, or to explain the lack of protective behaviors by the mother.

BWS testimony has been employed in personal injury cases to support the spouse's claim of abuse and to demonstrate mental damage. Most recently, the syndrome has been used to support tort claims regarding personal injury within divorce proceedings.

BWS testimony has even been used to explain recantation of an intimate's abuse claim to support prosecution against the accuser's wishes.

In cases of murder, when the abused intimate acts with no clear and immediate danger seen by outsiders, testimony regarding BWS cycles of violence and learned helplessness has been offered as support for claims of self-

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INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, "VALIDITY OF BATTERED WOMAN SYNDROME IN CRIMINAL CASES INVOLVING BATTERED WOMEN", p.4.

238 *The Validity and Use of Evidence Concerning Battering and Its effect in Criminal Trials: Report Responding to Section 40507 of the Violence Against Women Act*, U. S. DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE AND U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTE OF MENTAL HEALTH, "VALIDITY OF BATTERED WOMAN SYNDROME IN CRIMINAL CASES INVOLVING BATTERED WOMEN", p.7.

239 R. J. Patterson and R. W. J. Neufeld, *Clear Danger: Situational Determinants of the Appraisal of Threat*, 101 PSYCHOLOGICAL BULLETIN 404-416 (1987).

defense or diminished capacity. Most frequently, this testimony is intended to provide an explanation of the battered woman's state of mind with a view to having the trier of fact understand that, even though there is no outward sign of immediate danger (contrition-loving phase), the woman perceives that she is never out of danger and therefore kills to protect herself or others before the cycle begins again. The learned helplessness concept, in this context can be particularly important, because it seeks to explain why the battered woman could perceive or envision *no other reasonable* alternative such as fleeing the abuse. Walker notes:

> Most battered women who kill in what they perceive is self-defense report an escalation of the violence from the man right before the incident that resulted in the homicide. Sometimes this escalation in the man's abuse occurs when he perceives her emotional withdrawal or preparation to separate. Other times it occurs around custody and visitation issues when there are young children. Still others kill the man after they learn that he is sexually molesting a child. **In any case, the differences between those battered women who kill and those who do not have more to do with the man's behavior than with the woman's.[240] [Emphasis added]**

After analyzing 238 state court decisions, 31 federal court decisions, and 12 state statutes, the Department of Justice has determined that, in criminal cases, at least to some extent, expert testimony on battering and its effects has been ruled admissible in all fifty states and the District of Columbia.[241]

Twenty-one states have squarely admitted in criminal cases expert testimony regarding battering and its effects.[242] The highest court in thirteen states (Connecticut, Florida, Georgia, Kansas, Massachusetts, Montana, New Jersey, New York, Ohio, Pennsylvania, South Carolina, Texas, and Washington)[243] have squarely admitted expert testimony on battering and its effects. Subsequently, half of these states rendered a more restrictive decision. Only in Ohio, however, did these more limiting decisions present a more consistent refusal to allow the use of expert testimony in any case other than a traditional self-defense situation.[244] In six states (California, Hawaii, Illinois,

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240 Lenore Walker, *Battered Woman Syndrome and Self-Defense*, Symposium on Women and the Law, 6 NOTRE DAME JOURNAL OF LAW, ETHICS, AND PUBLIC POLICY, 333 (1992).

241 Department of Justice Report ix.

242 Department of Justice Report 13.

243 **Connecticut**–*State v. Borrelli*, 227 Conn. 153, 629 A.2d 1105 (1993); *Knock v. Knock*, 244 Conn. 776, 621 A.2d 267 (1993). **Florida**–*State v. Hickson*, 630 So. 2d 172 (Fla. 1993). **Georgia–***State v. Chapman*, 258 Ga. 214, 367 S.E.2d 541 (1988); *Smith v. State*, 277 S.E.2d 678 (Ga. 1981) (testimony regarding why person suffering from BWS would not leave mate, would not inform police or friends, and would fear increased aggression admissible because jurors could not ordinarily draw such conclusions themselves). **Kansas**–*State v. Crawford*, 253 Kan. 629, 861 P.2d 791 (1993); *State v. Clements*, 244 Kan. 411, 770 P.2d 447 (1989) (appeal after remand); *Hodges v. State*, 239 Kan. 63, 716 P. 2d 563 (1986), overruled on other grounds, *State v. Stewart*, 243 Kan. 639, 763 P.2d 572 (1988); *State v. Hundley*, 236 Kan. 461, 693 P.2d 475 (1985). **Massachusetts–***Commonwealth v. Rodriquez*, 418 Mass. 1, 633 N.E.2d 1039 (1994). **Montana**–*State v. Hess*, 252 Mont. 205, 828 P.2d 382 (1992). **New Jersey**–*State v. Kelly*, 97 N.J.178, 478 A.2d 364 (N.J. 1984) (expert testimony on BWS admissible to explain defendant's state of mind and rebut misconceptions regarding BWS). **New York**–*In the Matter of Nicole V.*, 71 N.Y.2d 112, 518 N.E.2d 914 (1987). **Ohio**–*State v. Koss*, 49 Ohio St.3d 213, 551 N.E.2d 970, 972 (Ohio 1990). However, in an opinion issued just three years earlier, the Ohio Supreme Court had found that expert testimony on BWS by a psychiatric social worker to support the defendant's self-defense claim was absolutely inadmissible because (1) it was irrelevant and immaterial to the issue of whether the defendant acted in self defense at the time of the shooting; (2) the subject of the testimony is within the understanding of the jury; (3) BWS is not sufficiently developed as a matter of commonly accepted scientific knowledge; and (4) its prejudicial impact outweighs its probative value. *State v. Thomas*, 66 Ohio St.2d 518, 423 N.E.2d 137 (1987). **Pennsylvania**–*Commonwealth v. Stonehouse*, 521 Pa. 41, 555 A.2d 772 (1989). **South Carolina**–*Robinson v. State*, 308 S.C. 74, 417 S.E.2d 88 (S.C. 1992); *State v. Hill*, 287 S.C. 398, 339 S.E.2d 121 (1986). **Texas--***Fielder v. State*, 756 S.W.2d 309 (Tex. Crim. App. 1988) (note that, in classifying the courts, the Department of Justice Report failed to recognize that this is the highest court for criminal cases in the state, rather than an intermediate court). See below for an in depth discussion of *Fielder*. **Washington**–*State v. Kelly*, 102 Wash. 2d. 188, 685 P.2d 564 (1984); *State v. Allery*, 101 Wash. 591, 682 P.2d 312 (Wash. 1984) (expert testimony on BWS helpful to explain why person will not leave mate and would fear increased aggression against herself); *State v. Janes*, 121 Wash. 2d 220, 850 P.2d 495 (1993) (en banc).

244 *State v. Engle*, 1994 Ohio App. LEXIS 3918 (8/11/94) (slip op.), appeal allowed by 71 Ohio St.3d 1446, 644 N.E. 408 (1995); *State v. Lundgren*, 1994 Ohio App. LEXIS 1722 (4/22/94) (slip op.); *State v. Dowd*, 1994 Ohio App. LEXIS 132 (1/19/94) (slip op.), dism'd, 69 Ohio St.3d 1476, 634 N.E.2d 1023 (1994); *State v. Pargeon*, 64 Ohio App. 3d 679, 582 N.E.2d 665 (1995).

New Mexico, Oklahoma, and Wisconsin),[245] there is a square holding by an intermediate court that such testimony is admissible in criminal cases. In the remaining two states (Minnesota and Utah),[246] the only square holding of admissibility is by a trial court.

