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Harvard Medical School

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Psychiatrists as Expert Witnesses

TO THE EDITOR: My congratulations to Renée L. Binder, M.D. (1), for her extensive review and thoughtful synthesis of the liability issues facing forensic expert witnesses in psychiatry and otherwise. Two themes were stimulated by that article.

First, the case quotations from the article seem to capture a more fundamental question than simply holding experts liable or not: the fundamental ambivalence that the law has for using experts at all. As in all hostile-dependent relationships, the ambivalence flows from the fact that the law both needs experts for its proper functioning, yet resents their potential role in "invading the province of the fact finder" (2). With such ambivalence, we cannot expect consistency from the courts on the matter.

The second theme is the concept I have elsewhere styled "the phantoms of the courtroom" (2). This term means that the actual attorneys and judges are treated by the legal system as though they were invisible. That is, when a ruling comes down in the case of *Smith v. Jones*, the language is, "The court found that Jones failed to plead the proper argument" when what is meant is that a specific person, Judge Leonard Adversarian, decided that Mel Feasance, Jones's lawyer, failed to do the proper thing. Jones himself would likely not know a proper argument if it bit him. But the judge and the attorney are concealed by "the court" and the named client.

This latter device is especially clear in the discussion dismissing cross-examination as a safeguard against inappropriate testimony (1, p. 1821):

> The Louisiana courts have acknowledged…that cross examination "seldom is of adequate value when thrust against the broadside of the litigation expert who can so gracefully stiff-arm his *unprepared* cross examiner. (emphasis added)

Here the regrettable but somehow expected lack of preparation by the attorney seems somehow to be at the root of the problem of the expert's testimony. Indeed, experience teaches that many a flaw in court procedure flows from attorney lack of preparation, a problem blamed on the witnesses, the parties, and even the judge—but not the invisible attorney.

In any case, our anxieties about insufficient employment of attorneys may be assuaged by this new territory of potential litigation.

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THOMAS G. GUTHEIL, M.D.
Boston, Mass.

Comment on Adult Baby Syndrome

TO THE EDITOR: We found the recent Clinical Case Conference by Jennifer E. Pate, M.D., and Glen O. Gabbard, M.D. (1), fascinating and illuminating. A similar case has also been described in a compendium of "interesting cases"(2). Recently, we had the opportunity to treat a patient with similar thoughts and symptoms. This patient had a higher level of psychiatric morbidity than the patient of Drs. Pate and Gabbard, and some clinicians involved felt that his symptoms were best explained by an obsessive-compulsive disorder (OCD) spectrum illness.

> **Mr. A was a 32-year-old, single Caucasian man who was referred to the inpatient psychiatric unit for symptoms of depression and a suicide attempt. In addition, he had recurrent, intrusive thoughts and behaviors involving wearing diapers, crawling on the floor, "anything relating to babies," and becoming a baby. These secretive, ego-dystonic thoughts and behaviors had plagued him since the age of 7. Furthermore, he adamantly denied any sexual gratification related to or connected to these thoughts and behaviors. During his hospitalization, he was treated with fluoxetine (titrated to an oral dose of 60 mg/day). Risperidone at an oral dose of 1 mg b.i.d. was later added to target his psychotic symptoms. He reported good relief from these interventions with regard to depressive symptoms and the aforementioned thoughts and compulsions. On admission, his score on the Yale-Brown Obsessive Compulsive Scale (3) was 22 (3 at follow-up). During his hospitalization and subsequent outpatient treatment, a psychodynamic approach was helpful in attempting to understand Mr. A and his symptoms. This was coupled with supportive psychotherapeutic techniques. Over the course of two inpatient hospitalizations and several months of intensive outpatient treatment, he improved and eventually left the area to live near family.**

When reviewing this case and studying that of the authors, several questions come to mind. Clinicians involved in the treatment of Mr. A often questioned whether his symptoms represented OCD, a paraphilia, or some new diagnostic entity. We respect the value of a psychodynamic understanding and approach in the case of the patient of Drs. Pate and Gabbard but also question if pharmacotherapy was considered during his brief presentation. Further information would have been useful, such as the extent to which he dwelt on the thoughts of "being a baby" throughout the day. In the case of Mr. A, the act of "being a baby" led to an episode of major depression with a suicide attempt. Other authors have postulated that some paraphiliacs may have subthreshold OCD and may benefit from serotonergic agents (4).

The views expressed are those of the authors and do not reflect the official position of the Department of Defense or the Department of the Army.

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PAUL CROARKIN, D.O.
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