CHAPTER 4

Forensic Psychology, Forensic Psychiatry, and Criminal Profiling

The Mental Health Professional’s Contribution to Criminal Profiling

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CONTENTS

Psychology and Psychiatry .......................................................... 102
Insanity and Competency to Stand Trial ........................................ 103
Case Example: Andrea Yates ......................................................... 102
Case Example: Jeffrey Dahmer ...................................................... 106
Case Example: O. C. Smith ........................................................... 107
Psychics ....................................................................................... 112
Forensic Psychologists and Psychiatrists as Profilers ....................... 113
Practice Is an Art .......................................................................... 114
Need for Critical Thinking ............................................................ 114
Independent Analysis .................................................................. 115
Review of All Available Data ........................................................ 115
Reliance on the Facts of a Particular Case or Cases ......................... 116
Need to Avoid Advocacy ................................................................ 116
Contextual Differences ................................................................. 117
Ethical Practice ............................................................................ 117
What Would a Forensic Psychiatrist of Psychologist Need to Competently Profile? ........................................... 117
Role of the Forensic Psychologist or Psychiatrist as Profiler ............. 117
Psychological Pitfalls and the Profiler .............................................. 117
Bias ............................................................................................... 117
Transference ................................................................................ 117
Projection ..................................................................................... 117
Summary ....................................................................................... 118
Questions ..................................................................................... 118
References .................................................................................... 119
KEY TERMS

<table>
<thead>
<tr>
<th>Competency to stand trial</th>
<th>Forensic psychologist</th>
<th>Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Countertransference</td>
<td>Forensic psychology</td>
<td>Transference</td>
</tr>
<tr>
<td>Forensic psychiatrist</td>
<td>Insanity (a.k.a. criminal responsibility)</td>
<td></td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Forensic psychology* and *forensic psychiatry* refer to the application of the behavioral sciences to legal questions (Hess, 1999). Common psychologal questions that forensic mental health professionals answer involve (1) risk for future sexual offense recidivism, (2) competency to stand trial, and (3) criminal responsibility/sanity at the time of the offense. In addition, forensic psychologists and psychiatrists, with their knowledge of human behavior, can add a unique perspective to ongoing investigations in the form of offender profiling. Profiling is often poorly understood, even by practitioners. Popular lore, driven by films and books, leads many to believe profiling is part of forensic psychology. In fact, few profilers have any background in the psychological sciences.

**PSYCHOLOGY AND PSYCHIATRY**

Psychology and psychiatry are two closely related fields but have some important differences. Both fields rely on the behavioral sciences. Psychiatrists are physicians who specialize in psychiatry after completing medical school. They can evaluate patients, diagnose illnesses (both psychological and medical), and prescribe medication. Psychologists are doctoral-level clinicians. They have studied psychology and have various levels of training in conducting research. They also are qualified to perform and interpret psychological measures, such as personality assessments, intelligence tests, and neuropsychological testing. There are practitioners in both forensic psychiatry and psychology who gained their expertise through experience, but currently there is an expectation that one has taken some advanced education and training to qualify as an expert in these fields (Bersoff et al., 1997).

In forensic work, the client can be the court (for a court-ordered assessment), or it can be one of the attorneys (retaining an expert to perform an assessment of an individual). The person (i.e., a defendant) evaluated in the forensic context may refuse to cooperate, and the forensic psychologist or forensic psychiatrist may have to complete the evaluation based solely on collateral information, although this is not common. Reliable collateral information is important in clinical and forensic evaluations and is essential in forensic assessments.

A pitfall for the clinician is performing both a therapeutic and a forensic role with the same person. Ethical guidelines generally recommend avoiding such a scenario (Committee on Ethical Guidelines for Forensic Psychologists, 1991). It is difficult if not impossible to maintain an objective mindset when you have had, or have, an ongoing relationship with a person who has a vested interest in what expert opinion you form. For example, how can a psychiatrist maintain objective neutrality when evaluating his own patient for psychological damages when he knows the patient is in dire financial straits? How can a clinician provide ongoing therapy to someone who may hold onto symptoms (consciously or unconsciously) that may lead to financial gain in a pending lawsuit where he or she is an expert witness for the patient? Such ethical conflicts must be both acknowledged and resolved.
Insanity and Competency to Stand Trial

Forensic mental health professionals may conduct evaluations in both civil and criminal cases. Civil cases involve matters related to property or torts (i.e., injury or some other loss that can be addressed through a lawsuit). Some evaluations involve risk assessments and child custody evaluations, for example. Criminal cases are those that involve a criminal act. Some common criminal evaluations are criminal responsibility at the time of offense (sanity) and competency to stand trial.

**INSANITY AND COMPETENCY TO STAND TRIAL**

Inability to stand trial is often equated with insanity, when that is not the case. Competency to stand trial relates to a defendant's current ability to understand his or her legal predicament (e.g., charges, possible outcomes) and to assist an attorney with his or her defense (Roesch et al., 1999). Insanity (or criminal responsibility) relates to the defendant's mental state at the time of the offense (Golding et al., 1999). There are different standards in different jurisdictions, but generally a person needs to be able (at the time of the crime) to understand that what he or she was doing was wrong or against the law. Many assume that a severe mental illness makes one incompetent or insane, but that also is not the case. While a severe mental illness (such as schizophrenia or bipolar disorder) or mental defect (such as mental retardation or brain trauma) is a prerequisite, such a disorder must then lead to an inability to meet the legal criteria for either competence to stand trial or criminal responsibility.

It is commonly believed that someone who has been acquitted by reason of insanity has “gotten away with it” (Hans and Slater, 1983). In reality, the insanity defense is rarely used and even more rarely succeeds. When it does result in an acquittal, the individual is usually committed to a secure mental health facility. It is a well-known fact in legal circles that individuals who successfully plead insanity are usually hospitalized (kept in a mental health facility) for much longer than they would have been incarcerated if they had pleaded or been convicted at trial (Callahan et al., 1992; Sloat and Frierson, 2005).