Seven states (Alabama, Alaska, Louisiana, Missouri, Nebraska, North Carolina, and Rhode Island)[247] have implicitly recognized the admissibility of expert testimony in criminal cases on battering and its effects, without discussing the issue. In another six states (Idaho, Kentucky, Michigan, New Hampshire, South Dakota, and Vermont),[248] such testimony is only admissible in criminal cases on a limited basis. Six other states (Arkansas, District of Columbia, Maine, Indiana, Mississippi, and Oregon)[249] allow the introduction of expert testimony only if certain conditions are met first, for example, that such testimony is accepted in the scientific community. Of the remaining eleven states, the courts of ten of those states (Arizona, Colorado, Iowa, Maryland, Nevada, North Dakota, Tennessee, Virginia, West Virginia, and Wyoming)[250] allow the admission of such testimony, but do not discuss the

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245 **California**–*People v. Romero*, 13 Cal. Rptr.2d 332 (Cal. App. 2 Dist. 1992), rev'd on other grounds, 35 Cal. Rptr. 2d 270, 883 P.2d 388 (1994); *People v. Day*, 2 Cal. App. 4th 405, 2 Cal. Rptr. 916 (1992). **Hawaii**–State v. Cababag, 9 Haw. App. 496, 850 P.2d 716 (1993), cert. denied, 74 Haw. 652, 853 P.2d 542 (1993). **Illinois**--*People v. Minnis*, 118 Ill. App. 3d 345, 74 Ill. Dec. 179, 455 N.E.2d 209 ([14th Dist.] 1983) (issue of self defense raised, but evidence of BWS offered to explain why dismembered husband's body, held BWS relevant to that issue). **New Mexico**–*State v. Gallegos*, 104 N.M. 247, 719 P.2d 1268 (N.M. Ct. App. 1986); *State v. Branchal*, 101 N.M. 498, 684 P.2d 1163 (N.M. Ct. App. 1984). **Oklahoma**–*Bechtel v. State*, 840 P.2d 1 (Okla. Crim. App. 1992) (appeal after remand). **Wisconsin**–*State v. Bednarz*, 179 Wis.2d 460, 507 N.W.2d 168 (Wis. Ct. App. 1993), review denied, 513 N.W.2d 406 (Wis. 1994).

246 **Minnesota**–*State v. Mick*, Order and Memorandum on State's Mo. in Limine, File No. K-84-497 (Dist. Ct., 8th Jud. Ct., Kandiyohi Co., MN, 7/30/84). This decision was later limited by the state's supreme court, *State v. Hennum*, 441 N.W.2d 793, 798 (Minn. 1989). **Utah**–*State v. Hazel*, (No. 931400263, 4th Judicial District Court for County of Utah, State of Utah (Memorandum Decision 9/7/73).

247 **Alabama**–*Ex parte Haney*, 603 So.2d 412 (Ala. 1992), cert. denied, 113 S.Ct. 1297 (1993). **Alaska**--*Brandon v. State*, 839 P.2d 400 (Alaska App. 1992). **Louisiana**–*Laughlin v. Breaux*, 515 So.2d 480 (La. App. 1 Cir. 1987). **Missouri**–*State v. Landrum*, Cause No. 576441, Div. 17, Team A, Cir. Ct., St. Louis Co. (MO 8/12/88) (unpub. order of 8/12/88). **Nebraska**–*State v. Doremus*, 2 Neb. App. 784, 514 N.W.2d 649 (1994). **North Carolina**–*State v. Clark*, 324 N.C. 146, 377 S.E.2d 54 (1989). **Rhode Island**–*State v. Ordway*, 619 A.2d 819 (R.I. 1992).

248 **Idaho**–*State v. Griffiths*, 101 Idaho 163, 610 P.2d 522 (1980), overruled on other grounds, *State v. LePage*, 102 Idaho 387, 630 P.2d 674 (1981), cert. denied, 454 U.S. 1057 (1981). **Kentucky**--*Commonwealth v. Craig*, 783 S.W.2d 387 (Ky. 1990), overruled by *Dyer v. Com.*, 816 S.W.2d 647 (Ky. 1992); *Commonwealth v. Rose*, 725 S.W.2d 588 (Ky. 1987), cert. denied, 484 U.S. 838 (1987), overruled by *Com. v. Craig*, 783 S.W.2d 387 (1990). **Michigan**–*People v. Wilson*, 194 Mich. App. 599, 487 N.W.2d 822 (1992). **New Hampshire**–*State v. Baker*, 120 N.H. 773, 424 A.2d 171 (1980). **South Dakota**–*State v. Burtzlaff*, 493 N.W.2d 1 (S.D. 1992). **Vermont**–*State v. Verrinder*, 161 Vt. 250, 637 A.2d 1382 (1993).

249 **Arkansas**–*Thompson v. State*, 306 Ark. 193, 813 S.W.2d 249 (1991). **District of Columbia**–*Ibn-Tamas v. United States*, 455 A.2d 893 (D.C. App. 1983) (Lenore Walker testified as an expert for defense) (implied that such testimony is admissible if it passes a 3-part test, here trial court upheld on appeal for excluding such evidence because "defendant failed to establish a general acceptance by the expert's colleagues of the methodology used in the expert's study of 'battered women'"). **Maine**–*State v. Anaya*, 438 A.2d 892 (Me. 1981) (testimony regarding BWS highly probative and more helpful than confusing to jury). **Indiana**–*Fultz v. State*, 439 N.E.2d 659 (Ind. App. 3d 1982). **Mississippi**–*Lentz v. State*, 604 So.2d 243 (Miss. 1992). **Oregon**–*State v. Milbradt*, 305 Or. 621, 756 P.2d 620 (1988); *State v. Moore*, 72 Or. App. 454, 695 P.2d 985 (1985), review denied, 299 Or. 154, 700 P.2d 251 (1985).

250 **Arizona**–*State v. Denny*, 27 Ariz. App. 354, 555 P.2d 111 (1976). **Colorado**–*People v. Yaklich*, 833 P.2d 758 (Colo. App. 1991); *People v. Hare*, 782 P.2d 831 (Colo. App. 1989), aff'd, 800 P.2d 1317 (Colo. 1990); *Morrison v. Bradley*, 622 P.2d 81 (Colo. App. 1980), rev'd on other grounds, 655 P.2d 385 (Colo. 1982). **Iowa**–*State v. Nunn*, 356 N.W.2d 601 (Iowa App. 1984). **Maryland**–*Banks v. State*, 92 Md. App. 422, 608 A.2d 1249 (1992). **Nevada**--*Larson v. State*, 104 Nev. Adv. 113, 766 P.2d 261 (1988). **North Dakota**–*State v. Leidholm*, 334 N.W.2d 811 (N.D. 1983) (admission of testimony regarding BWS and refusal of proposed BWS instruction upheld). **Tennessee**–*State v. Zimmerman*, 823 S.W.2d 220 (Tenn. Cr. App. 1991); *State v. Furlough*, 797 S.W.2d 631 (Tenn. Crim. App. 1990). **Virginia**–*Wilmoth v. Commonwealth*, 10 Va. App. 169, 390 S.E.2d 514 (1990); *Pancoast v. Commonwealth*, 2 Va. App. 28, 340 S.E.2d 833 (1986). **West Virginia**–*In Interest of Betty J.W.*, 179 W. Va. 60, 312 S.E.2d 31 (1984) *State v. Steele*, 178 W. Va. 330, 359 S.E.2d 558 (1987); *State v. Duell*, 175 W. Va. 233, 332

standards for that admission, and in the remaining state (Delaware)[251] such testimony has only been admitted at the trial level. Although all fifty states have admitted evidence of battering and its effects, eighteen states have excluded expert testimony on that subject in other cases either outright or in a limited way.[252]

Of the eight federal appellate courts (3rd, 5th, 6th, 7th, 8th, 9th, 10th, and 11th Circuits) and eleven federal trial courts (N.D. Ill., S.D.N.Y., E.D.N.Y., D. Kan., D. Hawaii, S.D. Ohio, N.D. Ala., S.D. Fla., W.D. La., E.D. Pa., and U.S. Tax Ct.) that have considered the issue, all but five have admitted expert testimony on battering and its effects. Only one (7th Cir.)[253] of those five have excluded the testimony outright. While the remaining four courts (6th and 9th Cir., S.D.N.Y., and S.D. Ohio)[254] have excluded the testimony on the facts of the case or some other limited basis, two of these courts (6th and 9th Circuits)[255] have admitted the evidence in other cases.