**Case Example: Andrea Yates**

The case of Andrea Yates (Figure 4.1) is well known, both because of the psychiatric aspects of the case and because of the accompanying issues regarding psychiatric testimony. It is illustrative of typical and atypical features related to forensic mental health assessment. Yates was a mother of five children, ranging in age from 6 months to 7 years old. She had suffered from depression (believed to be postpartum depression) and psychosis for some time and had been treated with antipsychotic medication and antidepressants (Parnham et al., 2004). In 1999, she had attempted suicide by overdose, taking her father’s medication. In March of 2001, her father passed away and it appears she began to deteriorate from then on. She was hospitalized and released to outpatient care shortly before the homicides. Two days before the killings, she was seen by her psychiatrist, who lowered her antidepressant medication but kept her off antipsychotic medication. On June 20, 2001, after her husband had gone to work, Yates methodically drowned her five children. She then called 911 to report what she had done and called her husband at work. Yates was taken into custody, and the judge issued a gag order around the case.

Yates told examiners that she believed she was not a good mother, that the mark of the devil was hidden under her hair, and that her children would suffer in Hell. At the time of her arrest and incarceration, the jail psychiatrist reported that Yates had no insight into her mental illness, was "profoundly" depressed, and

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1 Unless otherwise indicated, information related to the Yates case was drawn from the appellant brief filed with the Texas First District Court of Appeals. Quotation marks indicate text quoted from the brief, not necessarily actual quotes of speech.
was psychotic (not in touch with reality). For example, she thought that the cartoons her children watched "were sending them messages" (p. 29).

Andrea Yates reported to the psychiatrist that she began hearing voices after the birth of her first child. She also said she heard growling noises and reported "feeling" she was in the presence of Satan. Further, the children were not doing well (spiritually) and it was her fault. "She was convinced they were doomed to suffer in the fires of Hell." It was the psychiatrist's impression that Yates was "actively hallucinating [hearing voices] during the interview." Yates advised it was her belief that "her children would be tormented and they would perish in the fires of Hell if they were not killed" (p. 30). Yates was diagnosed with major depression, with psychotic features, with onset postpartum (i.e., postpartum psychosis). The jail psychiatrist advised during trial that Andrea Yates was the sickest patient she had ever treated. A psychologist performed neuropsychological testing on Yates while she was incarcerated. It was the psychologist's opinion that she suffered from schizophrenia and a comorbid depressive disorder.

In a high-profile case like this, questions related to competency to stand trial quickly surface and the defense moved to have Yates found incompetent. In September 2001, a jury deliberated over two days after hearing expert testimony from both defense and prosecution experts, to determine if Yates had "a rational as well as factual understanding of the proceedings against her" and the ability to work with her attorneys. The jury found Yates competent to proceed with her legal case. A different jury would later hear the criminal case.

There seemed to be no question that Yates was psychiatrically very ill. The question for the court was whether she met the criteria under Texas law for an insanity defense. The Texas statute requires that the person (as a result of a severe mental disease) did not know that what he or she was doing was wrong at the time the person did it.
Several defense experts testified that, in their opinion, Yates was unable to know right from wrong at the time she killed her children. One defense expert, Dr. Phillip Resnick, saw Yates several weeks after the homicides and again several months later. He noted that over time, Yates had memory alterations related to the events. This is important, as the new or altered memories are “often more rational” because of clinical improvement in the individual, in this case because of appropriately prescribed medication. Dr. Resnick testified that it was “possible for an individual to believe that an act was illegal, but yet not perceive it as wrong” (p. 40). The case, to a great extent, centered on whether Yates understood that killing her children was considered a criminal act. She did. She understood that society would see her behavior as bad. But, as Dr. Resnick testified, she believed the homicides were the right thing to do as Satan was inside her and her children would suffer eternal damnation if she did not kill them. She did, however, know the difference between right and wrong. So even though she believed what she was doing was right in a moral sense, she knew what she was doing was wrong in a legal sense.

Dr. Park Dietz (Figure 4.2), a forensic psychiatrist, was the only expert in behavioral science who testified for the prosecution. He examined Yates on November 6 and 7, 2001. By then she had been treated with antidepressant and antipsychotic medications. Dr. Dietz agreed that Yates suffered from a major mental disorder, schizophrenia, but disagreed that she met the criteria in Texas for an insanity defense. In assessing Yates’s ability to appreciate the wrongfulness of her actions, he divided the crime into three phases: prehomicides, homicides, and posthomicides. In the prehomicide phase, he noted that Yates hid her plan from others and attributed the impetus for the killings to Satan. This negates the fact that she hid what she was planning because carrying out the plan was necessary to save the children’s souls. If she had told someone and was stopped, (in her mind) the children would suffer eternal damnation. He testified (p. 53) that if she believed her children were in danger or that Satan was inside her, she would have sought counseling or help in dealing with the situation. This line of reasoning imposes a rational standard on an irrational psychotic process. Regarding the homicides phase, he noted that Yates admitted that she knew her actions were illegal, that she would be arrested, and that society would see her behavior as “bad.” Dr. Dietz opined if Yates actually believed she was saving her children, “she would have attempted to comfort them before the drownings.” That may or may not be accurate. Once again, a rational standard was applied to a psychotic act.

In the posthomicide phase, Dr. Dietz opined that covering the children’s bodies was evidence of “guilt or shame over her actions.” This is an opinion, not a fact. It may be accurate, and it may not. Regardless, the emotion of shame or guilt after killing one’s children does not rule out having acted for their ultimate benefit. Also, she had told the 911 operator that she had done “something wrong,” needed to be punished, and was ready to go to Hell. Yates had voiced a belief that her execution would kill Satan, but Dr. Dietz said she did not mention that at the time of the homicides. He gave his expert opinion that “at the time of the drownings, Ms. Yates knew her actions were wrong in the eyes of the law, wrong in the eyes of society and wrong in the eyes of God” (p. 55).

Dr. Dietz testified at the trial that weeks before the homicides, Yates had watched an episode of Law & Order on television in which a woman drowned her children and was found not guilty by reason of insanity. The fact that Yates watched Law & Order was included in information from an expert who had evaluated her for competency to stand trial. It was later noted that no such episode aired.

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2 If God had allowed Abraham to complete the sacrifice of his son, Isaac, would Abraham not have felt some guilt and shame at what he had done? Would he have covered the body?
Additionally, the prosecution used the nonexistent episode in cross-examining a defense expert (p. 62). Finally, the prosecutor used the issue of the nonexistent episode during summation (p. 63): "She gets very depressed and goes to Devereux and at times she says these thoughts came to her during that month. These thoughts came to her, and she watches 'Law and Order'; regularly she sees this program. There is a way out. She tells Dr. Dietz, that there is a way out."