Apart from the case law, eight states (California,[256] Louisiana,[257] Massachusetts,[258] Missouri,[259] Nevada,[260] Oklahoma,[261] South Carolina,[262] and Texas[263]) have passed statutes that mandate that expert

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S.E.2d 246 (1985); *State v. Lambert*, 173 W. Va. 60, 312 S.E.2d 31 (1984). **Wyoming**–*Frenzel v. State*, 849 P.2d 741 (Wyo. 1993); *Griffin v. State*, 749 P.2d 246 (Wyo. 1988).

251 *State v. McBride*, Criminal Action Nos. IK-80-05-0058, IK-80-05-0059, IK-80-05-0027, Super. Ct. Kent Co. (DE 1982).

252 **Alabama**–*Neeley v. State*, 624 So.2d 494 (Ala. Crim. App. 1993); **Arizona**–*State v. Green*, unidentified case no., Garland Co. Cir. Ct. (8/94) (information in NCDBW files); **Georgia**–*Clenney v. State*, 256 Ga. 116, 344 S.E.2d 216 (1986); *Pruitt v. State*, 164 Ga. App. 247, 296 S.E.2d 795 (1982); *Mullis v. State*, 248 Ga. 338, 282 S.E.2d 334 (1981); **Illinois**–*People v. Jackson*, 180 Ill. App. 3d 78, 535 N.W.2d 1086 (1989); *People v. White*, 90 Ill. App. 3d 1067, 414 N.E.2d 196 (1980); **Kansas**–*State v. Dunn*, 234 Kan. 414, 758 P.2d 718 (1988); **Kentucky**–*Foster v. Commonwealth*, 827 S.W.2d 670 (Ky. 1992), cert denied, 113 S. Ct. 337 (1992); *Brandenburg v. Commonwealth*, No. 86-CA-1834-MR-Ky. Ct. App. (8/5/88) (unpub. op.); **Louisiana**–*State v. Clayton*, 570 So.2d 519 (La. App. 5 Cir. 1990); *State v. Necaise*, 466 So.2d 660 (La. App. 5th Cir. 1985); *State v. Edwards*, 420 So.2d 663 (La. 1982); **Maryland**–*Boyd v. State*, 321 Md. 69, 581 A.2d 1 (1990); **Michigan**–*People v. Moseler*, 202 Mich. App. 296, 508 N.W.2d 192 (1993), appeal denied, 519 N.W.2d 899 (Mich. 1994); **Missouri**–*State v. Anderson*, 785 S.W.2d 596 (Mo. App. 1990), denial of habeas corpus aff'd by *Anderson v. Goeke*, 44 F.3d 675 (8th Cir. 1995), reh'g denied (2/15/95); *State v. Clay*, 779 S.W.2d 673 (Mo. App. 1989); *State v. Martin*, 666 S.W.2d 895 (Mo. App. 1984); **Montana**–*State v. Dannels*, 226 Mont. 80, 734 P.2d 188 (1987); **New Jersey**–*State v. McClain*, 248 N.J. Super. 409, 591 A.2d 652 (A.D. 1991), certification denied by 126 N.J. 341, 598 A.2d 897 (1991); **New York**–*People v. Powell*, 83 A.D.2d 719, 442 N.Y.S.2d 645 (1981); **Ohio**--*State v. Pargeon*, 64 Ohio App. 3d 679, 582 N.E.2d 665 (1995); **Tennessee**–*State v. Pendergast*, 1992 Tenn. Crim. App. LEXIS 766 (10/8/92); **Washington**–*State v. Riker*, 123 Wash. 2d 351, 869 P.2d 43 (1994); **Wisconsin**–*State v. Balke*, 173 Wis. 2d 306, 498 N.W.2d 913 (Wis. Ct. App. 1992), review denied, 501 N.W.2d 458 (Wis. 1993); **Wyoming**–*Jahnke v. State*, 682 P.2d 991 (Wyo. 1994); *Buhrle v. State*, 627 P.2d 1374 (Wyo. 1981) (Lenore Walker testified as expert for defense) (upheld exclusion of testimony regarding BWS, stating not saying this type of expert testimony inadmissible, merely holding that state of the art not adequately demonstrated).

253 *U.S. v. Thomas*, 11 F.3d 1392 (7th Cir. 1993).

254 **9th Circuit**–*U.S. v. Archer*, 1993 App. LEXIS 24875 (9th Cir. 9/23/93); **6th Circuit**–*Thomas v. Arn*, 728 F.2d 813 (6th Cir. 1984), cert granted, 470 U.S. 1027 (1985) and aff'd, 474 U.S. 140 (1985), reh'g denied, 474 U.S. 1111 (1986); **Southern District of Ohio**–*Tourlakis v. Morris*, 738 F. Supp. 1128 (S.D. Ohio 1990); **Southern District of New York**–*U.S. v. Taylor*, 820 F.Supp. 124 (S.D.N.Y. 1993).

255 **9th Circuit**–*U.S. v. Johnson*, 956 F.2d 894 (9th Cir. 1992), opinion supp. on denial of reh'g by *U.S. v. Emilio*, 969 F.2d 849 (9th Cir. 1992) and on remand to *U.S. v. Longoria*, 1992 WL 252122 (D. Or. 9/25/92), aff'd by *U.S. v. Baracco*, 15 F.3d 1090 (9th Cir. 1993); *U.S. v. Winters*, 729 F.2d 602 (9th Cir. 1984); *U.S. Sebresos*, 1992 U.S. App. LEXIS 17757 (9th Cir. 7/22/92) (unpub. disposition); *U.S. v. Gable*, 1994 U.W. App. LEXIS 22969 (9th Cir. 6/15/94) (unpub. disposition), cert. denied, 115 S.Ct. 376 (1994) and *Funderburk v. U.S.*., 115 S.Ct. 376 (1994); *U.S. v. Russell*, 1993 U.S. App. LEXIS 6952 (9th Cir. 3/24/93) (unpub. disposition); *U.S. v. July*, 1992 U.S. App. LEXIS 6394 (9th Cir. 3/25/92) (unpub. disposition); **6th Circuit**–*Meeks v. Bergen*, 749 F.2d 322 (6th Cir. 1984).