A producer of Law & Order contacted the defense to advise that no such episode had ever been made. When it was brought to Dr. Dietz’s attention that his testimony was false in regard to the Law & Order episode, Dr. Dietz wrote a letter, dated March 14, 2002, to the district attorney’s office advising of the situation. "I also wish to clarify that Mrs. Yates said nothing to me about either episode or about the Law & Order series." The court rectified this by giving a stipulation to the jury that, if Dr. Dietz would testify, his testimony would be that he was in error regarding the Law & Order episode. This was after the verdict, but before sentencing.

Yates was convicted of capital murder in the deaths of three of her children and sentenced to life in prison. An appeal was filed on January 6, 2005, and the Texas First Court of Appeals overturned her conviction. After a retrial, on July 26, 2006, Yates was found not guilty by reason of insanity for the deaths of three of her children, Noah, John, and Mary.

**Case Example: Jeffrey Dahmer**

In some cases, FBI-trained profilers have waded into the water of forensic mental health assessment. One of the first cases on record, and certainly one of the most notorious, was that of Jeffrey Dahmer. This case involved mental health professionals and FBI profilers alike.

On July 22, 1991, police officers arrested Jeffrey Dahmer. A handcuffed man had escaped from Dahmer’s apartment and was spotted by two Milwaukee police officers. Upon questioning, the man reported an encounter with a man that left him very uncomfortable and gave police the address of an apartment. Jeffrey Dahmer opened the door. Pictures of bodies and body parts, as well as body parts (including heads), were found in the apartment. Subsequent investigation revealed a 13-year killing spree.

Dahmer killed 17 victims between 1978 and 1991. His modus operandi was to invite homosexual men or boys to his apartment and drug them. When they were incapacitated, he would strangle them. He reported having sex with some bodies and occasionally eating body parts. Dahmer decided to plead guilty but insane (available in Wisconsin law) and went to trial. He was found guilty in 1992 and sentenced to 15 consecutive life terms. In November 1994, while Dahmer was in prison, another inmate killed him.

At Dahmer’s trial, defense and prosecution experts offered opinions as to his sanity. Insanity was a hard sell, as Dahmer did not have a major diagnosable mental illness (to the level of a psychosis), in spite of the bizarre nature of his crimes. Although Dahmer had initially entered a plea of not guilty by reason of insanity, he changed this to a plea of guilty but insane. A not guilty by reason of insanity adjudication is an acquittal; a guilty but insane adjudication is a guilty verdict. Consequently, this would result in Dahmer’s serving his sentence in a psychiatric facility under the jurisdiction of the corrections department in Wisconsin. Once “cured” (i.e., not requiring psychiatric hospitalization), he would be sent to a regular prison.

As previously mentioned, a former FBI profiler evaluated Dahmer for the defense. This was a scenario that was essentially unheard of before the Dahmer trial. Robert Ressler, one of the more notable members of the FBI’s Behavioral Science Unit, had retired from the FBI in 1990. In one of his co-authored memoirs, I Have Lived in the Monster (Ressler and Shachman, 1997, pp. 107–160), he describes his interview/evaluation of Dahmer. Ressler makes it clear (p. 109) that he believed he was evaluating Dahmer’s “mental condition.” The result of an evaluation of Dahmer’s mental condition was relevant to Dahmer’s plea of guilty but insane, and
should have been conducted by a qualified psychiatrist or a psychologist. Even Ressler admitted (p. 108): “It was unlikely that I would ever get to testify in this case, because of the presence of expert psychiatrists on both sides.” He noted: “My friend Park Dietz was going to appear for the prosecution, but in this instance my opinion differed from his and I agreed to consult for the defense” (p. 107). Since Park Dietz, a forensic psychiatrist, had the opinion that Jeffrey Dahmer was sane at the time he committed his crimes, if Ressler had a different opinion, it would seem reasonable to infer that his opinion was that Dahmer was insane. In another paperback memoir (Ressler and Shachtman, 1992, p. 280), the former FBI profiler stated: “There was no way to view this tormented man as having been sane at the time of his crimes.” It could be argued that Ressler appeared willing to offer an expert opinion that Dahmer was insane. He did not, however, appear in court. The salient point is that Ressler, who is neither a psychologist nor a psychiatrist, appeared willing to offer what he believed was an expert opinion as to Dahmer’s responsibility in the commission of his crimes (Figure 4.3).

Ressler’s involvement in the Dahmer case highlights the danger when those with investigative experience confuse or conflate their presumed area of expertise with other professions. Note the following section from I Have Lived in the Monster (Ressler and Shachtman, 1997, pp. 107–108):

> in my view, Dahmer was neither a classic ”organized” nor a classic ”disorganized” offender: while an organized killer would be legally sane, and a disorganized one would be clearly insane under law, Dahmer was both and neither—a ”mixed” offender—which made it possible that a court could find him to have been insane during some of the later murders.

Aside from the fact that Ressler relied on a dichotomy that has never been validated and is essentially worthless from any perspective, investigative or scientific, he attached psycholegal meaning with apparent implied certitude to an investigative tool. This is not an acceptable practice.

**Case Example: O. C. Smith**

Dr. O. C. Smith was a locally well-known physician and was at one time the medical examiner for Shelby County, Tennessee. Dr. Smith left work on June 1, 2002, a Saturday night, and was found several hours later by a security guard. The doctor was tied with barbed wire to a window grate in an outside stairwell and had an explosive device around his neck. He also had chemical burns to parts of his face from a caustic material allegedly thrown in his face by the assailant. He stated he had been attacked by a man and tied with the wire, as if crucified. The man only spoke briefly to him and left. “Push it, pull it, twist it, and you die. Welcome to death row.”

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3 The organized/disorganized dichotomy is discussed in Chapter 3, “Criminal Profiling: Science, Logic, and Cognition.”
A bomb squad removed the device. They determined that the device was real and could have exploded. The local police, the Bureau of Alcohol, Tobacco and Firearms (ATF), and the FBI each performed their own investigation of the case. This level of interest came in part because, three months earlier, another explosive device had been left in a hallway in the building where Dr. Smith worked. Additionally, a year earlier, a letter had been sent to the district attorney’s office threatening Dr. Smith. However, early in the investigation into the attack on Dr. Smith, federal investigators were forming the opinion that he was not telling the truth.

The case of Dr. O’Brien C. Smith (Figure 4.4) is interesting on several levels. First, it presents an investigative dilemma: Was the doctor a victim or a liar? Second, without actually having interviewed Dr. Smith, a forensic psychiatrist attempted to present trial testimony that the doctor suffered from a mental illness, the diagnosis of which relied on wanting to be a victim of a crime. Third, an ex-FBI profiler submitted a report for the prosecution wherein he appears to come close to offering a psychological opinion.

As noted, federal investigators doubted Dr. Smith’s story, for several reasons. For one thing, although a caustic chemical was thrown into his face, none got into his eyes. Also, while barbed wire had been wrapped several times around Dr. Smith’s face and head, there was limited injury. Further still, investigators were leery of his claim of being overpowered, especially when he was known to carry a firearm on occasion. On the other hand, there was no doubt that the device attached to his chest was a live explosive and could have gone off. Dr. Smith was arrested for lying to federal authorities and illegally possessing an explosive device. They pressed forward with charges in federal court. Ultimately, local authorities made no such charges.

**FIGURE 4.4**
Dr. O. C. Smith as photographed while receiving medical attention on the night he was found in 2002.
Dr. Park Dietz submitted a report to the attorney general’s office (Dietz and Ankrom, 2004) and was prepared to testify for the prosecution that, in his opinion, Dr. Smith suffered from a mental illness recognized by Dr. Dietz, specifically factitious victimization disorder. While others have used the term factitious victimization, it has had limited use in the context of being a diagnosable mental illness. The concept has been used more broadly in the context of describing a behavior (i.e., falsely claiming oneself or another to have been a victim of a crime or situation when that claim is false). Dr. Dietz was proposing that such behavior is diagnosable as a discrete mental illness. The first known public reference to factitious victimization by Dr. Dietz is in a *Time* magazine article in April of 2004 (Fonda, 2004). In this article (on the false report of Audrey Seiler that she had been abducted), Dr. Dietz is cited as stating that false reports of being a victim that are not motivated by money or revenge are rare. The infamous Tawana Brawley case was mentioned, noting that Dr. Dietz testified to the grand jury in 1988. The grand jury did not believe the black teenager’s claim of gang rape by several white men. "Dietz coined the term factitious victimization disorder to describe what occurs when someone claims to be a victim to win sympathy and support. The motives for individuals who stage their own victimization range from trying to get out of exams to stirring a boyfriend to pay more attention, Dietz says. “There is no mention in the article that Dr. Dietz was claiming that factitious victimization was a mental disorder.

In the “Analysis, Discussion and Conclusions” section of the Smith report, Dietz notes (p. 43):

> Behavioral analysis of the facts of this case suggests that the events in question are the product of a mental disorder suffered by the defendant. The phenomenon would account for this behavior is well-known in certain mental health and law enforcement circles, but is not familiar to most laymen.

This is an interesting statement, as familiarity with the case would not lead to this assertion. There is nothing in the facts of the case, even if one assumes Dr. Smith was lying about the assault, requiring the introduction of a mental illness to explain either the “facts” or the motivation. Also, the purported mental illness is not as “well known” as described. There is very little published literature that discusses the concept of false victimization and even less that claims it is a diagnosable mental disorder. Describing the psychodynamics of a behavior does not make the behavior a diagnosis.

Dr. Dietz presents his argument by noting that psychiatry has a category of mental illnesses that falls under the category of factitious disorder (FD) in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). This category covers a mental illness wherein a person presents physical or psychological symptoms to obtain whatever psychological benefit that would accrue from the role of being ill. Munchausen’s syndrome may be the most familiar form of a factitious disorder. In this illness, a person is motivated to appear physically ill, often undergoing diagnostic tests and even operations in an effort to assume the sick role. The DSM-IV-TR specifically preempts having external incentives for the behavior(s). In other words, the goal of the illness is to assume the sick role, not to make money (as in a lawsuit), or to get out of work, or to evade some other responsibility. These behaviors (e.g., feigning or exaggerating symptoms for secondary gain) are better described as malingering. There are two main types of FD: FD in which psychological symptoms dominate the picture and FD in which physical symptoms predominate. There is also an FD Not Otherwise Specified (NOS), which allows for the diagnosis of FD when the clinical picture consists of factitious symptoms not meeting the criteria of the first two mentioned. The most famous example of FD NOS is Munchausen’s syndrome by proxy, whereby a

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4 Dr. Dietz had not examined Dr. Smith, as the defense declined the opportunity. Therefore, Dr. Dietz worded his opinion: “I conclude with reasonable medical certainty that a clinician examining the defendant who had access to all of the above-referenced data would conclude that at the time of the events in question, the defendant suffered from Factitious Disorder Not Otherwise Specified, specifically Factitious Victimization” (p. 48).
caretaker reports or induces signs or symptoms of illness in another, often a child. Please note well that the motivation remains one of assuming the "sick role." In Munchausen's by proxy, the role of caretaker of an ill child is usually expected to garner sympathy for the caretaker. Although it is not required for diagnosis, there is an expectation that one who suffers from factitious disorder has an inner compulsion to act out the behaviors that lead to the diagnosis and therefore that the sufferer would have a history of numerous episodes/events over the course of years. The case of Dr. O. C. Smith does not fit the diagnostic category of factitious disorder.

Dr. Dietz (2004, pp. 43–45) presents a literature review (Burgess and Hazelwood, 2001; Dohn, 1986; Eisendrath, 1996; Eke and Elenwo, 1999; Feldman et al., 1994; Feldman-Schorrig, 1996; Fliege et al., 2002; Ford et al., 1988; Gibbon, 1998a, 1998b; Goldstein 1998; Gutheil, 1989, 1992; Kanin, 1994; Matas and Marriott, 1987; McDowell and Hibler, 1987; Pathe et al., 1999; Sederer and Libby, 1995) related to factitious disorders and false allegations of sexual assault, highlighting that for something to be factitious the reporter (by definition) has to be lying. He then relies on the fact he has assumed Dr. Smith to be lying to form the opinion (p. 44): "If Dr. Smith self-inflicted the chemical burns and abrasions that he suffered during the events in question, a diagnosis of factitious disorder would be technically correct." The authors would argue that this is circular reasoning. Dr. Dietz then goes on (p. 44) to opine that (assuming he is correct in making a diagnosis of factitious disorder): "it would be more accurate and insightful to regard the event as factitious victimization, since the role he sought to acquire was that of a crime victim rather than a patient."