256 CAL. EVID. CODE §1107 (uses the term "battered woman syndrome).

257 LA. CODE EVID. ANN. Art. 404(A)(2) (West 1989) (uses the term "domestic violence").

258 MASS. GEN. LAWS ANN. ch. 233, §23E (uses the term "physical, sexual or psychological abuse").

259 MO. ANN. STAT. (Crimes & Punishment) §563.033 (Vernon 1991) (uses the term "battered spouse syndrome").

260 NEV. REV. STAT. §48.061 (1993) (uses the term "domestic violence").

261 OKLA. STAT. ANN. tit. 22, §40.7 (West 1992) (uses the term "domestic violence").

testimony on battering and its effects in criminal cases "shall be admitted," "is admissible," or that the defendant "shall be permitted to introduce such evidence." In four other states (Georgia,[264] Maryland,[265] Ohio,[266] and Wyoming[267]), have passed statutes that use permissive language such as, "may introduce."

Texas first addressed BWS in *Fielder v. State*.[268] In *Fielder*, the defendant was convicted of voluntary manslaughter.[269] On appeal, the Fort Worth Court of Appeals was asked to determine whether it was error, pursuant to Section 19.06 of the Texas Penal Code, for the trial court to exclude the testimony of three experts regarding Fielder's state of mind and BWS.[270] Fielder attempted to introduce the testimony of Dr. Beatrice Matheeney, a psychologist, to show why Fielder did not abandon her marital relationship earlier and the testimony of two sociologists, Dr. Anson Shupe and Dr. William Stacy, to testify regarding their social research on BWS. Fielder argued that such evidence would aid the jury in comprehending the facts of the case and was relevant to the issue of self-defense.[271]

Dr. Matheeney testified, as part of the bill of exception, in response to a hypothetical question regarding why women remain with men who abuse them, that there were many reasons, including the following: love and desire to stay with somebody; motivation by society to get married and to stay married; a desire not to ruin the man's career; the embarrassment of admitting to physical and sexual abuse; a feeling of helplessness on the part of the woman and an inability to make decisions; fear of reprisal if she left; a desire not to admit failure in the situation of a second marriage; the tendency to have hope and therefore forgive and forget such abuses where the man is repentant and loving between the incidents of abuse; the need to keep up appearances and not let the couples' peers know about their problems; and that a woman will sometimes feel that she is the property of the man therefore she is deserving and in fact responsible for the abuse inflicted upon her. Dr. Matheeney also testified regarding the hopelessness and deterioration of self-esteem that occurs in such women.[272]

Subsequently, Fielder called Dr. Shupe to testify regarding his research on family violence and battered wives. After the State objected on relevancy grounds, Fielder's attorney attempted to make an offer of proof, after which the court allowed the state to voir dire Dr. Shupe regarding his research. Dr Shupe testified that his research included data collected from a questionnaire completed by over 542 women who had been abused. This data was then fed into a computer. He further testified that, based upon the questionnaire completed by Fielder, the defendant received 57 points out of a possible 59 points. After this testimony, the Fort Worth Court opined that it did not see how this evidence related to whether Fielder had acted in self-defense and sustained exclusion of the testimony.[273]

The Fort Worth Court of Appeals then went through a careful analysis of BWS and the admissibility of expert testimony regarding BWS by other jurisdictions. Without citation to authority or any specific testimony in the underlying case, the court described BWS in its opinion in detail.[274]

The Fort Worth Court of Appeals then analyzed the cases cited by the defendant, *Ibn-Tamas v. United States* and *Smith v. State*, to support her contention that other courts had found similar evidence admissible and relevant. The Court did a multi-state analysis of the courts, which had admitted such evidence and the bases for such

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262 S.C. CODE ANN. §17-23-170(A) (uses the term "battered spouse syndrome").

263 CODE OF CRIM. PROC. art. 38.36 (West 1994) (formerly TEX. PENAL CODE § 19.06) (uses the term "family violence").

264 GA. CODE ANN. §16-3-21(d) (Michie 1994) (uses the term "family violence").

265 MD. CTS. & JUD. & PROC. CODE ANN. §10-916 (1991) (uses the term "battered spouse syndrome").

266 OHIO REV. CODE ANN. §2901.06(B) (Anderson 1990) (uses the term "battered woman syndrome").

267 WYO. STAT. (Crimes & Offenses) §6-1-203 (1993) (uses the term "battered spouse syndrome").

268 *Fielder v. State*, 683 S.W.2d 565 (Tex. App.–Ft. Worth 1985), rev'd and remanded, 756 S.W.2d 309 (1988).

269 *Fielder*, 683 S.W.2d at 565.

270 *Fielder*, 683 S.W.2d at 584.

271 *Fielder*, 683 S.W.2d at 584.

272 *Fielder*, 683 S.W.2d at 585.

273 *Fielder*, 683 S.W.2d at 584.

274 *Fielder*, 683 S.W.2d at 587-88. Although the court fails to cite authority for this characterization of BWS, it appears to reflect the views of Lenore Walker, whose research is called into question earlier in this chapter. Also note that, throughout the opinion, the Court cites to various opinions in which Lenore Walker testified as an expert: *Hawthorne v. State*, 408 So.2d 801 (Fla.Dist.Ct.App. 1982); *People v. Powell*, 102 Misc.2d 775, 424 N.Y.S.2d. 626 (N.Y. Co. Ct. 1980) (testimony excluded); *Ibn-Tamas v. United States*, 455 A.2d 893 (D.C. App. 1983); *Buhrle v. State*, 627 P.2d 1374 (Wyo. 1981).

admission. The Fort Worth Court of Appeals then held that expert testimony on BWS was admitted in these cases for one of two reasons. First, this evidence was admitted "to dispel alleged common misconceptions held by a jury that a normal or reasonable person would not remain in such an abusive situation."[275] In essence, this type of testimony would bolster the defendant's testimony and lend it credibility.[276] Second, this evidence was admitted "to show the reasonableness of the defendant's fears that she was in imminent peril of suffering death or serious bodily injury.[277] Admissibility, under these circumstances seems to be based on the fact that, unlike the defendant who is in such fear of her life or physical well being that she arguably acts excessively in her own defense, the average juror subjected to the same facts and circumstances as the defendant might not fear for their life or physical well being.[278]

In conclusion, the Fort Worth Court determined that the trial court properly excluded Dr. Matheeney's testimony because Fielder's abusive relationship and her reasons for remaining there are not relevant to the issues raised by her claim of self-defense. What is relevant is whether a reasonable person would have retreated at the immediate time of the incident. The essence behind the theory of admitting testimony on BWS is that a battered woman does not react to outside stimulus in the same way as a reasonable person would react. Under the facts of this case, Fielder's reasons for not leaving the abusive relationship are not relevant to her particular claim of self defense.[279] Further, the Fort Worth Court determined that Fielder's stated reasons for not leaving the marital relationship was a matter within the comprehension of the average juror; therefore error, if any, in excluding the testimony was harmless.[280]

In concluding that the trial court was also correct in excluding the testimony of the sociologists, the Fort Worth Court of Appeals said that Dr. Shupe's testimony concerned only the analysis of Fielder's questionnaire and how her alleged batterings compared in severity to other women's alleged batterings, which is something that the jury could determine on their own. The Fort Worth Court, however, went on to attack the doctors' study, finding that "there was no showing of any type of control group used, any "norms" to go by, or that any research was done to verify the actual existence of any fact contained in the study."[281] The Fort Worth Court finally concluded that the study seemed to be "nothing more than a statistical analysis of various unsubstantiated battering incidents," which were totally irrelevant to the issue before the jury.[282]

In a final comment, the Court concludes that before the type of testimony, which Fielder sought to introduce in this case, is admissible and becomes more probative than prejudicial, the defendant first must establish that she is a battered woman through competent direct expert testimony.[283] What the Fort Worth Court failed to note, or possibly did not know, is that the research supporting BWS is no more credible or reliable than the sociologists' study.[284]

Fielder sought and was granted a petition for discretionary review of the lower court's upholding of the exclusion of the expert's testimony. The Court of Criminal Appeals begins its opinion by stating that the evidence established that Fielder had shot her husband of three years, firing seven rounds into his body, and that the trial court had instructed the jury upon the law of murder, self-defense, and voluntary manslaughter.[285] The Court of Criminal Appeals sets forth in graphic detail the evidence elicited during trial regarding the parties' marital relationship and what led up to the killing.