In Dr. Dietz's report, he offers 18 articles or chapters (noted earlier) as he makes his case for a diagnostic entity of factitious victimization. The sources cover the topics of factitious disorder in general, false reports of sexual assaults, and the concept of false reporting of a crime as a type of factitious disorder. Sources that (in the authors' opinion) discuss the diagnosis of factitious victimization, factitious sexual assault, factitious sexual harassment, or factitious report of a crime number only 6 (Dohn, 1986; Eisendrath, 1996; Pathe et al., 1999; Feldman et al., 1994; Feldman-Schorrig, 1996; Gibbon, 1998b), encompassing a total of 12 cases.

Dr. Dietz, assuming he has proven that the scenario surrounding Dr. Smith falls into the category of a diagnosable factitious disorder (which the authors do not accept), then goes on to claim Smith meets criteria for the new diagnostic subcategory of factitious victimization. On page 44 of the report, Dr. Dietz specifically notes he has described scenarios wherein someone falsely reports being a victim of a crime as "factitious victimization" and states that in DSM-IV it would fall under Factitious Disorder Not Otherwise Specified. As (apparent) criteria for this diagnosis, he lists (p. 45): (1) "Childhood trauma or loss, such as abuse or emotional deprivation during childhood, as this is a risk factor." (2) "A prior history of false allegations, as such behavior is often repetitive. If the defendant were the author of the [MJ] communications, this factor

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5 Apparently without knowing this to be the case, as he states (p. 45), when assuming the doctor is a pathological liar, a fact that was not established: "If any of the following unlikely stories were to prove untrue, as I expect they will [emphasis added], this factor [pathological lying] would be present." Note well that Dr. Dietz indicated only one "unlikely story" would be enough for him to make a diagnosis of pseudologia fantastica. This would seem to be a ridiculously low threshold.

6 One case report of a false "diagnosis" of rape.

7 One report of a woman who falsely reported a physical assault.

8 One case of factitious stalking.

9 Four cases of false reports of rape.

10 Four cases of factitious reports of sexual harassment.

11 One case report of a false report of rape.

12 Three threatening letters sent in 2001 to a defense attorney, a district attorney general, and a newspaper reporter. The letters contained religious references and appeared to reference Dr. Smith's involvement in the Workman death penalty case.
would be present.” (3) “A prior history of intentionally self-inflicted wounds. If any of the defendant’s scars were the result of intentionally self-inflicted injury, this factor would be present.” (4) “Pseudologia fantastica, a form of pathological lying.” There is no known validity or reliability to these four criteria being used to make a diagnosis for a disorder that is not an agreed-upon diagnostic category. Criterion 1, if interpreted broadly enough, includes half or more of the human race. Criterion 2 (in the O. C. Smith case) presumes guilt, a fact that has not been established.

If taken at face value, the diagnosis of factitious victimization can be made if one has had a childhood trauma or loss, a prior history of a false allegation, a prior history of a self-inflicted injury, and one is a liar. What appears lost in all this is that Dr. Dietz gives as a motivation for the behavior (p. 46):

The available record suggests that Dr. Smith was losing control at the Medical Examiner’s Office, had a history of repeated marital infidelity, became excessively involved with the Workerman case, and was exposed to a high-profile case in which a man had a bomb affixed to his body. These factors are likely to be involved in his decision to use this particular form of bomb-related pseudo-crucifixion to expiate his guilt, achieve a form of martyrdom, gain the sympathy of his coworkers and family, and elicit the support of the wider law enforcement community whom he betrayed.

Note well that Dr. Smith’s guilt had not been established, and it was not clear how well founded some of the assumptions (e.g., that Dr. Smith was a pathological liar and inflicted wounds on himself in the past) were on which Dr. Dietz appears to rest his opinion. Regardless, there is nothing in the motivation requiring the diagnosis of a mental illness called factitious victimization. If one has lied about being the victim of a crime to be seen sympathetically by others and to take pressure off oneself, this does not require diagnosis of a specific mental disorder related to lying about being a victim of a crime to make sense. Dietz further notes (p. 46) that “His motivation for staging the events was psychological and not intended to produce monetary or other obvious external gain,” yet the authors would argue that the very things listed by Dietz are external gains. Simply because some gains are “psychological” does not make it a mental illness. Even if one assumes that Dr. Smith arranged events to garner sympathy, one does not need to diagnose a mental illness to explain the behaviors. Diagnosing (as opposed to understanding) behaviors can be brought to absurd levels, as offered by Feldman and Hamilton (2006) when they seem to suggest that the “role of unemployed person” is a potential and treatable illness. Apparently one can diagnose it by identifying a “job-hopper” who appears to be looking for employment but sabotages his or her success in various ways. The authors would suggest that any diagnosis of such a malady, as well as many so-called factitious disorders, can be adequately described or diagnosed under a different rubric, such as a personality disorder or antisocial behavior.

Gregg O. McCrary, a retired FBI profiler, also submitted a 56-page report in the Smith case (McCrary, 2005). It was his opinion after reviewing the evidence that the June 1–2 (the event crossed midnight), 2002, crime scene was staged. He went further, stating (p. 45):

Presenting a false crime is analogous to “Munchausen’s syndrome” wherein an individual presents with a feigned or self induced illness. ... This syndrome is based on a pre-occupation with manipulation. ... Rather than feign or produce an ostensibly legitimate illness, some individuals feign or create an ostensibly legitimate crime. The goal is to manipulate the criminal justice system in the service of underlying pathological needs. Because the condition is chronic, most individuals who do have this have a history of other attempts that tend to be less dramatic in content. This lesser efforts

33 The only high-profile case found by the authors where a bomb was strapped to a person occurred on August 28, 2003, when a pizza delivery man robbed a bank and was killed when the device exploded. This was about a year after Dr. Smith was found wrapped in barbed wire with a bomb around his neck.
[sic] may include self-inflicted and pathological lying usually involving stories of dramatic events in which the individual is central. ... Based upon the totality of the circumstances, it is my opinion that the April 2001 letters, the March 13, 2002 discovery of incendiary and explosive devices ... and the alleged assault on Dr. O. C. Smith on June 1–2, 2002 are related incidents, staged by Dr. Smith for unknown psychological reasons.

One might be tempted to believe that McCrory is offering a psychological opinion here. Although not explicitly offering a diagnosis, he has equated Dr. Smith’s report of assault and harassment with a chronic (mental) disorder due to a psychological motivation. The point must be made again: simply being able to offer a psychological explanation for a behavior does not make it a mental illness.