In summary, Fielder alleged that she suffered physical and sexual abuse at the hands of her ob-gyn husband, Darwin, which increased in severity throughout the course of their marriage. She testified that the parties' sexual activity progressed from "playful" "bondage and discipline" games to acts of sado-masochism. As an example

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275 *Fielder*, 683 S.W.2d at 565, *with a see cite to, Ibn-Tamas,* 407 A.2d at 634; *Smith*, 277 S.E.2d at 683; *State v. Kelly*, 478 A.2d at 378; *State v. Anaya*, 438 A.2d at 894; *Hawthorne*, 408 So. 2d at 807; and *State v. Allery*, 682 P.2d at 316.

276 *Fielder*, 683 S.W.2d at 591.

277 *Fielder*, 683 S.W.2d at 591-92, *with a see cite to*, *Ibn-Tamas*, 407 A.2d at 634; *Smith*, 277 S.E.2d at 683; *State v. Kelly*, 478 A.2d at 377; *State v. Anaya*, 438 A.2d at 894; *Hawthorne*, 408 So.2d at 807; and *State v. Allery*, 682 P.2d at 316.

278 *Fielder*, 683 S.W.2d at 592.

279 *Fielder*, 683 S.W.2d at 592-93.

280 *Fielder*, 683 S.W.2d at 593.

281 *Fielder*, 683 S.W.2d at 594.

282 *Fielder*, 683 S.W.2d at 592.

283 *Fielder*, 683 S.W.2d at 595.

284 *See generally*, 27:03(2)(a).

285 *Fielder*, 756 S.W.2d at 311.

of this increased violence, Fielder testified that Darwin would administer what he told her was demerol "in order to force her to participate in such activities as piercing her genitals with a golden ring and nailing his own scrotum to wooden blocks while sitting before her as she hung, nude, shackled and tied to metal rings in a closet Darwin had customized for such activities." The parties referred to this closet as "the cave." As the violence increased, Fielder claimed that Darwin told her that, if she ever told anyone about their activities, he would kill her. These episodes lasted up to six or seven hours at a time. Fielder testified that Darwin's greatest fear was that his sexual proclivities would be exposed. Once, after Fielder had hidden some of Darwin's toys, which were described as a "black leather hood," "handcuffs," "shackles," "pinchers," and "discipline helmet," to name a few, he beat her and threatened to kill her. After these episodes of violence, Fielder testified that Darwin would be very contrite, beg her forgiveness, acknowledge he had a problem, and tell her he was motivated to be cured. Between these episodes of violence, which apparently were infrequent, the couple had what Fielder characterized as a normal, satisfying marriage.[286] The parties ultimately decided to separate and divorce, however, Darwin insisted that it be done on his timetable, without deviation. To assure that Fielder did not expose Darwin's sexual proclivities to an attorney, he insisted that she agree to involving only one attorney and that both parties be present in any meeting with that attorney.[287]

Contrary to Darwin's desires, Fielder went to see an attorney, who advised her package all of Darwin's "toys" and bring them to his office. After packaging up all of the toys, Fielder was seized with terror that Darwin would discover what she had done and, instead of bringing the toys to the attorney, she hid the toys in the cave, locked the door, and went about her business.[288] The next day Fielder went to Darwin's townhouse, where she discovered Darwin and his nurse, after which she confronted Darwin about that relationship and then went home. Darwin later went to the parties' home and told Fielder that he was in love with his nurse and no longer needed Fielder.[289] Fielder then told Darwin about seeing a lawyer, after which he became furious, banged his fist on the table, and then flew into the cave. Fielder, knowing where Darwin was headed, tried to escape by running outside, where "Darwin grabbed her by the arm and her hair and pulled her back inside, twisting her arm behind her and pushing her in front of him." The whole time, Darwin was screaming, "I've told you; I've told you." He then went to a cabinet above the bar and pulled out Fielder's gun, screaming at her, "What did you tell him? What did you tell him?" Darwin banged the gun down on the edge of the chair where he was sitting, with it still pointed at Fielder. Fielder then slammed a drink down next to the gun, grabbed the gun, and started backing away from Darwin, saying "Leave me alone." When Darwin came at Fielder, the gun went off.[290]

The Court of Criminal Appeals held that Dr. Matheeney's testimony was relevant because it was responsive to the main contested issue in the case, which was the reasonableness of the defendant's apprehension of fear that Darwin was about to use deadly force against her at the time of the killing.[291] The Court held: "Dr. Matheeney's testimony was offered to revitalize the violent past of the parties, in order to rehabilitate the inference of [Fielder's] ultimate apprehension of danger at the time of the killing." The Court also held that the court of appeals erred in determining that an expert could not offer an opinion based solely on a hypothetical question posed at trial; that Fielder was required to establish herself as "a battered woman" by direct testimony; that Dr. Maheeney's testimony would not assist the trier of fact; and that Dr. Shupe's and Dr. Stacy's testimony was irrelevant and unreliable because it was based on information provided by the defendant.[292]

The Court of Criminal Appeals neither commented nor referred to the reliability and/or validity of the underlying research upon which Dr. Matheeney based her opinion or the study conducted by the sociologists. The Court of Criminal Appeals also failed to comment on or refer to the holdings in other states that had allowed or not allowed the admission of such testimony. Four years later, the legislature enacted a statute that allows the admission of such testimony.[293]

27:03(3)

In conclusion, BWS testimony has been admitted in many different kinds of cases in Texas and in many other states. However, with the new challenges regarding the scientific underpinnings of social science evidence,

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286 *Fielder*, 756 S.W.2d at 311.

287 *Fielder*, 756 S.W.2d at 311.

288 *Fielder*, 756 S.W.2d at 311-12.

289 *Fielder*, 756 S.W.2d at 312.

290 *Fielder*, 756 S.W.2d at 312.

291 *Fielder*, 756 S.W.2d at 319, 320.

292 *Fielder*, 756 S.W.2d at 320-21.

293 TEX. PENAL CODE §19.06 (West 1992), now contained in TEX. CODE OF CRIM. PROC. art. 38.36 (West 1994).

testimony based on or regarding BWS will likely not meet minimum standards for admissibility. Furthermore, as there is sound research information available regarding trauma, trauma recovery, and dynamics of battering, it would seem wise to approach domestic violence, regardless of the nature of the case, from a stronger position than that of BWS. There is no question that the trier of fact can benefit from social science research information and from information regarding the specific relationships in question. Many factors such as the woman (or man's) appraisal of danger in the relationship, state of mind regarding an event(s), history of relationship violence, and trauma research, can assist the trier of fact. Offering this type of evidence, with more solid social science support, appears to be the better approach to working with these cases, as opposed to attempting to meet the criteria for BWS, with all of its attendant controversy.