As with Ressler in the Dahmer case, the question of whether McCrory is qualified to make such inferences is appropriate. On his website (www.criminalprofiler.com), McCrory’s biography notes he is an adjunct professor of forensic psychology at both Marymount University in Arlington, Virginia, and Nova Southeastern University in Ft. Lauderdale, Florida. He was awarded a B.A. degree in fine arts from Ithaca College in New York and did graduate work in criminal justice at Long Island University. Additional graduate work at the University of Virginia is cited, but a specific area of study is not mentioned. McCrory was awarded a master’s degree in psychological services from Marymount University of Arlington, Virginia, in 1992. However, this is not a degree one would be expected to pursue to practice as a psychologist. It appears better suited to prepare one for further study or to practice as a school guidance counselor.

There is a further discrepancy, however. When he was retained in the Sam Sheppard civil case in 2000 (The Estate of Sam Sheppard v. State of Ohio, Case No. 312322), McCrory’s curriculum vitae (CV) listed his 1992 degree as a master’s of arts in psychological services. When retained for the O. C. Smith case, McCrory’s CV listed his degree as a master’s of arts in psychology, a degree Marymount University did not offer in 1992. 14

McCrory did not appear as a witness in the Smith trial. After a pretrial evidentiary hearing, Dr. Dietz was allowed to testify to the existence of factitious disorders, including factitious victimization. He was not allowed to specifically opine that Dr. Smith suffered from one, as he had not examined him. 15 The jury could not reach a verdict, and a mistrial was declared. Eventually, all charges were dropped in lieu of a new trial, all but exonerating Dr. Smith.

**Psychics**

The issue of psychics must be addressed because many law enforcement agencies will “use” a psychic “when all else fails.” Unfortunately, this lends credence to the belief that psychics are real. Robert Ressler brought a psychic to the FBI academy to lecture (Ressler and Shachman, 1992). John Douglas (Douglas and Olshaker, 1995, p. 148) suggests that psychics “should be a last resort.” While waiting until other means have failed is helpful, this mentality still endorses the use of psychics in criminal investigations. That law enforcement ever uses a psychic is sad commentary on our society, but occasionally law enforcement officers lament that if they don’t use a psychic on a cold case they will be pressured to do so by family or some other quarter. 16

The authors were not sure whether to list Micki Pistorius, a South African criminal profiler, as a psychologist or a psychic. 17 Ultimately, we do so as a commentary, and cautionary tale, regarding psychics who cloak their advice with psychological garb to imply legitimacy.

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14 All documents are on file with the author and editor of this text.
15 As previously mentioned, the defense had declined to allow Dr. Dietz to examine Dr. Smith.
16 For those who cling to the belief that using psychics in an investigation is helpful, the authors would recommend Nickel (1994).
17 Dr. Pistorius is discussed in more length and context in the Preface to the Third Edition.
Dr. Pistorius is an “investigative psychologist” who, having studied IP under Dr. David Canter, worked for the South African Police Service for six years (Pistorius, 2005). In discussing whether profiling is an art or a science, she makes the following claims (p. 10):

- A “vibe” is a vibration of energy. Quantum physics teaches us that all matter vibrates, even thoughts vibrate, creating an energy field.
- Everyone has the ability to respond to energy fields in this way, but some people have a greater sensitivity than others.
- Crime scenes are laden with the residual energy fields of the killers and the victims and the acts that were committed there.
- Over time a profiler can develop a sixth sense to tune into this vibration of energy.
- Delta brainwaves are responsible for our instincts.

Keep in mind that Dr. Pistorius is arguably the preeminent profiler (at least by reputation) in South Africa. She continues (p. 11):

- My delta brainwaves were highly activated when I was working on a crime scene and this allowed me to tune into the “vibes” of the killer.
- We all have these brainwaves, but my delta brainwaves are apparently more active than average
- [M]y ability to “pick up the vibes of the killer” is not mumbo-jumbo (which is something I have been accused of); there is a scientific explanation for it.
- I could “feel” when they were killing and describe the crime scene to the detectives as if I were looking through the killers’ eyes, even though I might have been hundreds of kilometers away at the time of the killing.

It is difficult to read her work and wonder how anyone in her right mind would let Dr. Pistorius near a crime scene or be part of an investigation. Yet it happens. These quotes are no different from the commentary one might expect from a professed psychic.

**FORENSIC PSYCHOLOGISTS AND PSYCHIATRISTS AS PROFILERS**

Criminal profiling, as practiced by many, is more art than science. It is clearly a collection of proficiencies, with few practitioners engaged in criminal profiling full time. It is best considered one aspect of the practice of a well-rounded individual.

A significant aspect of criminal profiling is knowledge of human behavior and skill in interpreting its meaning, yet most profilers have no formal background or education in the behavioral sciences. In fact, law enforcement often looks askance at including a psychologist or a psychiatrist in an investigation, delegating their involvement as the second-to-last resort, with psychics generally occupying the last-resort niche.

Forensic psychologists and psychiatrists have a unique understanding and training in mental processes, physiology, thinking, human behavior, and psychopathology. Because of this, forensic mental health professionals can be well positioned to acquire further education related to investigations and the forensic sciences, which would allow them to review available evidence and offer an informed assessment (i.e., criminal profile) of the kind of individual who may have committed a particular criminal

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18 The remainder of this chapter is adapted, in part, from McGrath (2000).
act. It is incumbent upon them, as well as on all professionals, not to overreach or to go further than the evidence allows.

The behaviorally trained profiler may offer investigative advice, including proactive strategies and sometimes interviewing strategies in the event the offender is caught, although unless the strategies are carefully formulated, in some circumstances this last role may contravene professional ethics. The behaviorally trained profiler may also be utilized at the trial level to inform legal strategy. To competently profile, a forensic psychiatrist or psychologist needs to ensure that he or she has had adequate experience evaluating criminal offenders, so as to gain applied knowledge of antisocial individuals, especially those who fall into the category of sexual deviancy and sex offenders. Psychologists and psychiatrists may have much to offer when they are careful to limit investigative input to supportable opinions and to avoid mere speculation, with investigatively relevant insights being the goal of consultation, not the compilation of psychodynamically interesting, but ultimately useless, conjecture. Forensic psychiatry and forensic psychology share several characteristics with offender profiling, as discussed next.