State Bar of Texas
Family Law Section's

EXPERT WITNESS MANUAL

PART 2

Mental Health and Family Relations

Chapter 36

Intelligence Tests

36:03 McCarthy Scales of Children's Abilities[294]

36:03(1) Description

The McCarthy Scales of Children's Abilities (MSCA) is designed to determine general intellectual levels, together with strengths and weaknesses in important abilities in preschool children. It has been described by one Buros reviewer as "one of fewer than a handful of well-standardized, carefully developed, comprehensive ability measures suitable for preschoolers and early elementary school children."[295] Originally published in 1972 by Dorothea McCarthy, the testing materials are gamelike and nonthreatening. Preschool children seem to enjoy the activities and move easily through the subtests. A second Buros reviewer noted that the directions to the subtests are easily understood, and the sequence engages young children who are often shy, nonverbal, and distractible.[296]

While the test is appropriate when a child 2 ½ to 6 years demonstrates delays in expressive language, nonverbal, or motor spheres, it is less desirable for older children. Three technical limitations have been identified: (1) lack of social comprehension and judgment tasks, (2) problems in testing older school-age children, and (3) difficulties pertaining to scale interpretation.[297] These limitations apply primarily to very young children and older children. As a result, the test is best suited for those in the mid-range, between the ages 3 and 6 ½.[298] Because of the MSCA's limited floor, the Stanford-Binet would likely yield a more accurate picture of a 2½ year-old's functioning, while the limited ceiling and the lack of tasks measuring social judgment, abstract problem solving, and verbal expression would likely lead to the decision to use the WISC-R for a child age 6 ½ to 8 years.[299] In that instance, the WISC-R is preferable because of its research base and superior verbal items.[300] Missing from the battery are indicators of school-age children's function, including social comprehension, maturity and judgment, verbal reasoning and abstract puzzle solving tasks.[301] Reviewers have specifically cautioned that the test is not recommended for the assessment of older gifted students and younger retarded children.[302]

36:03(2) Administering Test

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294 Author: Ann Crawford McClure, Justice, Eighth Court of Appeals, El Paso.

295 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

296 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

297 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994), *citing* A.S. Kaufman and N.L. Kaufman, CLINICAL EVALUATION OF YOUNG CHILDREN WITH THE MCCARTHY SCALES (New York: Grune & Stratton, 1977).

298 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

299 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 231 (1994).

300 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 233 (1994).

301 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

302 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

The test is composed of six scales, including the Verbal and Perceptual-Performance Indexes, Quantitative Index, General Cognitive Index (GCI), Memory Index, and Motor Index, and incorporates eighteen different subtests. The GCI is a composite cognitive score essentially equivalent to IQ.[303]

Examiners have found the MSCA reasonably easy to administer and score although production of derived scores is time consuming.[304] Designed to capture and maintain a preschooler's attention, nonverbal items precede verbal items, allowing the child time to "warm up".[305] A series of game-like gross motor tasks is situated between traditional tasks that require attention and persistence.[306] Reviewers have concluded that young and restless children can be assessed in a single examination session lasting between 45 and 90 minutes.[307]

Reviewers disagree about the quality of the test manual. One commends the test for its outstanding technical manual, which she describes as "an exemplary piece of work comprised of elaborate information about the test's psychometric soundness, the standardization process, norms tables and guidelines for administration and interpretation."[308] A second reviewer complains that the test manual is unchanged since its original publication. According to this reviewer, because "over a decade of research on the test's psychometric and clinical properties is left unavailable to the clinician", the manual is dated and inadequate.[309]

36:03(3) Scoring Test

A child's profile of MSCA Index scores reflects performance in domains of cognitive and motor ability and demonstrates particular strengths and weaknesses.[310] The Verbal, Perceptional-Performance, Quantitative, Motor and Memory Indexes are reported as T-scores (mean = 50, standard deviation = 10).[311] One reviewer criticizes this scoring, noting that interpretation and intertest comparison would be improved if the indexes were the equivalent of Wechsler subtests or IQS.[312] Because the general Cognitive Index score has a mean of 100 and a standard deviation of 16, the reviewer believes it "would have been more consistent with contemporary trends if a standard deviation of 15 had been selected."[313] Both Buros reviewers question the Qualitative Index, one commenting that it should be interpreted with extreme caution and that it may not correspond to any real ability in children below the age of five, the other referring to it as having "questionable content validity and dubious clinical utility."[314] The latter also notes that interpretation problems arise with the Memory and Motor Index scores ("Precisely what is measured and what these index scores mean is not entirely clear.").[315] The former suggests that the major problem in the meaning of the scores is the exclusion of exceptional children from the standardization sample.[316] Indeed she characterizes the problems in understanding the meaning of scores for exceptional children relative to normal children as creating the major obstacle to widespread acceptance of the MSCA.[317]

McCarthy originally suggested that for individual assessments, low GCIs should be reported as "below 50" and high GCIs as "above 150". One reviewer suggests that the extrapolated GCI should not be used for individual assessment of gifted children.[318]

Reviewers agree that there appears to be an overlap in content between some of the scales. The Memory Scale overlaps with the Verbal and Quantitative Scales.[319] The Memory Index is composed of tests that contribute

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303 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

304 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

305 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

306 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

307 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 226-227 (1994).

308 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

309 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

310 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

311 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 233 (1994).

312 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 233 (1994).

313 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 233 (1994).

314 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229, 236 (1994).

315 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

316 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

317 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

318 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

to the GCI; the Motor Index includes fine motor tasks that contribute to the GCI and gross motor tasks separate and apart from the GCI.[320]

One reviewer has noted certain scoring limitations, including the discrepancy of one standard deviation between the GCI and the Stanford-Binet IQ, the fact that Weschler Full Scale IQS are consistently higher than GCIs, and the difficulty with interpretation of the Memory and Quantitative Indexes.[321] Another credits the test noting that "derived scores are not provided for the brief, unreliable constituent tests that compose the various indexes" so that clinicians will be disinclined to overinterpret test data.[322]

36:03(4) Reliability

Standardization procedures followed in the development of the test norms have been described as exemplary.[323] The MSCA was standardized on a sample of 1,036 children stratified by race, geographic region, father's occupation, and urban-rural residency.[324] As reported in the test manual, the internal consistency coefficients for the GCI averaged 0.93 across 10 age groups between the ages of 2 ½ and 8 ½. Mean reliability coefficients for the other index scales ranged between 0.79 to 0.88. A study using a Spanish-speaking sample reported an average coefficient of 0.93.[325]

While the internal consistency of the test has been described as "beyond reproach", the key reliability issue for preschool children is stability because of the fluctuation in test behaviors of young children.[326] Although the stability data of the MSCA indicate adequate test-retest consistency for the GCI, the studies used small samples of children, most of whom were age 5 or older.[327] One Buros reviewer commented that none of the investigators examined stability for exceptional children, although exceptional children compose a large percentage of the children tested with the MSCA.[328] "Longitudinal studies are still needed which will evaluate MSCA stability over several age ranges and time intervals."[329]

36:03(5) Validity

Most of the research on the MSCA has been geared toward determining its validity.[330] Specifically, attention has been focused upon the construct validity of the factor structure, the relationship of GCI to IQ, its ability to discriminate among various groupings of children, its ability to predict school achievement, and its validity with minority populations.[331]

The test manual indicates that the content of the MSCA and the organization of the six scales were developed through "intuitive and functional considerations" based upon McCarthy's teaching and clinical

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319 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

320 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

321 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

322 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 233 (1994).