Practice Is an Art

Forensic psychiatry and forensic psychology and profiling can be thought of as being based on scientific principles, but the actual application of one’s skill, education, training, and experience to a specific case is an art. When evaluating a person in a forensic setting, the psychologist or psychiatrist relies on the science of the field (diagnostic criteria, theories of behavior, etc.). The application of that scientific base is dependent on the skill of the practitioner; in turn, the skill of the practitioner is dependent on the person’s education, training, and experience. It should be no different with a criminal profiler. While accepting that the practice of a field may be an art, reliance on one’s experiential knowledge in the absence of a scientific mindset or approach opens the door to error. For example, it was not that long ago that we were taught that the Sun revolved around the Earth or that there was an “organized/disorganized” dichotomy that was helpful in determining the characteristics of serial killers.

Need for Critical Thinking

Critical thinking skills are extremely important for the three fields. One must be willing to question every aspect of a case. The profiler must not simply review reports or information for inclusion in his or her profile but should critically review the data, ensuring that results or inferences are reasonable and supported by the evidence. One cannot assume the facts of a case. One should be willing to question the supplied “facts” and evidence as necessary. If the profiler asks an investigator if the victim had a significant other (SO) and the response is that the SO was already considered and has been “cleared,” the profiler should ask on what basis and assess to his or her own satisfaction if the SO is in the clear. If the investigator is troubled by this approach, the authors would suggest they do not want the services of a qualified profiler. Incredibly, FBI profilers doing an equivocal death analysis in the USS Iowa explosion stated to a congressional committee looking into the botched investigation that it was not their practice to critically examine information supplied to them by others.

19 The reader is referred to Thompson (1999). This book shows how institutional bias and a lack of critical thinking, as well as an unwillingness to question the validity of evidence, led to erroneous conclusions.

20 This is what others would call a psychological autopsy. Since those performing the “autopsy” did not have a psychological background, it would be necessary to change the name ascribed to what they were doing.
“Whenever we are requested to do a case for an investigative agency, we make the assumption that we are dealing with professionals. They provide us with materials for review, and that’s what we review” (The USS Iowa, 1990, pp. 25–28).

**Independent Analysis**

The profiler/psychiatrist/psychologist should (ideally) work in concert with, but independent of, the agency that engaged him or her. Subtle pressure to find what the client wants needs to be scrupulously resisted. The results of not adhering to this should be obvious. A tragic example of in-house pressure was the Branch Davidian standoff in Waco, Texas. In that scenario, an FBI profiler was pressured to change his assessment of how David Koresh would respond to various siege tactics. The profiler recommended negotiating with Koresh, while supervisors favored “tactical pressure” on the compound (U.S. Department of Justice, 1993). After being advised that his memos cautioning against an aggressive approach were “tying their hands,” he wrote another memo supporting a more aggressive strategy. This memo was part of the argument to utilize a gas attack on the compound, an attack that resulted in significant loss of life (Freedman, 1995).

**Review of All Available Data**

Clearly, having access to all available data will make for a more informed opinion. Just as the forensic psychiatrist or psychologist will want to review all available records and interview the defendant in a criminal case before forming an opinion, the profiler will want to visit the crime scene (if possible) and review all available data related to victimology and forensic evidence.

If this is not possible for any reason, the omission and the reasons for it should be clearly elucidated in the report. All parties involved should be clearly informed about what was done, what was not done, and why.

**Reliance on the Facts of a Particular Case or Cases**

Just as a forensic psychologist/psychiatrist should not form an opinion based solely on his or her experience, the profiler needs to be careful to make inferences from the data in the case at hand. A forensic psychiatrist or psychologist would not make a diagnosis based on one symptom, no matter how often he or she may have seen the symptom in a certain diagnosis. In an analogous fashion, the fact that most homicides are intraracial tells a profiler little in a specific case, unless there are other indicators relevant to race.

**Need to Avoid Advocacy**

Forensic psychiatrists, psychologists, or profilers can be advocates for their opinions but should not advocate for either side in an adversarial (legal) arena or even on the investigative level. It is not the profiler’s role to help a particular side prevail or to help a particular entity prove something. The profiler’s only duty is to render opinions consistent with the facts of a case. Subtle pressures to assume an advocacy position abound and the best defense is awareness.

**Contextual Differences**

A psychiatrist or psychologist practicing from his or her office may diagnosis a mental illness and prescribe a course of treatment. At some later date, the practitioner could be asked in court, during a lawsuit or criminal action unrelated to the treatment, what the diagnosis was. The practitioner should consider the context. If testifying as a fact witness, he or she would give the diagnosis in the medical record. If testifying
as an expert, the practitioner should reply that he or she has no forensic opinion, because the patient was never examined for the purpose of testifying in court. The evaluation of the patient would (and should) be markedly different in the two contexts, treatment versus forensic. With profiling, the profiler needs to understand the difference between rendering an investigatively helpful profile and a profile meeting a court-level threshold that imparts probative value. It is inappropriate to offer a criminal profile developed for investigative purposes in a court of law and to imply that it meets the standard of a court proceeding, unless the profile was developed to that standard initially.

**Ethical Practice**

Both profiling and forensic psychiatric or psychological practice need to be performed in an ethical manner. Practitioners in these fields need to take reasonable care that others do not misuse their work product and do not materially misrepresent their expertise. In addition, the profiler needs to understand that his or her profile cannot and should not be used to indicate the guilt of a particular individual. If asked if a specific person “fits” a profile, it is reasonable to indicate if it is so. But one should offer that “fitting” a profile is not the same as an identification. The standard is no different from the standard for a criminalist who offers an opinion that two hairs are a “match.” Not attempting to add what a “match” means from a scientific perspective\(^{21}\) is to mislead the jury.

**What Would a Forensic Psychiatrist or Psychologist Need to Competently Profile?**

A forensic psychiatrist or psychologist who would like to pursue profiling as part of his or her professional repertoire would need to have adequate experience evaluating criminal offenders to gain applied knowledge of antisocial individuals, especially those who fall into the category of sexual deviancy and sex offenders. He or she would need to gain extra knowledge in the forensic sciences and in investigative issues to be able to understand what will and what will not be helpful to the investigator in the field. The avenues one may pursue to gain such knowledge are varied, and there is no agreed-upon curriculum. A significant amount of work can be done through reading of applied texts and taking available courses online, at colleges and universities, and through professional organizations. One caveat is that the practitioner will need to use his or her critical thinking skills to weed out dubious courses or programs. Taking a one-day profiling course from someone who claims you will learn what you need to know to competently profile is likely to be unhelpful.

**Role of the Forensic Psychologist or Psychiatrist as Profiler**

A forensic psychologist or psychiatrist acting as a profiler can consult with law enforcement, prosecutors, or defense attorneys on a specific issue related to profiling or on a “cold case,” or act as part of a multidisciplinary team (profiler + investigators + forensic scientists) engaged in a current investigation. The psychiatrist/psychologist-profiler can provide investigatively relevant interpretations related to crime scene behaviors and victimology, with the key word being “relevant.” Opinion that vaginal mutilation is an unconscious attempt on the part of a murderer to get back to the womb may meet the needs of the profiler, but it is not likely to be of much help to the investigator attempting to solve the crime. In contrast, inferring (if warranted) that emasculation of a young boy in a sexual assault was an attempt to undo a homosexual act by turning the boy into a girl may save the investigators time by avoiding their concentrating on overt homosexuals as suspects.

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\(^{21}\) That is, that the hairs share similar characteristics, but one cannot state with certainty that they came from the same source.
The forensic psychiatrist/psychologist profiler can serve as a consultant to other profilers, laying claim to added expertise in the behavioral sciences, just as a profiler more proficient in the forensic sciences might entertain a question in his or her area of expertise from the psychiatrist. A forensic psychiatrist/psychologist can also educate other nonpsychiatric profilers about the psychiatric pitfalls of profiling (discussed next). Lastly, the forensic psychiatrist/psychologist can act as a researcher, using his or her knowledge of the behavioral sciences as a nexus for research in applied offender profiling, an area so far neglected by all disciplines.

**Psychological Pitfalls and the Profiler**

Whatever the educational and training background of the profiler, there are certain issues or problems that he or she must be aware of and make efforts to avoid or to minimize their effect on the work product.

**Bias**

Profilers, like all other human beings, are subject to bias, both conscious and unconscious. Whether the issue is dislike of pedophiles or men who physically abuse women, one must be on guard not to let personal biases influence a profile. The issue is not that one needs to get rid of all negative feelings but rather that one needs a mature outlook and to minimize the number of preconceived (ill-conceived?) notions one brings to a case. One can view autopsy photos of a mutilated corpse and exclaim that the perpetrator of the crime is sick, but this is not helpful to the investigation and does little to put the profiler in the mindset of the offender.

**Transference**

Transference is a psychoanalytical term for the phenomenon that occurs when a patient relates to a therapist in a manner that mimics other relationships from the patient’s past. An example is when a male patient interacts with a male therapist as if he were the patient’s father. Countertransference is the term for a similar phenomenon in reverse (i.e., the feelings that the patient evokes in the therapist). In a less formal sense, one could talk about transference in other situations, although psychiatrists and psychologists would argue the specifics. The authors suggest that it is possible for a profiler to experience transference in a case (as could anyone on the investigative or legal team). In other words, the profiler could react unconsciously to a case based on some facet that strikes him or her. This unwarranted emphasis could affect the profiler’s judgment and the direction of a resulting profile. The issue could be related to prior case material or to aspects of the profiler’s personal life. For example, a profiler could have had a bad relationship with his or her father and unconsciously assume that the offender in a case is a male when in fact no evidence exists to indicate the sex of the offender. The unconscious need is to punish the father, but this gets played out in the profiler’s work product.

**Projection**

Projection is a psychoanalytical term for ascribing to others the thoughts, feelings, or motives of oneself. For example, a man may be sexually attracted to his friend’s wife. The man then tells his friend that he had better watch his wife, as she appears to be attracted to him. It is possible (in the authors’ opinion) for a profiler to project part of his or her unconscious issues into/onto a crime scene or victimology assessment. For example: A female profiler has ambivalent feelings about motherhood. She has a teenage child who is difficult to control and she resents the child and wishes she were not responsible for her. In assessing
victimology in a case where a 12-year-old girl was abducted, the profiler focuses on some signals that the mother and the victim did not get along and pursues an avenue of case analysis unconsciously designed to prove that the mother wanted to get rid of the child victim.

All the issues mentioned (bias, transference, and projection) can only be minimized, not realistically eliminated entirely. Potential profilers are cautioned to know themselves, to keep themselves healthy both mentally and physically, and to have a life with gratification outside of profiling. Case conferencing with colleagues is often helpful in limiting bias, transference, and other issues. For the sake of clarity, these issues can never be entirely negated, but through awareness of them and their impact we can minimize their harmful effects.

The forensic psychiatrist or psychologist has much to offer the developing field of behavioral profiling. He or she can bring a technically proficient aspect of the behavioral sciences to the professional table. Some, but not all, forensic psychiatrists and psychologists will make good behavioral profilers, just as some investigators and forensic scientists, but not all, will make good profilers. If one is willing to invest the necessary extra effort to educate oneself to the basic forensic sciences and investigative issues, the field of offender profiling has much to offer the forensic psychiatrist or psychologist and much to gain from his or her expertise.

**SUMMARY**

Forensic psychology and psychiatry involve the application of the behavioral sciences to legal questions. Common psychological questions that forensic mental health professionals answer involve (1) risk for future sexual offense recidivism, (2) competency to stand trial, and (3) criminal responsibility/sanity at the time of the offense. In addition, forensic psychologists and psychiatrists, with their knowledge of human behavior, can add a unique perspective to ongoing investigations in the form of offender profiling.

Forensic psychologists and psychiatrists are specifically trained mental health professionals with set levels of education, patient contact, licensure, and certification. Not everyone who calls himself or herself a psychologist, or a forensic psychologist, in the profiling community can meet these standards. Those employing profilers should be particularly wary of those who cloak their advice with psychological garb to imply legitimacy, including so-called investigative psychologists and psychics.

Forensic psychologists and psychiatrists have a unique understanding of, and training in, mental processes, physiology, thinking, human behavior, and psychopathology. Because of this, forensic mental health professionals can be well positioned to acquire further education related to investigations and the forensic sciences, allowing them to review available evidence and to offer an informed assessment (i.e., criminal profile) of the kind of individual who may have committed a particular criminal act. However, they are also bound to operate within set ethical limits and guidelines.

**Questions**

1. What are the differences between a forensic psychologist and a forensic psychiatrist?

2. True or False: The role of the mental health professional is to get the patient to confess to involvement in a crime.

3. Give an example of projection.

4. Explain the difference between sanity and competency to stand trial, if any.

5. What is collateral information, and how is it used?
REFERENCES