323 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

324 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

325 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994) *citing* S. Shellenberger, A CROSS-CULTURAL INVESTIGATION OF THE VALIDITY OF THE SPANISH VERSION OF THE MCCARTHY SCALES OF CHILDREN'S ABILITIES FOR PUERTO RICAN CHILDREN. Unpublished doctoral dissertation, University of Georgia, 1977.

326 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994), *citing* A.S. Kaufman, *An integrated review of almost a decade of research on the McCarthy Scales*, T. Kratochwill (Ed.), 2 ADVANCES IN SCHOOL PSYCHOLOGY 122 (Hillsdale, NJ: Lawrence Erlbaum Assoc., 1982).

327 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

328 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

329 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994), *citing* R.J. Nagle, *The McCarthy Scales of Children's Abilities: Research Implications for the Assessment of Young Children*, 8 SCHOOL PSYCHOLOGY DIGEST 319-366 (1979).

330 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

331 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

experience.[332] Studies have indicated generally good support for the construct validity of the battery for normal children.[333] While the large factor analytic studies were based on data for normal children, rather than exceptional children, smaller studies of atypical groups "generally confirm the overall results of the factor analytic data for normal children: good construct validity for the global score (GCI and for the Verbal, Perceptual-Performance, and Motor Scales, and limited validity support for the Memory Scale."[334]

Efforts to determine the concurrent validity of the MSCA by comparing the GCI with Stanford-Binet and WPPSI IQ scores have yielded conflicting results. Some studies have found no significant differences between GCI and Binet IQ for kindergarten and first-grade children and 2 ½ to 8 ½ year old children from Mexican backgrounds, or between GCI and WPPSI Full Scale IQ.[335] These studies suggest that the MSCA, the Stanford-Binet and the WPPSI measure abilities in a similar fashion.[336] Other studies, however, show statistically significant differences between GCI and IQ for preschoolers, children diagnosed as learning disabled and "minimal brain dysfunction" children experiencing learning problems in school.[337] "With methodological improvements, the GCI-IQ differences may not be as dramatic as once believed, although statistically significant differences may still be found. . ."[338] Experts disagree as to whether the MSCA should be used for classification purposes, for estimating mental functioning, or for diagnosis of learning disability.[339]

The test appears to be nondiscriminatory with regard to race and differentiates between learning disabled and normal children.[340] However, a post-publication study found some learning disabled children earned "General Cognitive Index" (GCI) scores in the mental retardation range, raising the possibility that the MSCA overidentifies

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332 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

333 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994), *citing* A.S. Kaufman & N.L. Kaufman, CLINICAL EVALUATION OF YOUNG CHILDREN WITH THE MCCARTHY SCALES 83-103 (New York: Grune & Stratton, 1977).

334 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994), *citing* T.Z. Keith & L.M. Bolen, *Factor Structure of the McCarthy Scales for Children Experiencing Problems in School*, 17 PSYCHOLOGY IN THE SCHOOLS 360-366 (1980); J.A. Naglieri, A.S. Kaufman & P.L. Harrison, *Factor structure of the McCarthy Scales for school-age children with low GCIs*, 19 JOURNAL OF SCHOOL PSYCHOLOGY 226-236 (1981); and A.S. Kaufman, "An integrated review of almost a decade of research on the McCarthy Scales.", T. Kratochwill (Ed.), II ADVANCES IN SCHOOL PSYCHOLOGY, Hillsdale, NJ: Lawrence Erlbaum Assoc., 1982.

335 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994), *citing* E.E. Davis, *Concurrent Validity of the McCarthy Scales of Children's Abilities*, 8 MEASUREMENT AND EVALUATION IN GUIDANCE 101-104 (1975); E.E. Davis & C. Walker, *Validity of the McCarthy Scales for Southwestern Rural Children*, PERCEPTUAL AND MOTOR SKILLS, 1976, 42, 563-567; A.S. Kaufman, *Comparison of the WPPSI, Stanford- Binet, and McCarthy Scales as Predictors of First-Grade Achievement*, 36 PERCEPTION AND MOTOR SKILLS 67-73 (1973); E.E. Davis & T. Rowland, *A Replacement for the Venerable Stanford-Binet?*, 30 JOURNAL OF CLINICAL PSYCHOLOGY 517-521 (1974).

336 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994).

337 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994), *citing* K.C. Gerken, K.A. Hancock, & T.H. Wade, "A Comparison of the Stanford-Binet Intelligence Scale and the McCarthy Scales of Children's Abilities with Preschool Children.", 15 PSYCHOLOGY IN THE SCHOOLS 468-472 (1978); B.L. Phillips, R.A. Pasewark, & R.C. Tindall, "Relationship Among McCarthy Scales of Children's Abilities, WPPSI, and Columbia Mental Maturity Scale", 15 PSYCHOLOGY IN THE SCHOOLS 352-356 (1978); D.L. DeBoer, A.S. Kaufman, & D. McCarthy, THE USE OF THE MCCARTHY SCALES IN IDENTIFICATION, ASSESSMENT, AND DEFICIT REMEDIATION OF PRESCHOOL AND PRIMARY AGE CHILDREN, Symposium presented at the meeting of the Council for Exceptional Children, New York, April, 1974; N.L. Kaufman & A.S. Kaufman, "Comparison of Normal and Minimally Brain Dysfunctioned Children on the McCarthy Scales of Children's Abilities", 30 JOURNAL OF CLINICAL PSYCHOLOGY 69- 72 (1974).

338 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994), *citing* J.A. Naglieri, A COMPARISON OF MCCARTHY GCI AND WISC-RIQ SCORES FOR EDUCABLE MENTALLY RETARDED, LEARNING DISABLED AND NORMAL CHILDREN. Unpublished doctoral dissertation, University of Georgia, 1979.

339 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994), *citing* B.A. Bracken, "McCarthy Scales as a learning disability diagnostic aid: A closer look.", JOURNAL OF LEARNING DISABILITIES, 1981, 14, 128-130; A.S. Kaufman, "An integrated review of almost a decade of research on the McCarthy Scales.", T. Kratochwill (Ed.), ADVANCES IN SCHOOL PSYCHOLOGY, Vol. II. Hillsdale, NJ: Lawrence Erlbaum Assoc., 1982.

340 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

mental retardation.[341] Indeed, use of the MSCA with retarded children is potentially limited because of the test's limited floor.[342] The validity of the MSCA for use with retarded children has not been extensively studied.[343] With significant discrepancies between the GCI and both Stanford-Binet and Weschsler, preliminary results have been called discouraging, suggesting hesitation in using the MSCA for classification of individual retarded children.[344]

The MSCA appears to be effective in discriminating between learning disabled and non-learning disabled children, but results of efforts to distinguish reading disabled from non-reading disabled children has been mixed.[345] Correlations with school achievement are strong and studies suggest that the test has the ability to predict school functioning.[346]

36:03(6) Common Issues, Critical Analysis, and Case Law

The test has major strenths that rank it among the best of available broad-based diagnostic instruments for use with preschool children.[347] It contributes substantially to the preschool assessment repertoire provided the psychologist has an awareness of its limitations.[348] For preschool children between the ages of 3 and 6 ½, the advantages far outweigh the disadvantages.[349] For younger or older children, and for retarded or gifted children, the test has structural limitations.[350] "Rather than widespread acceptance and popularity, the conclusion from the research is one of caution -- that the test should be used in some circumstances and not in others."[351]

36:03(7) Proposing and Opposing Admissibility

The 1994 Buros reviews do not address the legal reliability of the McCarthy Scales.

36:03(8) Comments

None.

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341 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 236 (1994).

342 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

343 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 229 (1994).

344 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994).

345 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994), *citing* D.L. DeBoer, A.S. Kaufman, & D. McCarthy, THE USE OF THE MCCARTHY SCALES IN IDENTIFICATION, ASSESSMENT, AND DEFICIT REMEDIATION OF PRESCHOOL AND PRIMARY AGE CHILDREN. Symposium presented at the meeting of the Council for Exceptional Children, New York, April, 1974; D.S. Goh & M.R. Simons, *Comparison of learning disabled and general education children on the McCarthy Scales of Children's Abilitites*, PSYCHOLOGY IN THE SCHOOLS, 1980, 17, 429-436; D.A. Johnson & J.P. Wollersheim, *A Comparison of the Test Performance of Average and Below Average Readers on the McCarthy Scales of Children's Abilities*, 8 JOURNAL OF READING BEHAVIOR 397-403 (1976); R.J.Nagle, K.D. Paget & M.S. Mulkey, *Comparison of Good and Poor Readers on the McCarthy Scales*, NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS CONVENTION PROCEEDINGS, 1980, 138-140; L.I Weiss, THE UTILITY OF THE MCCARTHY SCALES OF CHILDREN'S ABILITIES IN THE IDENTIFICATION OF POTENTIALLY READING DISABLED KINDERGARTEN CHILDREN AND ITS APPLICATION TO THE MATURATIONAL LAG HYPOTHESIS. Unpublished doctoral dissertation, University of Southern Mississippi, 1977.

346 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230 (1994), *citing* A.S. Kaufman, *An integrated review of almost a decade of research on the McCarthy Scales*, T. Kratochwill (Ed.), 2 ADVANCES IN SCHOOL PSYCHOLOGY, (Hillsdale, NJ: Lawrence Erlbaum Assoc., 1982).

347 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

348 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 227 (1994).

349 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 228 (1994).

350 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 230-231 (1994).

351 Buros Desk Reference, PSYCHOLOGICAL ASSESSMENT IN THE SCHOOLS 226 (1994).

4-27-99

State Bar of Texas
Family Law Section's

EXPERT WITNESS MANUAL

PART 3

FINANCIAL ISSUES

Marketability Discount

When no established market exists for an ownership interest in a closely-held business, appraisers will apply a marketability discount. This discount reflects the owner's inability to quickly convert his/her interest into cash.[352] The discount applies no matter whether you are valuing a controlling interest or a minority interest.[353] The marketability discount is applied at the enterprise level, before any adjustments to value for partial interests. If there is a marketability problem peculiar to a minority interest in the business, that factor is included in the minority discount, not the marketability discount.

Even if there is a market for the ownership interest, sometimes an owner cannot liquidate his/her interest without the consent of other owners. This leads to what is called a "lock-in" or "lock-up" discount.[354] The appropriateness of this discount will be affected by the exact nature of the restriction on selling the interest in the business. Different degrees of restriction in different situations can make it difficult to find comparables.

Shannon Pratt offers three sources of empirical data as guidance for quantifying the discount for lack of marketability: 1) discounts on sales of restricted stock of publicly traded companies (i.e., letter stock); 2) discounts on sales of closely held company shares compared to subsequent public offerings of those shares; 3) cost of floating a public offering.[355]

Where a public market could be created for the interest, one way to measure the marketability discount is to determine the "cost of flotation," or the cost associated with the printing, underwriting, legal and accounting services, etc. necessary to take the stock public.[356] This approach is not appropriate in instances where the cost of flotation would approach or exceed the proceeds of the public offering, or where no market could be made.[357] This approach would rarely be applicable held to a closely-held business or professional practice.

When the entire business is being valued, the marketability discount should seldom reduce the value of the business below the value at which the assets of the business could be sold.

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352 Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 449 (1997).

353 *Snyder v. Commissioner*, 93 T.C. 529 (1989); *Estate of Frank v. Commissioner*, 69 T.C.M. (CCH) 2255 (1995); Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 438 (1997). *See Estate of Bennett v. Commissioner*, 65 T.C.M. (CCH) 1816 (1993) (allowing a 15% discount for lack of marketability for a 100% ownership interest in a shopping center).

354 Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 450 (1997). Such a discount was recognized for the owner of a minority partnership interest in *Harwood v. Commissioner*, 82 T.C. 239, 264 (1984).

355 Shannon P. Pratt, VALUING A BUSINESS: THE ANALYSIS AND APPRAISAL OF CLOSELY HELD COMPANIES, p. 239 (2nd ed. 1989).

356 Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 438-39 (1997), citing *First Trust Co. v. U.S.*, 3 A.F.T.R.2d 1726, 1739 (W.D. Mo. 1958).

357 Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 439 (1997), citing *Estate of Reilly v. U.S.*, 88-2 U.S.T.C. 12, 782 (S.D. Ind. 1988) (criticizing use of flotation costs derived from 1971 SEC study); *Northern Trust Co. v. Commissioner*, 87 T.C. 349 (1986) (20% marketability discount).

Control Premium

Sometimes a premium is applied when valuing a controlling interest in a business.[358] The rationale for the premium is that the party controlling a business can determine salaries, distribution of profits, who is employed, and other factors that give value to ownership of the business.

On the other hand, in some situations the fact that there is a minority shareholder limits the majority owner's freedom of action and causes the price of the controlling interest to be reduced below its percentage share of total value.[359]

Shannon Pratt notes that "[w]hether an interest is a controlling or a minority interest is not necessarily a cut-and-dried distinction," but may instead be a matter of decree.[360]

The value of control depends on the owner's ability to exercise the rights typically associated with control, including: 1) electing directors and appointing management; 2) determining management's compensation and perquisites; 3) setting policy and determining the course of the business; 4) acquiring or liquidating assets; 5) selecting who to do business with; 6) making acquisitions; 7) liquidating, dissolving, selling out, or recapitalizing the business; 8) selling or acquiring treasury shares; 9) going public; 10) paying dividends; 11) amending the articles of incorporation and bylaws.[361]

Factors that diminish control rights include: 1) cumulative voting; 2) contractual restrictions;[362] 3) government regulations; 4) financial condition of the business; 5) rights of minority owners under statutes and case law; 6) whether control is composit.[363]

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358 *Estate of Chenowith v. Commissioner*, 88 T.C. 1577 (1987) (control premium added to 51% interest in corporation).

359 Hood, Mylan & O'Sullivan, "Valuation of Closely Held Business Interests," 65 UNIV. MO. AT KANSAS CITY L. REV. 399, 440 (1997). Such a diminution of control rights should mitigate the offsetting minority discount. Shannon P. Pratt, VALUING A BUSINESS: THE ANALYSIS AND APPRAISAL OF CLOSELY HELD COMPANIES, p. 58 (2nd ed. 1989).

360 Shannon P. Pratt, VALUING A BUSINESS: THE ANALYSIS AND APPRAISAL OF CLOSELY HELD COMPANIES, p. 55 (2nd ed. 1989).

361 Shannon P. Pratt, VALUING A BUSINESS: THE ANALYSIS AND APPRAISAL OF CLOSELY HELD COMPANIES, pp. 55-56 (2nd ed. 1989).

362 An example would be restrictions on the business imposed by lenders.

363 Shannon P. Pratt, VALUING A BUSINESS: THE ANALYSIS AND APPRAISAL OF CLOSELY HELD COMPANIES, pp. 57-58 (2nd ed. 1989). "Composit control" describes the situation where a minority interest gains control by allying with other minority owners to achieve voting control. *Id*., pp. 57-58.